Testimony of John D Matthew, M.D.
before the
United States Senate Committee on Health, Education, Labor, and Pensions
hearing on
"Primary Care Access Reform: Community Health Centers and The National Health Service Corps"
April 30,2009

Mr. Chairman, members of the Committee, My name is John Matthew. I am a primary care physician. I have been practicing primary care medicine in rural Vermont for the past 36 years. I appreciate the opportunity to offer to you my insights and opinions concerning the crisis in primary care access and the potential that Community Health Centers and The National Health Service Corps offer to address this core challenge in our present circumstances and to any health care reform program the nation may undertake.

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Good, accessible primary care is the essential foundation of all care and for any hope of constraining the costs of health care for the nation. But primary care is, and has been for a decade or more, in precipitous decline, with some 60 million Americans now unable to find a personal physician. The causes and consequences of this situation are multiple and complex., I addressed some of these last year in the appended article "The Coming Crisis in Primary Care is Soon Upon Us", which provides some detail concerning the dynamics of this accelerating calamity.

Arresting and reversing this decline must be a matter of the highest priority. Without an adequate supply of primary care providers, located and organized to make accessible, high quality care available to all residents in all of our communities, good health care is in jeopardy. Care will not just be less and less available, it will, when accessed, be of lower quality and of much greater cost, in human and in economic terms. Without primary care the population delays care, visits emergency rooms as sources of basic care, and often uses medical sub-specialists in lieu of those trained to provide primary care.

When primary care is available, it is most costly when provided in multi-specialty settings. It is almost as expensive in the hands of Internal Medicine physicians, much less costly in Family Medicine practices, and most economical, with equal outcomes, in Community Health Centers.(Federally Qualified Health Centers or FQHCs). There are also short and long term impacts on health and on health care costs that devolve from primary care quality and availability, or the lack of these, played out in other settings and for years to come. Early intervention, preventive medicine, and risk factor control are key parts of good primary care. Those who lack access pay the price and society pays the bill.

The days of physicians setting up shop in small communities and suburbs, even if we did train a sufficient number to care for the population, are going fast, if not gone. No primary care physician has set up a private practice in Central Vermont in many years. Most physicians now are not entrepreneurs: they seek employment in which they can practice on a salary and without investing in buildings, equipment, and staff. Rural communities, suburbs, and city neighborhoods, if they are to have accessible care would do very well to have an FQHC in their area, providing an organizational structure, economies of scale, economies of scope, efficient use of providers organized in teams of physicians and mid level practitioners, integration of behavioral health services, well equipped dental units, community outreach and social services, and access to less costly prescription medications With a community board of directors in charge, the program of each FQHC can be tailored to the needs of its particular community. These services are not only for the poor, the uninsured, or the medicaid population. FQHCs provide care to all persons regardless of their inability – or ability – to pay. We do not discriminate against the insured or better off in our population. We take pride in providing care as good as or better than that which insured persons might find anywhere else to everyone, whatever their insurance status.

Just as all politics is local, so is all health care, whether in an exam room or in the community. Every community is different in some way. We need flexible, locally controlled institutions such as FQHCs to organize and operate the structures which can tailor their programs to meet local needs. These established agencies can then better attract professionals to provide the primary health services -- medical, dental, mental health, and medications -- needed in every community, rural or otherwise. FQHCs are the prototypical patient centered medical homes, committed to patient participation in their care and viewing health care as far more than a series of episodic or periodic office visits. Informing and empowering people are key concepts of the community health center movement.

Our organization's evolution and the value of our becoming a Federally Qualified Health Center to the people whom we serve is illustrative. At the start we established The Health Center as a non profit corporation, which employs the staff and owns the practice. We have always had a board of directors made up of community members and it has always been our mission to provide care for everyone from our area who wants to come to the center, whatever their insurance status. We functioned for years as a freestanding Rural Health Clinic (RHC). The RHC caps for cost based reimbursement were always too low. We lost money on every Medicare and Medicaid office visit and it was a struggle to keep the organization afloat, though we always did. Our sliding scale was self funded, in the sense that we had no outside monies to support the un-reimbursed care we provided for the less fortunate. We had to know where every nickel was and to scrimp and save all we could to pay our staff and operating costs and still break even at each year's end. We were always constrained by very tight finances. But for a very dedicated core staff putting in extraordinary hours, we might well have foundered and folded up shop. We did good work, but in a very crowded facility, and our margin was far too tight for comfort. I spent as many sleepless nights concerned about our finances as I did up admitting patients to the hospital and taking after hours calls

When we became an FQHC --- after once having our application receive a grade of "95" but not be funded --- higher reimbursement caps provided more income than we had received as an RHC for the very same work. We reduced our losses on Medicare visits, though the caps still cause us to receive less than our costs, and were able to recoup our costs for Medicaid visits. Our 330 grant has allowed us to have community resources persons on staff, to expand the hours of our operations manager to coordinate fund raising for and construction of an expanded facility, to have the luxury of time free for program development, and to expand the number of uninsured persons we serve on sliding scale, We are enabled to provide not just one-on-one care in a series of office calls and hospital visits, but also to innovate, to collaborate, and to reach out to our community and to other agencies and local systems that compliment the provision of these services.

In the past two calender years our active patient population has increased from 7800 persons to 9400 persons. By this Fall our staff will have grown from 34 full time and 19 part time employees to 47 full time and 30 part time staff members. We are consolidating our fiscal position and are poised to do more, with more medical, dental, and behavioral health patients and more persons accessing our 340b pharmacy program, all with sliding scale discounts for uninsured persons with incomes below 200% of the federally determined level of poverty.

We are expanding our medical and our dental staff to meet the the unmet medical and dental needs in the area. All of the local medical practices, other than The Health Center, have been closed to new patients for most of the past few years. And no local dental practice accepts medicaid patients except on a very limited basis.. Our medical practice has about 45% medicare and medicaid patients. Our dental practice does 65% or more of total

work for medicaid patients. There is a region wide need for more dental care for medicaid and uninsured patients

To accommodate the unmet need, we will add a physician and a physicians assistant this summer. We anticipate taking care of about 1200 to 1800 more medical patients with this summer's staff additions, with eventual growth to 12,000 patients, or twenty percent of the county population as we find another physician and another PA or nurse practitioner.

We have moved from five to nine dental chairs and are now going to add four more.. We are expanding our in house dental program and cooperating with other FQHCs in an innovative mobile dental program for rural kids and youth. Adding two dentists this Fall and another in December will allow our staffing the dental care mobile in six locations around the state and will allow our caring for about 2000 more patients in the dental service of the center.

Our "mental health" staff, with added counseling, PTSD treatment, behavioral neurology, rehabilitation, and onsite psychiatric skills is growing to meet a large unmet need. We have teamed with other FQHCs to set up a tele-psychiatry link for consultations with the University of Vermont child and adolescent psychiatrists.. We have submitted a request for a Change of Scope to allow our contracting for child and adolescent, general, and geriactric psychiatric consultations for our medicaid and uninsured patients who otherwise have substantial problems receiving this care.

We have been able to bring 340b pharmacy services to our patients in a collaborative effort with four other FQHCs, including an automated dispensing unit – effectively a branch of the pharmacy -- in our center.

We have brought two staff members on to expand our outreach and case management efforts. We are taking on more medical students for teaching in the practice, improving continuing education for our professionals, and strengthening our community health education efforts.

This fall we will, through a cooperative agreement with the local transportation agency, start to offer transportation to patients who do not have reliable private transportation.. We are already open 60 hours a week. We will add another evening medical clinic and more evening dental hours this Fall.

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It is an enormous relief as head of the agency to be on a more solid financial footing and to have more adequate support staff in the business and operations components of the center, necessary to our addressing the needs of those whom we serve.

It is an equal relief as a physician to be able to provide more sliding scale and nominal charge care for the unfortunate, downtrodden, and marginallized – and now for the newly unemployed and uninsured who are suffering in the current great recession. We wish that we could provide a sliding scale fee schedule to persons or families with incomes under 300% of FLP, as we did when we were a Rural Health Clinic.

It is heartening to be able to expand our dental program. We have become the defacto dental practice for those seen in our local emergency room with dental pain. We draw dental patients from a large geographic region. This includes many persons who have medicaid dental coverage but no other practice which will see them. We have always understood dental care to be an integral part of the promise of good heath care. To be able to deliver on

this promise is very heartening.

We have always been very comfortable and capable, nearly unique amongst practices in our region, caring for behavioral heath problems in our practice, but we have always recognized the need for other skills in this domain. We are very pleased to have been able to offer more services on site, where they are more accessible and affordable for our patients..

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And it is a very substantial benefit to providers and patients alike to have access to more affordable medications through the collaborative 340b program. For some patients the postal delivery of these medications is about as helpful as the lower prices, since getting to the drug store, often several times a month due to PBM restrictions, and waiting for overworked pharmacists has been a burden and a barrier that we did not recognize before we had the 340b option in house and by mail.

And ,,,,,,, I am sleeping better, concerned with service delivery rather than with survival.

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Many of these improvements in our ability to address our community's needs would be impossible without our having become an FQHC. Others would only occur slowly and incrementally, because tight finances would constrain innovation and the starting of new or expanded services, despite these being badly needed by the population.

To staff the FQHCs that we envision being established across the nation, as well as other primary care settings in every corner of the country, we will need to attract a very much larger proportion of the graduates of our medical schools to work in primary care. Slowing and then reversing the trend to fewer and fewer graduates entering primary care will require a multifaceted and multi-year effort. One important step will be to relieve physicians who undertake primary care training of some of the substantial debt that they accumulate as they pursue their professional education and post graduate studies. It is telling that our community, with most practices closed to new patients and having lost three primary care doctors in the past year, has been unable to recruit replacements. The last primary care MD brought to our area by the local hospital and the new physician who will join our organization this summer are both veterans with years of practice. experience, not the thirty year olds fresh out of residency training. These veterans will not practice forever, nor will my physician colleagues at The Health Center, nor will I, as much as we enjoy most aspects of our practice lives. The same limits apply to the very fine Physicians Assistants and nurses who work with us every day.

Expansion of the National Health Service Corps will be one mechanism to address the need to replace the nation's aging cadre of primary care medical and dental providers. Knowing that NHSC loan forgiveness or scholarships are available will help attract students to primary care. Having the NHSC professionals located in various communities will provide professional staffing for the interval of the professional's commitment. And some will remain to dedicate their professional lives to the communities which they get to know as NHSC members.

Expansion of funding for FQHCs and for the NHSC has the potential to help reverse the decline of primary care and to bring excellent, accessible care to all --- not just the poor or uninsured --- in all of our communities. This is the essence of health care reform. This is what America needs. Not just the poor or the uninsured – all of us. All Americans.

John Matthew, M.D. FACP
The Health Center
Plainfield, Vermont

Summary

John Matthew, M.D. April 30, 2009

Good, accessible primary care is the essential foundation of all health care and for any hope of constraining the costs of health care for the nation. But primary care is, and has been for a decade or more, in precipitous decline, with some 60 million Americans now unable to find a personal physician. Arresting and reversing this decline must be a matter of the highest priority.

When primary care is available, it is most costly when provided in multi-specialty settings. It is almost as expensive in the hands of Internal Medicine physicians, and it is much less costly in Family Medicine practices. But care is most economical, with equal outcomes, in Community Health Centers.(Federally Qualified Health Centers or FQHCs).

When care is unavailable, those who lack access pay the price and society pays the bill.

Rural communities, suburbs, and city neighborhoods, to have accessible care for all, need to have an FQHC in their area. These services are not only for the poor, the uninsured, or the medicaid population. FQHCs provide care to all persons regardless of their inability – or ability – to pay. We do not discriminate against those who are insured or economically better off.

We do “Health Care the Way it Ought to Be” every day, for everyone.

Our organization, The Health Center in Plainfield, Vermont, functioned for years as a freestanding nonprofit Rural Health Clinic. it was a struggle to keep the organization afloat, We had to scrimp and save all we could to break even at each year’s end. We were always restrained by very tight finances.

Since becoming an FQHC two years ago, we have been able to expand the number of uninsured persons we serve on sliding scale and our active patient population has increased from 7800 persons to 9400 persons. By this Fall our staff will have grown from 34 full time and 19 part time employees to 47 full time and 30 part time staff members. We are consolidating our fiscal position and are poised to do much more, with more medical, dental, and behavioral health patients and more persons accessing our 340b pharmacy program, all with sliding scale discounts for uninsured persons with incomes below 200% of the federally determined level of poverty.

To accommodate the unmet need, we will add a physician and a physicians assistant this summer. We anticipate taking care of about 1200 to 1800 more medical patients with this summer’s staff additions, with eventual growth to 12,000 patients, Adding two dentists this Fall and another in December will allow our staffing a dental care mobile in six locations around the state and will allow our caring for about 2000 more patients in the dental service of the center. We will also see substantial growth in our behavioral health and 340b pharmacy services.

It is an enormous relief as head of the agency to be on a more solid financial footing. And as a physician it is extremely gratifying to be able to provide a broader scope of services and care to all our patients and to offer more sliding scale and nominal charge care for the unfortunate, the downtrodden, and the marginallized – and

now for the newly unemployed and uninsured who are suffering in the current great recession.

Many of these improvements in our ability to address our community's needs would be impossible without our having become an FQHC. Others would only occur slowly and incrementally, because tight finances would constrain innovation and the starting of new or expanded services, despite these being badly needed by the population.

Expansion of funding for FQHCs and for the NHSC has the potential to help reverse the decline of primary care and to bring excellent, accessible care to all --- in all of our communities.

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This is what America needs.
Not just for the poor or the uninsured – but for all of us.
Health Care for All

The Coming Crisis in Primary Care is Soon Upon Us

John Matthew, MD

Vermonters were pleased recently to have been told we live in the healthiest state in the nation. The state launched the new Catamount health plan, an ambitious effort to reduce the number of persons without health insurance in the state. The UVM School of Medicine was rated very highly for its education of primary care physicians. The past two years have seen the expansion in Vermont of Federally Qualified Health Centers chartered to serve all persons in their geographic area, regardless of their ability to pay.

But these recognitions, innovations, ratings, and successes have occurred in circumstances that, beneath the radar of most of the public and many policy makers, threaten to undermine our collective efforts to make health care available to all, especially in rural areas. In fact, the very structure of our health care system, if it should be called a system, is threatened by the coming collapse of primary care, which is the foundation of quality and any hope of economy in this realm.

There is a substantial and worsening lack of physicians and dentists to work in primary care nationwide, with rural areas suffering disproportionate shortages. While our need for these essential professionals is projected to grow by as much as forty percent in the coming decade, the number of medical students moving on to primary care residencies after graduation has fallen by about fifty percent in the last ten or twelve years. Our cadre of primary care providers, both medical and dental, is aging and not being replaced. If this trend continues – and it appears to be accelerating – we will find ourselves in a circumstance with 50% of our present supply trying to provide care for 140% of our present demand. This may understate the problem, since the aging population, in little more than twenty years, will need about seven times the present number of geriatric physicians, a group already available at half of current need.

About half of the estimated fifty-six million Americans who now have no primary care doctor have health insurance but still can find no source of primary care. We are already seeing many practices in Vermont closed to new patients and the professionals working longer hours to take care of those enrolled in their practices. In Vermont, and across the nation, increasing numbers of patients are being seen and experiencing worsening delays in our emergency rooms. This trend has been aggravated in other states by the closure of many ERs by for-profit hospitals which have discovered that these services lose money, particularly as they attract the uninsured and the down and out. The care that people without a regular source of primary care receive, if they do receive care, is almost certain to be much more costly, in both the short and the longer run, in financial and in human terms.

Primary care is one of the most challenging disciplines in medicine, requiring broad scientific knowledge and exceptional interpersonal "soft" skills. It is also one of the most rewarding, involving long-term relationships with individuals and families which many other specialties do not offer. It is also the most cost effective component of our system. But primary care is in trouble.

Many primary care physicians, feeling under appreciated and under reimbursed compared to their professional colleagues in other fields, report diminished satisfaction with their professional work. After working more and more un-reimbursed hours contending with Medicare pharmacy program companies and an unending stream of prior approval forms, changing formularies, and barriers to care, some are getting out of practice. They are not recommending similar careers to their children or others, and increasingly report feeling undervalued, overworked, and taken for granted.

There are many disincentives to choosing primary care that devolve from our medical education system, including what sort of person is chosen to be admitted to medical school, how they are influenced by the role models and practice organizations in academic medical centers, and the great costs they confront to get through college, medical school, and residency training before starting practice. Medical students graduate with substantial debt after four years of college and four of medical school, so they are apt to opt for specialties that provide higher incomes after residency training. For the same time in training and no less work, primary care incomes are often half or a third of what other specialists earn.

We not only have half as many graduating doctors choosing primary care post-graduate training but also find that half of the new residents in family medicine programs are graduates of foreign medical schools, half of whom are foreign nationals. We do not seem to be able to manage to attract and educate enough of our own bright young people to take care of our own population.

Unlike attorneys, physicians can not bill for telephone work or most paperwork, so roughly 35% of the regular working hours of primary care physicians are not reimbursed. The average family physician, prior to the extra hours demanded by managed care and pharmacy benefits management companies, worked a 54 hour week, not including the hours on call with a beeper on their belt or a phone on the bedside table. More and more "free" work is the result of companies, often for profit companies, requiring physicians and their staff to complete forms, answer questionnaires, or make telephone calls to justify their decisions in order to have their patients receive care.

The private physicians still attempting to survive in unsubsidized situations are trying to make ends meet with increasing numbers of persons in the expanded Medicaid program, which nickels and dimes providers at every turn. Medicaid also has its own formulary program, which adds to the difficulty of caring for these patients. Quite a number of these physicians are limiting or ceasing enrollment of Medicaid patents in their practices, because of the poor reimbursement.

One of the great ironies of our present circumstance is that state government, the state colleges, and some of our leading and more successful companies reduce their operating costs by insuring with Cigna, which, when patient management fees are taken into account, pays primary care providers in the fee for service sector less than Medicaid pays. The state and some employers often appear to be surprised and even mystified by the shrinking supply of doctors for their beneficiaries and employees, but some simple accounting would solve the mystery. (It's the reimbursement, stupid)

The public, where primary care is still available, seems unaware of the accelerating crisis in access that faces all of our citizens. If they knew the true situation, there might be a clamor for solutions, but any of these, when adopted, will take years to change the supply of doctors for the population. Things are virtually certain to get much worse before getting better, if that is going to happen. The primary care system, with dwindling numbers of providers contending with increasing patient loads and expanding mandates, dictates, expectations, and demands, including those of such laudable quality initiatives as the Vermont Blue Print for Health, is much closer to breaking down than most people realize.

Those leading the march to health care reform run the risk of turning around to discover that there are no primary care physicians and dentists behind them in the parade. Those who do continue in the work – some would say the calling – of taking care of the sick will all be entirely too busy with patients who are aging and have more complex illnesses, while trying to get pharmaceuticals and tests approved by companies which increase their profits – or non-profit insurers which must try to compete with those companies – by

reducing access to care.

Also missing from the parade will be the numerous Physician's Assistants and Nurse Practitioners who are essential and capable components in our primary care efforts. They too will be overwhelmed as more and more need confronts our shrinking numbers, physicians and "physician extenders" alike.

There will be increasing numbers of foreign medical graduates filling out the ranks of America's primary care providers, but leaving their native lands with even less care in a global brain drain to the more affluent United States. Hospitals will increasingly employ primary care providers, subsidizing their practices by shifting income from imaging and surgery services to attract and retain primary care doctors, whose value is not as obvious until they are not available in their communities.

President Bush may be proven to have been inadvertently prescient when he stated recently that all Americans have access to health care because they can go to the emergency room. More and more, this will be the health care entry point of necessity: crowded, expensive, and poorly suited to attend to the tasks of primary care. It is a chaotic and worrisome picture to contemplate.