



January 7, 2019

Wayne A. Smith
President & CEO

**Delaware Healthcare Association
Primary Care Collaborative Submission for Final Report**

Dear Senator Townsend, Representative Bentz, and Dr. Fan:

*Alfred I. duPont Hospital
for Children*
Roy Proutjansky, MD,
Chief Executive of
Nemours Delaware
Valley Operations

Thank you for the opportunity to comment on the draft report (the “Report”) of the Primary Care Collaborative that was circulated for stakeholder input late last week. I respectfully submit this comment letter on behalf of the members of the Delaware Healthcare Association (“DHA”).

Bayhealth
Terry Murphy,
President & CEO

As DHA noted in last year’s legislative debates about the primary care legislation, we agree that a robust system of primary care is the lynchpin of a high value health care delivery system for the neighbors we serve. Access to primary care increases health and saves money.

Beebe Healthcare
Jeffrey M. Fried
President & CEO

*Christiana Care Health
System*
Janice E. Nevin, M.D.
MPH
President & CEO

A core mission of the hospital and health systems that serve all of Delaware is the maintenance of a robust primary care network in service of local communities. Delaware health systems are the backstop to ensuring primary care exists for those we serve. Delaware health systems invest significant resources to recruit, maintain and support primary care service providers that in many cases would not exist in certain locals absent health system support. As we also noted in last year’s discussions about the proposed primary care legislation, our emergency rooms are the health care setting of last resort for patients whose physicians have retired or converted to concierge practices. DHA members are investing heavily in primary care infrastructure to alleviate the current shortages.

Nanticoke Health Services
Steven A. Rose, RN, MN
President & CEO

St. Francis Healthcare
Daniel Sinnott
President & CEO

*Delaware Healthcare
Association*
Wayne A. Smith
President & CEO

The availability of primary care is a national issue and has national causes. Local influences in Delaware also contribute to the current environment. These local influences are important, but one cannot ignore major factors such as the rise of specialists and subspecialists to address ever more complex and sophisticated treatment and the low number of new primary care physicians being trained. To the extent the presentations to the Collaborative addressed causes, there was little focus on national trends. Also unexplored during this process were ways in which primary care is being delivered beyond traditional avenues such as via virtual visits, walk-in clinics, and the growing utilization of telemedicine in the continuum of care.

A significant assumption of this report is that the Delaware issue with primary care providers is a direct result of how primary care physicians are paid here. This is held out as the sole cause of the decreasing number of physicians in Delaware. Based on direct experience with the recruitment and deployment of primary care providers, Delaware hospitals and health systems and other recruiters know that the issues with primary care acquisition and supply

are multi-faceted, and, as described above, national as well as local in nature.

There is no exploration in this Report of why we have a smaller percentage of healthcare spending going to primary care other than reimbursement. Questions such as, *Is the actual pay of Delaware primary care physician's less than the national or regional average?*, and, *Are the rates paid by Medicaid and commercial less here than other similar locations?*, would be important to answer before contemplating action. An assessment of the success or failure of the significant SIM grant monies used to support primary care transformation “for over 100 practices” would also be important as well as regulatory, reimbursement, and training barriers that have hindered broader deployment of advance practice registered nurses and physician assistants as seen in other states.

Data collection and assessment were not a part of this process. While the opinions and qualitative observations provided by those who presented at the Collaborative's meetings are certainly important inputs in framing the issue, an examination of local and national data regarding primary care acquisition, deployment and maintenance was largely absent from the proceedings. Understanding of the scope of the problem and the opportunities available for action would be significantly increased were quantitative assessment and analysis undertaken.

While we fully agree that a well-resourced primary care system is critical for a high-value health care delivery system in Delaware, DHA members are very concerned about the nature of the recommendations outlined in the draft Report. Our concerns are briefly outlined below, and we look forward to further opportunities to provide input and feedback on these recommendations.

(1) A hospital cost cap will ultimately reduce access to health care for Delawareans.

Our fundamental concern is that imposing a cap on hospital rates in order to fund higher insurance payments to primary care providers will ultimately *reduce* access to health care services for Delawareans—including primary care services.

The proposal to cap hospital rates is precisely the type of cost cap that was soundly rejected in the 2017 Congressional proposals to “Repeal and Replace” the Affordable Care Act with a Medicaid system that imposed per-capita caps on the cost of health care services for Medicaid beneficiaries. A cost cap is a blunt instrument that fails to account for significant structural issues in the health care system at the federal and individual state levels. For example, Delaware is one of only three states that CMS has classified as “all-urban” (meaning there are no small, rural hospitals as federally defined), accounting for the fact that Delaware health systems are competing for physicians, nurses and other health care delivery professionals with large health system employers in neighboring cities and states (including Philadelphia and Baltimore).

Hospitals lose millions of dollars annually in recruiting and then supporting primary care providers for those networks that are the access point for many underserved Delawareans. Delawareans who would otherwise have very limited primary care options they could easily or affordably access. A cap on hospital rates would reduce the money needed to underwrite the losses incurred by our non-profit hospitals in ensuring primary care where it otherwise would not exist.

(2) The recommendations outlined in the Report reflect the need for additional data and stakeholder input.

At the outset, and with no disrespect to the considerable time and effort expended by the Collaborative Co-Chairs, the Primary Care Collaborative was structured in a way that limited the opportunities to work toward sustainable systemic solutions. No work groups of stakeholders met collaboratively to discuss ways to better ensure access to primary care. Sessions were a series of discrete meetings where stakeholders (physicians, nurse practitioners, hospitals, insurers) singularly described the primary care environment as they saw it and put forth to a greater or lesser degree suggestions to address concerns with the existing system. These meetings were augmented by a few outside presenters who shared experiences from other states – states with very different health environments than found in Delaware.

What was missing, perhaps in large part due to the very compressed time window required by SB 227 for initial recommendations, was the collaborative back and forth that is the important feature of stakeholder member task forces. Dialogues among stakeholders are the best way to identify common approaches that might actually address the issue and avoid unintended consequences.

In addition, and as further outlined below, SB 227 contemplated that data from the Delaware Health Care Claims Database (HCCD) would inform the dialogue and discussions about the primary care delivery system in Delaware, including providing the baseline data about primary care spending that has been conspicuously absent in the State’s ongoing policy discussions.

(3) Imposing an arbitrary cost cap on hospital and health care services will undermine the State’s goals to move to value-based payment in health care delivery.

Senate Bill 227 – the law that produced this Primary Care Collaborative also directed the Delaware Health Care Commission to take the opportunity to measure and facilitate reaching a goal of having at least 60% of Delawareans attributed to meaningful value-based payment models by 2021. Value Based Contracting is the national trend and practice in changing a broken fee-for service payment system to one that incentivizes high quality and economy in delivery of health care. It also incentivizes a robust primary care component in order to treat on the front end those ailments that grow ever costlier if left alone. However, Value Based Contracting requires a playing field where insurers and providers can negotiate freely toward sustainable value based contracting models. Artificially set or capped rates by the state would destroy the environment in which productive value-based negotiations could take place and severely limit the ability of one or both sides in the negotiations to arrive at mutually agreeable and sustainable Value Based payment models.

This report contradicts the Administration’s Benchmark assertions and statements that a Benchmark is not a cap on spending. Secretary Kara Walker emphatically and repeatedly made this point during last spring’s Advisory Panel meetings on the Benchmark in her “Myth Busters” document.

This report also advocates changes in payment and mandates that were laid on the table during the legislative process that produced SB 227. Critical parts of SB 227 have a three-year duration. This three-year period will only be eight days old at the release of this report. The Health Care Commission has yet to even begin the measurement process of accretion in the market toward the 2021 goal of 60% coverage of patient lives by value-based contracts.

Clearly this report is an opinion document by a small group of governmental officials and not the product of a stakeholder process. The unintended consequences of the report's recommendations risk lessening the provision of primary care services in areas where it is hard to attract physicians and nurse practitioners without hospitals underwriting losses in primary care. The recommendations run counter to the Administration's stated position that the Benchmark is not rate setting or rate capping. This report also would severely distort the effort undertaken in SB 227 to drive greater support for primary care by encouraging a significant increase in patient lives covered by value-based contracts.

SUGGESTED PATH FORWARD.

The best opportunity to identify the scope of the primary care issue, contributing factors, and workable action plans would be to include stakeholders and those with experience and expertise in a discussion and search for recommendations. The issue of primary care support is complex and multi-faceted, and it is a subset of the complex and multi-faceted issues relating to health care delivery in a system defined by high value.

We propose the convening of a stakeholder and experience work group that would include providers, payers (commercial and governmental), and the public. This group would undertake a systematic examination of the issue and work towards recommendations that can move towards the goal of serving a robust primary care system for all Delawareans with a minimum of disruptive and unintentional consequences.

All who read this report will recognize such a suggested workgroup as the time-honored path toward meaningful and effective change in Delaware. It should be deployed in pursuit of the objective of maintaining a robust system of primary care for the health of those we serve.

Sincerely,



Wayne A. Smith
President and CEO

