PRIMARY CARE REFORM COLLABORATIVE REPORT 2024

Table of Contents

Letter from the Chair 2
Executive Summary 4
Introduction 6
Purpose and History of the Primary Care Reform Collaborative 6
- Legislative History 6
- Development of Current PCRC Priorities 7

Primary Care Reform Collaborative Overview 11
- PCRC Strategic Priority Setting 11
- Workgroup Overview and Goals 12
- Summary of 2024 Workgroups 13
  - Value-Based Care 13
  - Quality Metrics 15
  - Practice Model 16
  - Communications 18
- Highlights of 2024 PCRC Activities 18

Collaboration with the Office of Value-Based Health Care Delivery 20
- Additional Collaborative Efforts with OVBHCD 22

Delaware Enhanced Primary Care Model 22
- Overview and Background 22
- Additional Hybrid Model Components 25
  - Standard Quality Investment 25
  - Continual Quality Investment 26
  - National Scan 26
  - Recommendations 27

Conclusions and Next Steps 28
Appendices 29
- Appendix A. National Academy of Science and Engineering Medicine (NASEM) Survey Results 29
- Appendix B. Strategic Priority Environmental Scan Overview 30
- Appendix C. PCRC Workgroup Members 32
- Appendix D. PCRC Meeting Minutes – 2024 33
- Appendix E. Enhanced Primary Care Model - Quality Measure Descriptions 34

Letter from the Chair

DELAWARE GENERAL ASSEMBLY
STATE OF DELAWARE
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DOVER, DELAWARE 19901

When the Delaware General Assembly passed SB 227 in 2018 and established the Primary Care Reform Collaborative (PCRC), I knew it was an important and crucial first step toward supporting and expanding primary care as essential and foundational for the delivery of accessible, quality healthcare in Delaware. Ensuring that the people in our state have access to quality care has always been the mission of the Delaware Health Care Commission (DHCC), and developing meaningful policy for primary care investment has been the driving force behind the PCRC since its creation.

Though Delaware enacted a policymaking process for primary care, it was in response to a crisis in access to primary care because of a shortage of primary care providers. The state had become the actualization of what was noted in the 2021 comprehensive publication from the National Academies of Sciences, Engineering and Medicine (NASEM): "Yet, in large part, because of chronic underinvestment, primary care in the United States is dying." (Appendix A) The same publication went on to note, "High-quality primary care is the foundation of a robust health care system, and perhaps more importantly, it is the essential element improving the health of the U.S. population."

For me, NASEM translated the PCRC's mission "to support, improve and enhance sustainable access to primary care" into a vision of increasing financial investment in primary care, decreasing administrative burden, and strengthening the primary care workforce so that primary care in Delaware is not just stable, but thriving and growing and meeting the healthcare needs of all Delawareans. During this process, we have encountered many obstacles and challenges over the last six years, which have provided valuable lessons learned. Change has been slow, in stops and starts, and incremental. The fact that annual report has not been published since 2020, which reflected the work of 2019, demonstrates the far-reaching consequences of the COVID pandemic on productivity and progress, with a loss of continuity and engagement. Even the "bright light" of progress with the development of the Office of Value Based Health Care Delivery (OVBHCD) and the implementation of the primary care spending targets under SB 120 in 2021, has been dampened by the reality of how healthcare is delivered in Delaware, with an outsized effect of health plans not subject to the legislative mandate under SB120, notably the State Employees Benefits Plan, Medicaid, and large employer, self-insured health plans, otherwise known as ERISA (Employee Retirement Income Security Act) plans.

Additionally, when the Delaware PCRC was established, only two other states, Oregon and Rhode Island, had deliberative, formal policymaking processes, specifically for primary care. Now, in 2025, at least six other states have established formal primary care collaboratives or policymaking bodies to support and sustain

primary care. Some of those states have advanced more productive and impactful policies in the last six years. If Delaware is serious regarding improving its health outcomes, which are ranked in the bottom half of the 50 United States, and decreasing our healthcare costs, which are in the top 10 percent of all states, then serious work needs happen in 2025 to improve our investment in primary care.

While the PCRC stakeholder process was productive early on, it has stagnated, with passive engagement at best, over the past few years. I believe, for the future of the PCRC, there needs to be a return to in-person interaction and accountability for all stakeholders regarding their role in achieving the mission of the PCRC. There will never be a "perfect" policy, but meaningful, effective policy will need compromise from all those involved in healthcare delivery, including providers, healthcare systems, payers and the state. Examples could include:

- All payers participate in hybrid payment models, such as the Delaware Enhanced Primary Care Payment model, which the PCRC has developed
- Providers accepting downside risk for prospective payments
- Overall meaningful discussion and analysis of the factors driving Delaware's high healthcare costs, such as the data provided in the annual reports of the OVBHCD since 2021, and which will be reflected in the work of the Diamond State Hospital Review Board

These difficult discussions and the continuing development of impactful policy is the real challenge I hope the PCRC is willing to meet in 2025 during in-person meetings. The NASEM publication has tangible recommendations to build comprehensive policy. As I move off as Chair of DHCC and therefore, as chair of the PCRC, I believe we have the right building blocks in place, with the current Collaborative members, workgroups and partners, such as the OVBHCD. The PCRC should continue to be the preeminent leader for primary care policy, and I hope it will continue to move forward.

Nancy Fan, MD

Nancy Fan, MD
Chair, Primary Care Reform Collaborative
Chair, Delaware Health Care Commission

Executive Summary

The Delaware Primary Care Reform Collaborative (PCRC) was established in 2018 by a legislative mandate in SB 227 to address fundamental deficiencies in the delivery of primary care services, which had resulted in a crisis in access to primary care. Primary care is foundational to a cost-efficient, sustainable healthcare delivery system that provides accessible, affordable, quality health care and achieves better health outcomes for Delawareans. Supporting primary care in these efforts has been the mission of the PCRC, and its vision has been focused primarily on payment reform as an initial but crucial step in achieving stability, sustainability, and growth of primary care services.

Throughout the last six years, the state has made incremental progress in addressing the challenges to increasing investment in primary care, specifically through three legislative mandates, SB 227, SB 116, and SB 120. The last annual PCRC report in 2020 documented the Collaborative's activities in 2019, and no further yearly summary of activities has been issued since. This report begins with a review of how these legislative mandates have been implemented, have shaped the PCRC's priorities since 2019, and summarizes the group's work since then.

The Office of Value Based Health Care Delivery (OVBHCD) was established in 2019 and has worked closely with payers to meet primary care spending targets through value-based payment (VBP) models since SB 120 was enacted in 2021. It has provided essential data collection and analysis of primary care spending and investment in Delaware and has closely collaborated with the PCRC regarding such policy. Because of the OVBHCD's efforts to increase primary care investment through VBP models, the PCRC moved forward with developing a hybrid payment model, the Delaware Enhanced Primary Care Payment Model, with seminal work on a feasible framework provided by the consultants at Mercer Government, and then expanded upon by Health Management Associates, Inc. (HMA), including a proposed prospective payment per member per month system.

Exploring initiatives that are advancing primary care reform in other states has provided valuable information on what might work in Delaware. This research and the initial PCRC efforts also incorporated extensive stakeholder engagement through three workgroups to address issues of attribution, clinical care coordination, and a standardized set of quality metrics. The lack of multi-payer alignment and PCRC consensus on the leverage for implementation, however, has halted the next steps of implementing such a payment model. These challenges remain a persistent obstacle in advancing payment reform.

To get back on track, PCRC has reformed its workgroups to include a valued-based model workgroup, a practice model workgroup, and the initially established Quality Metrics Workgroup, thereby create an opportunity to advance multi-payer alignment through a common VBP model, as well as address opportunities to expand practice transformation and decrease administrative burden for practices with a standardized set of quality metrics.

The priorities for the workgroups are the product of the PCRC's deliberate approach to developing strategic priorities, which started in 2023. HMA assisted the PCRC through a strategic planning process with

recommendations for the strategic priorities through 2025−2026. This process included discussion at the PCRC level and discussions with a broader group of stakeholders, including providers in independent practice and healthcare systems, and payers, both state and commercial plans. Though the strategic priorities guided the reformation of the workgroups, they represent broad concepts, which may be more focused as the workgroups develop specific approaches to implementation.

Stakeholder engagement has always a hallmark of the PCRC, and the various changes in the composition of the PCRC through SB 227, SB 116, and SB120, demonstrate the importance and complexity of having appropriate representation of all stakeholders who can collaborate to develop a clear, feasible vision for the future of primary care in Delaware. The National Academy of Science, Engineering, and Medicine (NASEM) issued a report summarizing results from a survey of primary care providers, which reinforced the need to have effective payment reform, with increased investment in the delivery of primary care.

The PCRC also examined in 2024 whether the Collaborative should be revised because of the stagnation in work during 2023−2024. Though the PCRC voted to keep the current membership, as the landscape of healthcare delivery in Delaware continues to evolve with new federal and state leadership, as well as initiatives that address the ongoing healthcare workforce crisis and the unsustainable increases in total healthcare spending, the PCRC will need to be open to change and adjust to achieve its mission of supporting and advancing primary care reform.

Introduction

The Primary Care Reform Collaborative (PCRC) presents its annual report for 2024—the first summary of its activities since 2020. This report provides a thorough examination of the PCRC's foundational legislative framework, organizational structure, and strategic priorities. It includes a lookback on previous annual reports, additional reports regarding primary care physicians, and information from the Office of Value Based Health Care Delivery (OVBHCD). It also provides a detailed update on the activities of the PCRC and its workgroups in 2024, highlights its collaboration with the Office of Value Based Health Care, delineates the elements of the Delaware Enhanced Primary Care model, and offers recommendations regarding the direction and work of the PCRC throughout 2025.

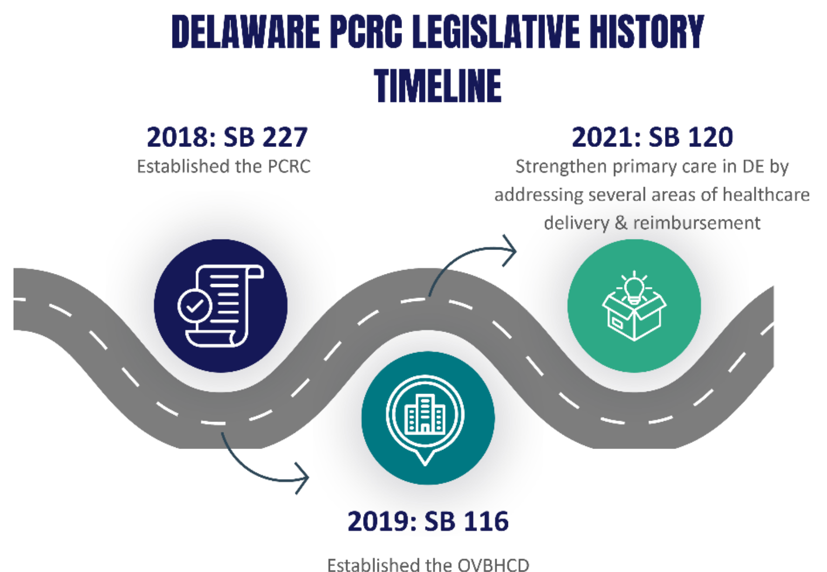
Purpose and History of the Primary Care Reform Collaborative

Legislative History

The Delaware General Assembly enacted three different statutes to reduce costs and increase access to high-quality, cost-efficient healthcare by supporting and strengthening the delivery of primary care services through payment reform.

Senate Bill 227 (SB 227) passed in 2018 and established the PCRC as a means of developing recommendations for strengthening primary care in Delaware. At that time, approximately one in four residents lived in a primary care shortage area.[1] The first PCRC report was released in 2019 and indicated that "[t]his inadequacy [was] expected to worsen as the average age of the population increases and (as) there continues to be an increasing deficit between new primary care providers coming into practice compared to the rapid increase in providers leaving or downsizing their practices." A detailed analysis of the primary care access crisis, which prompted the legislative action, can be found in the 2018 PCRC annual report.

Figure 1. Delaware PCRC Timeline



As per SB 227, the PCRC, established under the purview of the DHCC, was directed to make recommendations regarding payment reform, value-based care, workforce development, and recruitment; direct resources to support and expand primary care access; and

[1] Primary Care Reform Collaborative. Primary Care Collaborative Report 2019. Available at: https://dhss.delaware.gov/dhcc/files/collabrpt_jan2019.pdf

advance integrated care, including for women's and behavioral health (Details available at Bill Detail - Delaware General Assembly). In addition, SB 227 required all carriers to participate in the Delaware Health Care Claims Database, which operates under the authority of the Delaware Health Information Network, to ensure an accurate systemwide analysis of the current investment in primary care services. The legislation also raised the basic reimbursement rate for primary care services to 100 percent of Medicare rates.

Recognizing that all stakeholders were deeply concerned about accurate data collection and analysis, Senate Substitute 1 for SB 116 (SB 116) in 2019 created the Office of Value-Based Health Care Delivery (OVBHCD) within the Department of Insurance and expanded the PCRC's membership. Included in the mandate for the OVBHCD was the establishment of affordability standards and targets for carrier investment in primary care. (Details available at Bill Detail - Delaware General Assembly).

Senate Substitute 1 for Senate Bill 120 (SB 120) was passed in 2021 in recognition of the need to establish targets for primary care spending as a percentage of total healthcare spending. This legislation built on previous efforts to strengthen the primary care system in Delaware. Specific provisions included:

1. A directive that the Delaware Health Care Commission (DHCC) monitor compliance with value-based care delivery models and develop and monitor compliance with alternative payment methods that promote value-based care
2. A requirement that rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services to certain percentage increases over the subsequent four years
3. A mandate that insurance carriers spend a certain percentage of their total cost on primary care over the next four years (see Bill Detail - Delaware General Assembly)

SB 120 states that by 2025 at least 11.5 percent of the total cost of medical care should be directed toward primary care (see

Table *1* below). The legislation provided a five-year window for full adoption of the primary care spending targets, with 2022 considered "passive" implementation of the spending goals and full implementation by all carriers in 2026.

Table 1. Highlights of SS 1 for SB 120 and Related Regulations

Rate Filing Year	Plan Year	Minimum % Total Cost of Medical Spent on Primary Care
2022	2023	7%
2023	2024	8.5%
2024	2025	10%
2025	2-26	11.5%

Development of Current PCRC Priorities

In 2018, the PCRC established the core concepts driving its mission, which included:

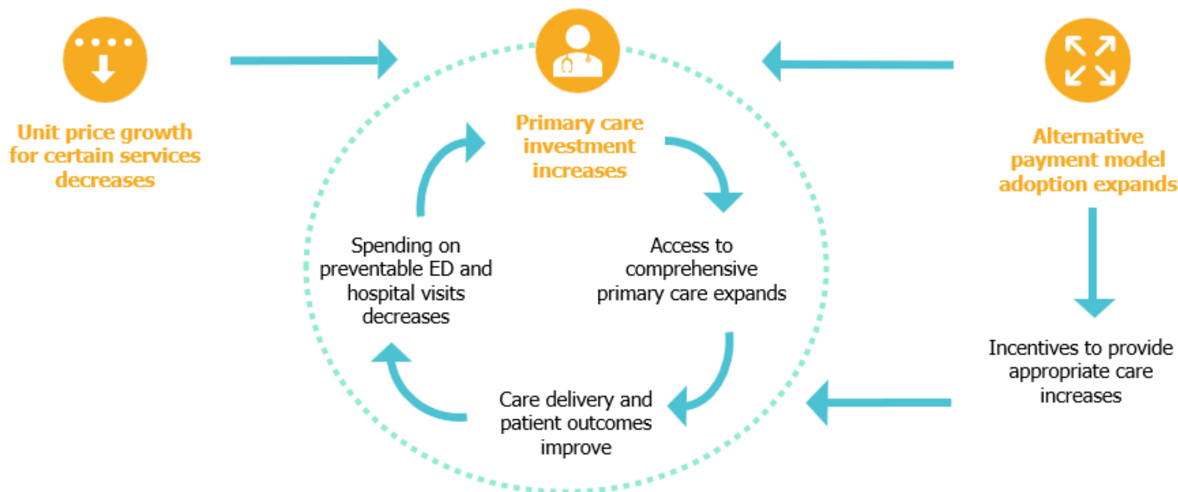
1. Ready access to quality primary care is essential for the health of the community and is the foundation for an effective health delivery system.
2. Delaware continues to have a crisis in primary care access across much of the state.
3. The low investment in primary care services in Delaware has been a primary factor in the development of this crisis.

4. The continuing lack of access to primary care contributes to the high total cost of healthcare.

The OVBHCD provided the following schematic theory of change diagram (see **Figure 2**) during its presentation at the January 2022 PCRC meeting to illustrate the overarching themes which have been foundational since the Collaborative's formation in 2018.

Figure 2. Theory of Change

Theory of Change



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As noted in the 2020 annual report (Primary Care Reform Collaborative Report 2020), SB 116 expanded the PCRC in 2019. PCRC meetings that year largely centered on extensive discussion regarding various pathways to increase investment in primary care services (the right side of the theory of change diagram). Members of the Collaborative reached the following conclusions:

1. The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should also include an upfront investment of resources to build and sustain infrastructure and capacity, including the use of health information technology, through advanced clinical practice models, such as team-based care or patient-centered medical homes, especially in cost savings structures such as accountable care organizations.
2. There should be meaningful movement toward participation in alternative payment models, whether through prospective (upfront) or retrospective payments.
3. Regardless of the type of investment, an increase in primary care spending should not increase total healthcare spending.

4. These investment measures may occur through additional legislative statute or within regulatory authority.

Immediately following the publication of the 2020 annual report, the work of the PCRC was put on a pause due to the COVID pandemic. When the PCRC reconvened in 2021, it was primarily focused on the proposed legislation, SB 120, and conducted only two formal meetings. Since the passage of SB120, the OVBHCD has provided extensive data regarding the level of investment (spending) in primary care services and the impact of the legislative mandates under SB 116 and SB 120. For example, it was noteworthy that the OVBHCD report for the January 2022 PCRC meeting demonstrated an increase to 5.5 percent to maintain Medicare payment parity. Additionally, OVBHCD analyzed the impact of SB 120 and possible systemwide savings. Since then, the OVBHCD has provided data regarding the increased level of investment, but the information is limited to the commercial carriers and their plans—which fall under Department of Insurance regulation—exclusive of Medicare, Medicaid, and large employer, self-insured health plans. What has been determined is that the number of lives covered by these health plans is lower than initially estimated, which has produced a narrow impact on the overall primary care investment as well as any cost savings.

The OVBHCD's ongoing spending data collection and analysis is crucial to formulating effective policy on primary care reform. Future legislative or regulatory actions should be directly related to this work and not just in relation to enforcement of current primary care spending targets given its narrow scope of authority. For meaningful progress and impact, the PCRC should provide specific recommendations that maintain and expand the intent and scope of SB 120. The PCRC should explore possibilities that can be leveraged for broad implementation of payment models that promote patient-centered care and support practice transformation, moving practices away from fee-for-service and toward prospective and retrospective payment models.

Recognizing that SB 120 mandated greater participation in VBP models, the concept of a Delaware Primary Care Payment Model was introduced, to the PCRC with the initial design framework based on the work of state consultants at Mercer Government. This framework called for starting with practice transformation and the need for payment models to invest in practice transformation with rewards for practices that provide accessible, quality care while reducing costs. The iterations of this model over the past two years are further documented in the following section.

Most of the PCRC's work has focused on payment reform, even more so after the publication of the 2021 NASEM report, Implementing High Quality Primary Care. In addition, the Delaware Division of Public Health published its tri-annual reports on the status of primary care physicians in Delaware in 2018 and 2021. The division's reports are based on surveys and relevant to the PCRC given that the lack of adequate reimbursement for primary care services has directly led to the outsized loss of providers and, therefore, the workforce shortage across Delaware. As a data-driven snapshot of the workforce status of primary care physicians, these studies could provide a tangential reflection on the impact of primary care reform. Though neither NASEM nor the Division of Public Health reports provide analysis and policy recommendations and are limited by the methodology of surveying licensed but not necessarily practicing physicians, the statistical analysis of active practice physicians in Delaware may be an indication of the sustainability and expansion of primary care and the impact of the various legislative measures.

In 2022, the PCRC developed an initial framework for the Primary Care Payment Model (see **Figure 3**). This framework encompassed desired parameters for quality measures, patient attribution, clinician panel size, payment to primary care practices, and payments based on patient needs and the practice's infrastructure.

Figure 3. Initial Design Framework for Primary Care Payment Model

In 2024, a serious discussion took place regarding the PCRC's composition (see **Table 2**) in light of the lack of any significant progress on primary care reform in the prior 18 months despite passage of SB 120. Ultimately the PCRC voted to maintain the current membership and to provide high level oversight of the work of the reconfigured workgroups described in the next section of this report.

Table 2. 2024 Current Composition of PCRC

PCRC Roles as Specified in Legislation	2024 Specific Representative
The Commission Chairperson also chairs the Collaborative	Dr. Nancy Fan
The Chair of the Senate Health & Social Services Committee	Sen. Bryan Townsend

The Chair of the House Health & Human Development Committee	Representative Nnamdi Chukwuocha
One member, appointed by the governor from a list of names provided by the Medical Society of Delaware	Dr. Jason Hanne-Deschaine
One member, appointed by the Governor from a list of names provided by the Delaware Nurses Association	Vacant
One member, appointed by the Governor from a list of names provided by the Delaware Healthcare Association	Dr. Rose Kakoza
Two members representing insurance carriers, appointed by the Governor	Kevin O'Hara (Highmark) Deborah Bednar (Aetna)
The Secretary, Department of Health and Social Services	Steven Costantino, proxy for Secretary Josette Manning, Esq.
The Director, Division of Medicaid and Medical Assistance	Andrew Wilson
The Insurance Commissioner, Insurance Department	Cristine Vogel, proxy for Insurance Commissioner Trinidad Navarro
The Chair, State Employee Benefits Committee	Faith Rentz
One member representing a Federally Qualified Health Center, appointed by the Governor	Maggie Norris-Bent

To accomplish the statutory objectives and requirements, the PCRC formed workgroups that proposed the concepts of two prospective payments—the Standard Quality Investment (SQI) and the Continual Quality Investment (CQI). HMA developed recommendations for SQI and CQI in accordance with SB 120 based on a national landscape scan that provided details and comparisons with similar programs in other states. These recommendations are based on the analysis and are intended to help the PCRC achieve the Delaware Enhanced Primary Care Model.

In 2024, the PCRC's efforts focused on three multi-stakeholder workgroups: Value-Based Care, Quality Measurement, and Practice Model. This report primarily highlights the work these bodies conducted during calendar year 2024, and in the next section we provide some context by summarizing the work that the workgroups accomplished during the previous two years.

Primary Care Reform Collaborative Overview

PCRC Strategic Priority Setting

HMA, a national research and consulting firm, supported the PCRC by developing an 18-month strategic plan in 2024. To establish the strategic plan, HMA and the PCRC applied the processes outlined as follows.[2]

[2] Thomas-Henkel C, Nagrath G, Sheriff N, Javadi K. DE PCRC Strategic Plan. Health Management Associates, Inc. Available at: https://dhss.delaware.gov/dhcc/files/pcrcstrategicplanrpt24.pdf.

Establish a PCRC Working Group. HMA collaborated with the DHCC Chair, Dr. Nancy Fan, to create a working group to guide the work of developing the strategic and implementation plans. The working group meets monthly to discuss milestones and next steps toward establishing overarching PCRC goals. This working group reviewed the results from the 2021 NASEM report in Appendix A.

Key takeaways from the working group's meeting included:

- The need for a more significant effort to decrease inpatient costs, which account for the highest rise in cost of care.
- The PCRC should set goals for allocating the investment in primary care.
- Expand patient-centered care to look beyond SB 120's focus.
- Delaware should find a solution that matches the policies it wants to move forward with.
- Develop three to five strategic objectives that the PCRC feels passionate about.

Environmental Scan. HMA conducted a primary care environmental scan that focused on authority and governance, primary care cost containment strategies, investments in primary care, and quality measures. The scan was conducted across seven states—Connecticut, Maryland, Massachusetts, New Jersey, Oregon, Rhode Island, and Vermont. A summary of the findings can be found in Appendix B.

Stakeholder Interviews. We interviewed 15 individuals from various backgrounds, including providers, managed care organizations (MCOs), and state officials.

Support the PCRC in developing strategic priorities and synthesizing findings to develop a strategic plan. After reviewing the findings from the NASEM survey, environmental scan, and stakeholder interviews, the PCRC Working Group created five strategic objectives. The PCRC voted on the strategic objectives, and all five recommendations were approved.

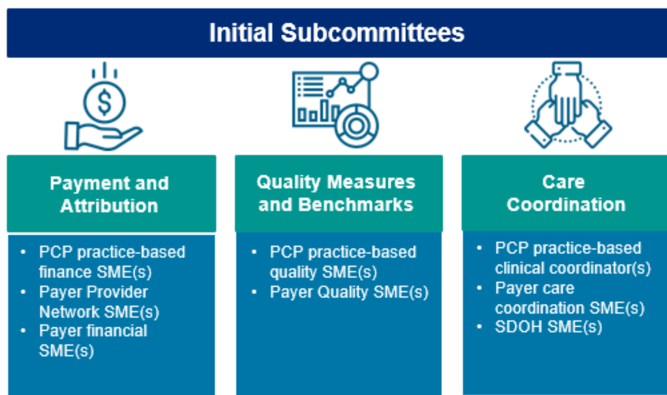
The summary recommendations of strategic priorities for the PCRC are as follows:

1. The PCRC should focus on increasing multi-payer participation and buy-in for primary care spending.
2. The PCRC should inform policies that will improve primary care investments without increasing overall healthcare costs.
3. The PCRC should promote and advocate for quality measures aligned across payers based on the highest cost of care drivers.
4. The PCRC will develop a more comprehensive communication strategy, such as an annual report, to increase transparency around the vision, goals, and progress of the PCRC.
5. The PCRC should explore a more inclusive strategy across the spectrum (i.e., employed practices, ACOs, etc.) to reflect the needs of all primary care specialties.

Workgroup Overview and Goals

The development of the Enhanced Primary Care Model (formally the Delaware Primary Care Payment Model) began in the spring of 2022 with the establishment of the following workgroups: (1) Payment and Attribution, (2) Care Coordination, and (3) Quality Metrics and Benchmarks.

Figure 4. PCRC Initial Subcommittees



The 2022 workgroups in 2022 had different priorities and goals than the current workgroups and were specific to the Delaware Primary Care Payment Model, with a focus on the development and implementation of a hybrid VBP model and addressing the issues displayed in **Figure 4**. However, as it became clear that it would be difficult at the PCRC to achieve consensus on how this model should be implemented and a lack of support to mandate, either through regulation or legislation, such a model, the PCRC pivoted to developing strategic priorities for a clearer vision and approach in advancing the Collaborative's work. This deliberative process produced several strategic priorities, and the PCRC determined that the iterative work to achieve the objectives should be conducted through workgroups, again, with the PCRC providing high level oversight and policy recommendations.

In May 2024, the PCRC collaboratively voted to reassemble four workgroups based on the strategic plan:
1. Payment and Attribution (now the value-based care model)
2. Quality Metrics and Benchmark
3. Practice Model
4. Communication

The workgroups vary in size (3−8 members depending on the group) and comprise previous as well as new representatives from the PCRC, Delaware commercial payers, primary care providers, and other relevant partners specializing in value-based care and/or model development. The list of the PCRC workgroups can be found in Appendix C.

Summary of 2024 Workgroups

Value-Based Care

The goals of the Value-Based Care Workgroup include:
- Focus on increasing multi-payer participation and alignment in Value-Based Care (VBC) initiatives
- Ensure buy-in for primary care spending and the importance of practice transformation
- Strategies to align attribution and payment models across different payers
- Develop policies that promote primary care investment and maintain or reduce overall healthcare costs

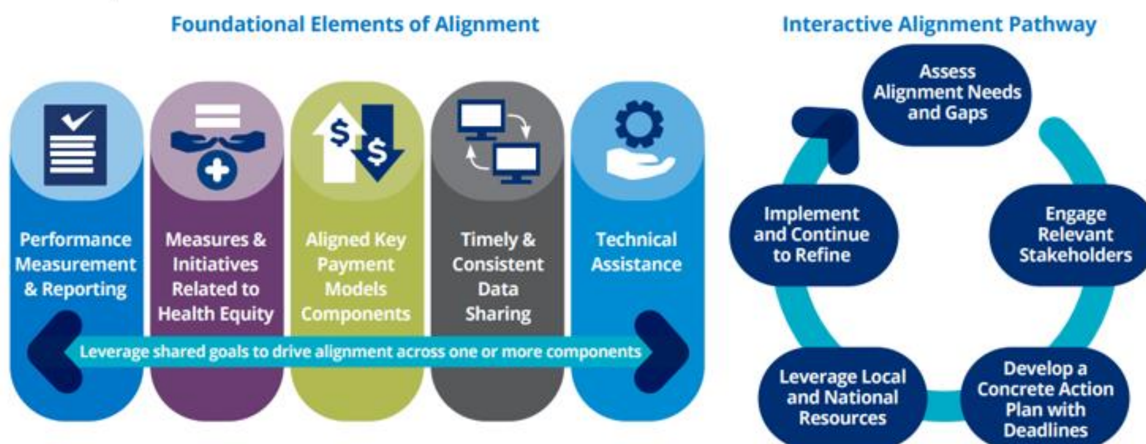
The VBC Model should emphasize and promulgate a shift from FFS to a system that prioritizes patient health outcomes and cost-efficiency. Further, it should incentivize healthcare providers to focus on quality of care rather than service volume. Workgroup priorities include:

- Increasing multi-payer participation and alignment in VBC initiatives to ensure buy-in for primary care spending
- Emphasizing the importance of investment in practice transformation, promoting strategies that align attribution and payment models across different payers and supporting sustainable practice transformation
- policies that promote primary care investments while maintaining or reducing overall healthcare costs

Provider engagement and education, challenges in data integration, outcomes, and metrics, and provider readiness and IT systems require clearly delineated resolution pathways and supports. The workgroup negotiated several challenges associated with muti-payer participation and alignment in value-based care initiatives. The fully insured market segment is relatively small (approximately 10%), and the primary care investment follows a similar path because many providers may never see a commercial, fully insured patient. Payers with low memberships are reluctant to design value-based programs. Likewise, provider practices need to focus on multiple carrier programs, and it is not prudent financially to make significant upfront investments for a few patients assigned to each payer, especially when providers struggle with multiple and conflicting program designs. Significant collaboration hurdles exist in *localizing* payer models and metrics from a primarily regional approach. Issues requiring further examination include Medicare fee-for-service (FFS) parity and regulatory challenges navigating disparate state and federal agencies.

The workgroup reviewed the Duke University Policy Think Tank on Pragmatic, Iterative, Multi-payer Alignment Framework as a methodological bedrock toward alignment, as shown in **Figure 5**.

Figure 5. Duke University Policy Think Tank on Pragmatic, Iterative, Multi-payer Alignment Framework



The workgroup aligned across four domains: Standardization, Attribution, Payment Reform, and Provider Outreach as working recommendations for ongoing discussion and adjudication.

The Standardization Approach includes:

- Standardizing member and cost attribution approaches
- Standardizing the approach to member realignment, particularly with Medicaid and other payers and practices

- Standardizing lookback timelines for realignment of patients (i.e., 12 or 18 months)
- Standardizing quality measures to minimize the number of measures and simplify the process for achieving shared savings

The Attribution Approach Includes:
- Simplifying the attribution and reconciliation process across payers
- Supporting organizations (modify attribution based on complexity) that take on complex patients, as they might face penalties "for doing the right thing"
- Emphasizing the importance of a "smooth attribution process" for practices and hospitals
- Mitigating challenges of multistate organizations and the need for clear cost attribution
- Allaying concerns about models that penalize organizations that cross state lines, leading to inaccurate healthcare expense reporting (e.g., multistate organizations that shift their "expenses," which are enterprise/organizational costs, to Delaware to demonstrate a higher cost burden)

The Payment Reform Approach Includes:
- Establishing enhanced monthly population-based payments with a glide path to reduce FFS reimbursements (e.g., the Primary Care Flex Model)
- Requiring prospective payments by carriers with requirements and expected outcomes for different practice levels (e.g., hospital system vs. community provider)
- Charging a carrier assessment/fee (primary care investment) for process improvement
- Practices to decide on a health plan with which to contract, rather than a state program such as Rhode Island and Maryland have implemented.
- Directly linking CQI payment to practices for process improvement or practice transformation and not to care management

The Provider Outreach Approach builds on the Payment Reform Approach and includes:
- Establishing enhanced monthly population-based payments with a glide path to reduce FFS reimbursements (e.g., the Primary Care Flex Model)
- Requiring prospective payments by carriers with requirements and expected outcomes for different practice levels (e.g., hospital system vs. community provider)
- Charging a carrier assessment/fee (primary care investment) for process improvement
- Practices to decide on a health plan with which to contract, rather than a state program such as Rhode Island and Maryland have implemented.
- Directly linking CQI payment to practices for process improvement or practice transformation and not to care management

The workgroup suggests that the Standardization and Attribution approaches be combined into one subject area given their interconnected nature. The workgroup will continue prioritizing the topics in future meetings and reframing concepts as needed. For example, provider capacity in healthcare will be included as a discussion item for future meetings.

Quality Metrics

The goal of the Quality Metrics Workgroup are to promote and advocate for quality measures aligned across payers based on the highest cost of care drivers.

The workgroup discussed the importance of quality measure alignment across payers because physicians can find it difficult to respond to different insurer measures, particularly when the specifications or requirements vary. Furthermore, this challenge can adversely affect the ability of independent primary care practices to recruit new talent. As a structural consideration, measures should have a minimum patient requirement for practices that qualify for the measure to avoid receiving lower scores because fewer patients “meet” the measure. Among other considerations, the workgroup recommends that measures be updated annually with advance notice to practices; alternative pathways for practices to qualify for insurance company incentives, such as meeting National Committee for Quality Assurance (NCQA) or Patient-Centered Medical Home (PCMH) recognition. Cervical cancer screening measures merit further examination because of concerns that the measure caps at age 65, which would not align with much of the Medicare population.

The workgroup recommends the following adult and pediatric measures as a pathway for alignment across payers.

Adult Recommended Measures include:

- Colorectal cancer screening
- Breast cancer screening
- High blood pressure control
- Hemoglobin A1c control
- Depression screening
- Follow-up after emergency department (ED) visits for people with multiple chronic conditions and mental illness
- Follow-up after inpatient admissions for people with multiple chronic conditions

Pediatric Recommended Measures include:

- Depression screening (12 or older)
- Weight assessment and counseling for nutrition and physical activity for children and adolescents
- Child and adolescent well-care visits
- Immunization (childhood immunization status; immunizations for adolescents)

Future discussion will continue to focus on measures refinement and specification, such as tobacco vaping/smoking cessation for children and adolescents. The workgroup, however, noted that the PCRC has no authority to standardize measures across payers.

Practice Model

The Practice Model Workgroup met on August 26, 2024, and December 5, 2024. This workgroup is composed of both physician and nurse clinicians across different practice models. Established to address Strategic Priority #5, the purpose of this workgroup is to address the needs of all primary care practice models across the spectrum of practice type. The first meeting established the following possible goals:

- Decrease administrative burden and cost
- Billing transparency from both payers to practices and from healthcare systems as employers for the work of their employed practices
- Educate practices regarding practice transformation and success in VBC
- Ideas to incentivize all practices to participate in VBC

The December meeting began by addressing the relationship between the Practice Model Workgroup and the other two workgroups. The discussion noted the challenges practices face regarding VBC and quality metrics and potential solutions for addressing these challenges.

The challenges include (1) the number of patients who need to be seen, which has increased, and (2) independent practices vary in size, and the value-based initiatives can be a massive burden for smaller practices. Regarding the latter, the resources available to smaller practices differ (e.g., staffing, access to artificial intelligence technology), and the state would need to help smaller practices with data collection and reporting. Participants commented that the PCRC must consider how to address the needs of all different types of practices and address them accordingly.

Several solutions were proposed during the discussion, including:

1. A multi-track approach similar to Maryland's, while noting that the funding would be a significant challenge in Delaware given that Maryland's program is completely state-funded
2. Prospective payments to ensure adequate compensation for primary care providers and the importance of moving away from FFS models
3. The Enhanced Primary Care Payment model would provide upfront payments to practices and allow them to continue with FFS payments
4. Focus on Medicaid given its significant impact on patient populations and the struggles facing MCOs due to patient attribution
5. Apply a population-based payment model to allow flexibility in delivering care, potentially alleviating provider burnout and improving patient care

To inform subsequent deliberations and activities, Dr. Fan shared several survey questions for the workgroup member feedback:

I. One of the strategic priorities of the PCRC is for practice sustainability in Delaware. One aspect is payment reform as recommended by NASEM. The PCRC developed the Delaware Enhanced Payment model. Do you think this is a feasible model for multi-payer alignment?
    a. Do you have clinical considerations that should be included in this type of hybrid payment model, (e.g., specific care coordination coverage, etc.)?
II. What would you like to see implemented to ensure practice sustainability?
III. Previous discussions addressed practice transformation education and resources and transparency between employers (healthcare systems) and employees (physicians, nurse practitioners, physician assistants) regarding billing and revenue. What do you think is a priority for all primary care practices, regardless of practice model; e.g., independent, employed?

Preliminary reactions included the observation that a population-based payment model might provide freedom in how care is delivered, potentially alleviate burnout, and improve patient care. A payment reform model should consider provider burnout, provider well-being, and connection to patients. It should also decrease administrative burden and enhance compensation for the kind of care that providers want to deliver. Providers need payments in advance, universal performance metrics, and compensation for delivering quality care.

Strategies discussed included the developing an "Innovation Zone" and multi-payer partnerships. It was suggested that PCRC work backwards to align Delaware models with those already established in Pennsylvania, which might be more appealing to payers that would otherwise be hesitant to change processes

to accommodate a Delaware-specific model. On the other hand, Delaware would be a good state to model an Innovation Zone for multi-payer partners given its small size and closely knit clinical community. Another approach would be to start with a simplified model and advance to a more complex model over a three-year period.

The workgroup plans to consider achievable goals for 2025 to integrate and align goals with the VBC and quality metrics workgroups and contribute to the development of prospective payments, adequate compensation for quality care, and decreased administrative burden.

Communications

This workgroup was formed to address Strategic Priority #4 regarding improved communications through measures such as an annual report and recommendations to increase awareness and general education regarding the work of the PCRC, highlighting its mission, vision, and the impact of the various legislative measures that have been enacted to address the primary care crisis. This annual report is the first step. The workgroup is on hiatus at present but will reconvene when it is adequately staffed.

Highlights of 2024 PCRC Activities

The PCRC met seven times in 2024. The links to the approved meeting minutes can be found in Appendix D.

January 22, 2024

- Strategic Planning: Provided an update on PCRC Strategic Priority setting, including updates from the DE PCRC Subcommittee Working Group, an overview of the goals for an environmental scan on national primary care landscape, and key takeaways from the focus groups. The focus groups included representatives from the state, MCOs, and providers. The focus group questions were designed to understand the perspectives of different groups regarding SB 120 and how it is working.**Error! Bookmark not defined.**
- HMA provided an updated on its national scan of prospective payment models and examples of program activities.

February 12, 2024

- Dr. Fan reviewed the findings from survey based on the NASEM Survey Payment Reform White Paper (see Appendix B for survey results).**Error! Bookmark not defined.**
- Discussed the white paper's applicability to Delaware and naming the primary care VBC payment model.
- HMA presented its findings on SQI and continuous quality improvement.**Error! Bookmark not defined.**
- The PCRC voted on the Strategic Priorities for the PCRC.**Error! Bookmark not defined.**

March 18, 2024

- Reviewed the PCRC Strategic Priority Recommendations.**Error! Bookmark not defined.**
- Discussed remodeling the PCRC Workgroups to address the Strategic Priority recommendations.
- Reviewed the executive summary of HMA's final report, which provided an overview of the components of Delaware Enhanced Primary Care Model.[3] PCRC members provided feedback on the executive summary and considerations for the Delaware Enhanced Primary Care Model.

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[3] Please see section: **Delaware Enhanced Primary Care Model.**

- Dr. Fan reviewed next steps for the workgroups legislation and explained that SB 120 has a sunset date in 2025. PCRC discussed how HB 350 could relate to the PCRC's ongoing efforts.

April 15, 2024

- Reviewed Colorado's PCRC Annual Report and how the DE PCRC could format a similar annual report due to similar PCRC structure. Discussed cadence of PCRC meetings.
- Discussed the implementation of the Delaware Enhanced Primary Care Model and how elements from other states in the national scan can be considered for implementation.
- Dr. Fan presented on the Centers for Medicare & Medicaid Services (CMS) AHEAD (States Advancing All-Payer Health Equity Approaches and Development) and ACO Flex Models.

May 13, 2024

- Reviewed the PCRC 2020 Annual Report.
- PCRC voted on continuing with the current PCRC structure. Discussed comments on why the PCRC should change their structure. PCRC agreed that its current membership included the correct stakeholders/organizations.
- Reviewed the new workgroup structures and PCRC voted on the new workgroups.

July 15, 2024

- Updated the PCRC on the members of the PCRC workgroups. See Appendix D.
- OVBHCD presented the final 2023 Primary Care Investment Results and Lessons Learned.
- Each payer representative provided an update on the adoption and progress of VBC models, with a focus on payment reform and quality improvement initiatives.
    - **Highmark:** Highmark Delaware successfully transitioned more than 60 percent of its network providers to value-based contracts by the end of 2023. Reported a 10 percent reduction in hospital readmissions and a 12 percent increase in preventive care services. Challenges highlighted were ongoing struggles with smaller practices adapting to the complexities of value-based contracts.
    - **Aetna:** Aetna expanded its VBC programs, at the time covering 55 percent of their primary care network. This effort included integrating behavioral health services into primary care. Aetna observed significant improvements in patient outcomes for chronic disease management and a 20 percent increase in telehealth utilization, particularly for behavioral services. Challenges included consistency across provider networks, particularly in rural areas.
    - **Division of Medicaid and Medical Assistance:** As of the meeting date, 40 percent of Medicaid primary care providers were participating in value-based programs, and Medicaid programs had introduced health equity metrics to address disparities in care. Challenges include the difficulty of balancing the need for cost savings with the goal of improving health equity.
- Meeting attendees discussed the role of community health workers in value-based care, how telehealth can be integrated into value-based care, and incentives for smaller or rural providers to participate in VBC.

October 7, 2024

- OVBHCD reviewed State Primary Care Scorecards in Virginia, New York, and Massachusetts and considerations for a Delaware Primary Care Scorecard, including expenditures, workforce/capacity, and performance and access measures.

- The PCRC discussed the progress of the Value Based Care Workgroup, the Practice Model Workgroup, and the Quality Measures and Communications Workgroup. The PCRC discussed the potential topics and priorities identified by the workgroups. Topics included: improving multi-payer alignment, decreasing administrative burden, enhancing transparency in billing, educating primary care providers about VBC and practice transformation, reviewing and possibly updating the quality measure set, addressing social determinants of health (SDOH), exploring participation in CMS Innovation Center payment models, and creating a comprehensive policy across all relevant state programs.

Inter-Workgroup Meeting, January 29, 2025

The PCRC's three workgroups—the VBC Workgroup, Quality Metrics Workgroup, and Practice Model Workgroup—met on January 29, 2025, to share its progress and priorities for 2025. The respective workgroup chairs presented a summary of their activities and objectives, such as:

- The VBC Workgroup is addressing the standardization of attribution of members/patients to primary care clinicians and approaches to primary care payment reform.
- The Practice Model Workgroup is focusing on decreasing administrative burden, promoting transparency in payments from plans to providers, educating providers about VBC and practice transformation, and considering the incentives that would encourage PCPs to participate in a VBC program.
- The Quality Metrics Workgroup is trying to align quality measures across payers and has recommended several measures for adults and children.

Following the workgroup chairs' reports, the inter-workgroup discussion focused on setting performance targets, aligning quality measures across payers to reduce provider burden, and regulatory and legislative strategies to ensure the sustainability of primary care VBP. The participants agreed that inter-workgroup meetings would be held quarterly throughout 2025.

Collaboration with the Office of Value-Based Health Care Delivery

In 2019, the Delaware General Assembly passed SB 116 which established the Office of Value-Based Health Care Delivery within the Department of Insurance (DOI) as one component of a multi-faceted effort to address the state’s long-standing high healthcare costs. The overarching goal of the OVBHCD is to “reduce healthcare costs by increasing the availability of high quality, cost-efficient health insurance products with stable, predictable, and affordable rates.” Specifically, SB 116 charged the OVBHCD with three tasks:

1. Establish Affordability Standards for health insurance premiums based on recommendations from the Primary Care Reform Collaborative and annually monitor and evaluate these standards
2. Establish targets for carrier investment in primary care to support a robust system of primary care by January 1, 2025
3. Collect data and develop annual reports regarding carrier investments in healthcare, including commercial reimbursement rates for primary and chronic care services

As the OVBHCD began collecting data and stakeholder information to develop the Affordability Standards, three key challenges were identified as contributing to high healthcare costs and, as a result, higher health insurance premiums for Delawareans. These challenges to affordability are as follows:

- Limited primary care investment and, in turn, access to primary care

- Health systems and health insurance carriers with strong market power, which results in fewer choices and higher prices
- An older, sicker population

Additional legislation, SB 120, recognized the benefits of effective and accessible primary care. SB 120 is based on the findings from the OVBHCD's 2021 Inaugural Report, Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value, which provided extensive research on Delaware's healthcare market, key findings, and offered the following Affordability Standards:

1. Increase primary care investment
2. Decrease unit price growth for certain services
3. Expand adoption of alternative payment models

SS 1 of SB 120 charges the DOI with ensuring that commercial insurers increase primary care investment with the belief that the increase in primary care investment will result in more comprehensive primary care delivery and access, which would result in a decrease in downstream spending. At the same time, SB 120 directs the PCRC to develop a Delaware Primary Care Model to increase participation in value-based models designed to reduce health disparities and address SDOH.

Together, the newly enacted statutes and regulations will be the catalyst in creating a robust primary care system without increasing healthcare cost growth. The OVBHCD meets regularly with the commercial carriers and holds them to compliance with five regulatory requirements:

Requirement 1. Reimburse at least as much as Medicare for Primary Care and Chronic Care Management Services
Requirement 2. Increase primary care investment to reach minimum annual thresholds (8.5% of total medical expense)
Requirement 3. Target 75 percent of primary care providers in care transformation activities by 2026
Requirement 4. Limit price growth for hospitals and other non-professional services to better align with growth in the overall economy
Requirement 5. Expand meaningful alternative payment model adoption by making healthcare providers more accountable for spending and value

During the first year of implementation in 2023, the Delaware primary care system experienced an increase in investment to $43.9 million (8.2%) from $29.7 million (6%) in 2022, and more than $59 million (10.2%) in 2024. These numbers are a result of the commercial, fully insured market adhering to the primary care investment regulatory requirements.

An important factor in regulating Delaware's primary care spending is the focus on the portion of the investment dedicated to non-claims-based payments. In 2022, the non-claims portion was $1.4 million, in 2023 it totaled $10.4 million, and in 2024 non-claims costs are expected to have reached $21.0 million. OVBHCD measures several components of non-claims to ensure that primary care spending is reliable and predictable.

The OVBHCD and the PCRC understand that transforming care delivery and payment is complex, requires collaboration, and takes time. Transformation also requires significant resources, which would result from increased investment in primary care. Over the long term, these efforts should improve the value of care delivery and produce better care experiences for patients.

Additional Collaborative Efforts with OVBHCD

DOI, OVBHCD, and the PCRC have been collaborating to ensure alignment of the care model with investment requirements. Following are some of the additional activities on which the OVBHCD and the PCRC have collaborated:

- Developing consistent policy across all stakeholders (e.g., carriers, providers, healthcare systems)
- Arriving at the OVBHCD's definition of primary care investment with the support of a technical subcommittee of the PCRC.
- Providing OVBHCD support for the implementation of the Delaware Primary Care Model, including:
    - Collaborating with the PCRC to develop the model and feasible implementation, inclusive of OVBHCD priorities and possible changing care delivery expectations and models
    - Determining whether primary care providers will need to offer specific care delivery capabilities
- Developing a Current Procedural Terminology (CPT) code set with input from the PCRC to reimburse at least as much as Medicare for primary care and chronic care management services
- Creating and annually evaluating Affordability Standards per Delaware 18 Code § 334, which empowers the OVBHCD to fulfill this goal through a transparent process in collaboration with the PCRC.

Additional reports from the OVBHCD:

- In December 2021, OVBHCD updated the Inaugural Report and published an Annual Review of Carrier Progress Towards Meeting Affordability Standards. This report provides a baseline to measure future progress, reinforces the need for the new law (SB 120), and highlights opportunities for meaningful progress that will improve physical, mental, and financial health in Delaware.
- The 2023 OVBHCD Annual Report reviews the first year of implementation (2022) and 2023 compliance requirements.

Delaware Enhanced Primary Care Model

Overview and Background

The development of the Delaware Enhanced Primary Care Model (formally the Delaware Primary Care Payment Model) began in the spring of 2022 with the establishment of the following workgroups: (1) Payment and Attribution, (2) Care Coordination, (3) Quality Metrics and Benchmarks.

The workgroups comprised members of the PCRC, Delaware commercial payers such as Highmark and Aetna, primary care providers, and other relevant stakeholders that specialize in VBC and/or model development. The workgroups met on a regular basis to develop the framework.

The model is based on recommendations rather than mandates. At present, neither payers nor primary care providers are required to use this model; instead it was developed so that payers and providers can adjust certain components based on their needs. The model consists of the following main components.

Patient attribution. Payers and providers may use existing or new attribution methods mutually agreed upon by both parties (i.e., no specific attribution is recommended). Payers should transparently communicate the patient attribution methodology and provide timely and useful information to the practices/providers regarding this methodology. Providers should manage their attribution lists and collaborate with payers regarding attributed members.

Panel size considerations. The recommended panel size is a minimum of 250 attributed members to ensure smaller practices qualify for participation in the hybrid payment model. There is no maximum panel size.

Payments to primary care providers (PCPs). The workgroups recommended two prospective payments to providers:[4]

(1) **SQI Payment.** **Figure 6** indicates the primary care services applicable to the SQI. Any evaluation and management (E/M) codes that do not fall into this SQI payment may be billed as traditional FFS.

Figure 6. CPT Codes Applicable to the SQI Payment

(2) **CQI Payment.** The CQI is an incentive to improve practice infrastructure and advance the practice toward VBC. Practices that are already doing significant VBC work may receive a higher CQI payment.

[4] A payment amount has yet to be determined for the SQI and CQI. See section on Additional Hybrid Model Components (page 26) for more information.

Payment flexibility. Payers and providers may negotiate the CQI payment based on the value proposition and the anticipated return on investment.[5] The guidance should include the service component using objective and reasonable methodologies to assess member risk and needs, while avoiding overly complex or administratively burdensome methods.

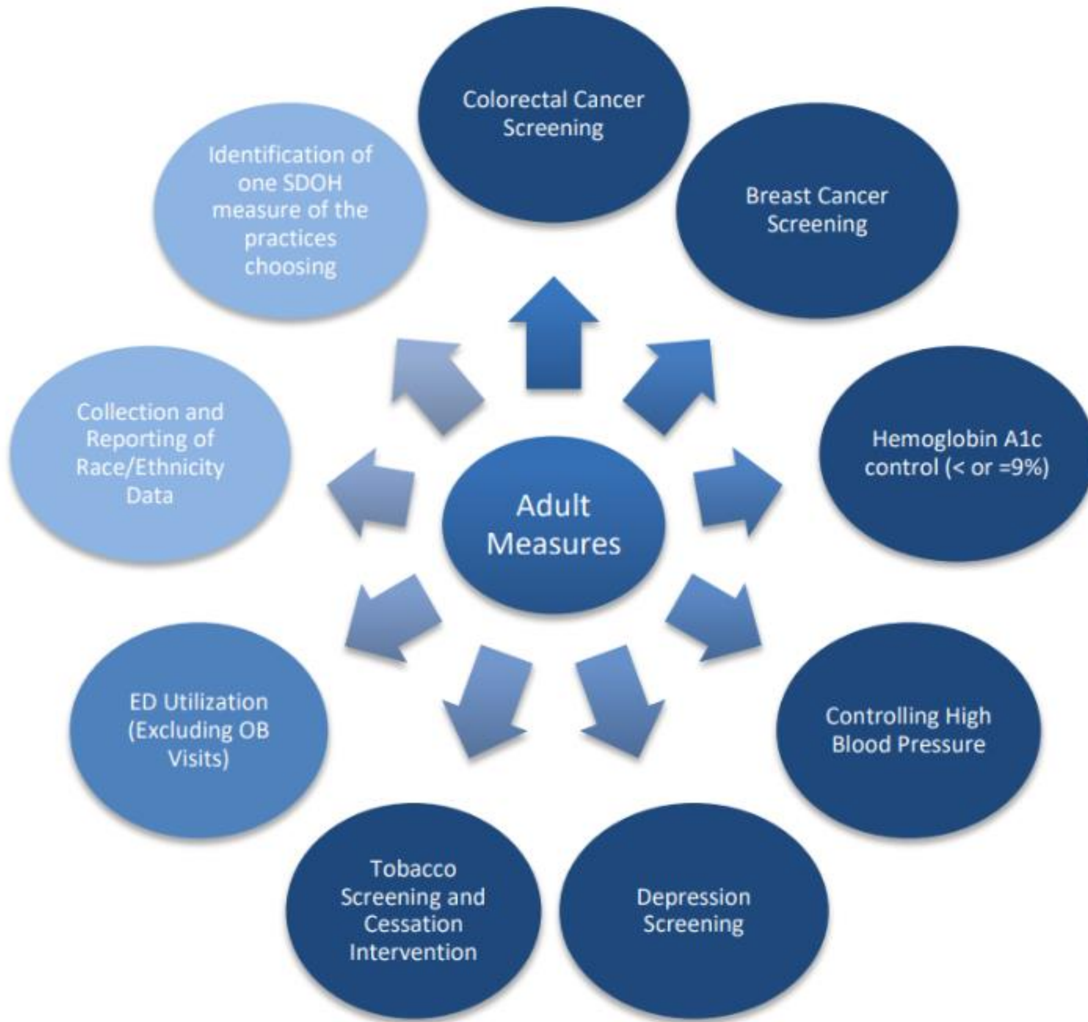
Quality metrics. The Quality Metrics Workgroup recommended two sets of quality metrics, one for adult populations and another for pediatric populations as shown in **Figure 7** and **Figure 8** below. These measures were decided upon for Year 1 of the model with the intention of evolving the measures over time. Additional quality metrics recommendations are as follows:

1) Year 1 of the model should be considered pay-for-reporting only
2) Following Year 1, begin phasing out some of the clinical measures in favor of more SDOH and patient experience measures
3) Consider adding Tobacco Screening and Cessation Intervention as a pediatric measure (for patients 12 and older) once better guidelines are available on how to do so

See Appendix E for descriptions of the quality measures.

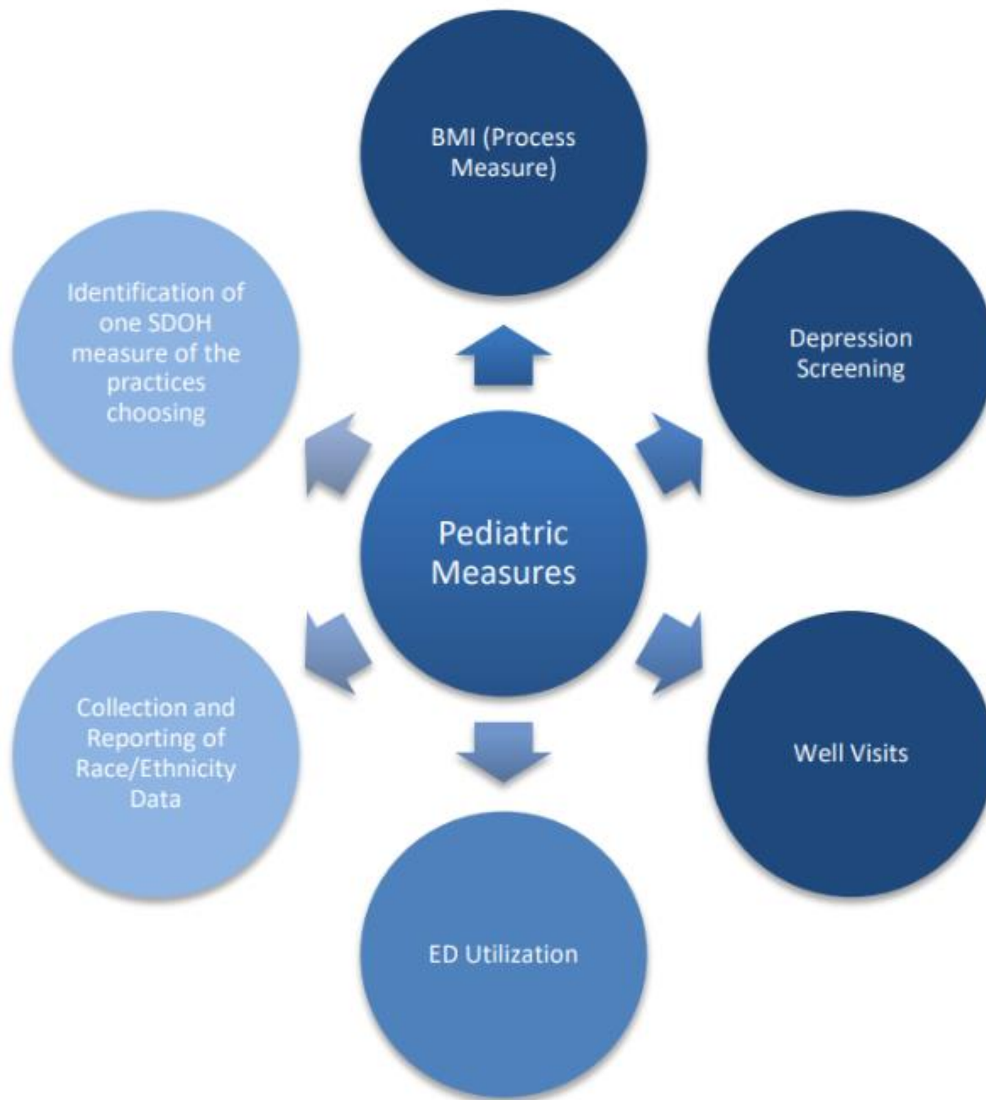
[5] Primary care providers were hesitant to accept this concept, as they feel they have limited, if any, power to negotiate with payers.

Figure 7. Recommended Adult Quality Measures for the Enhanced Primary Care Model



Note: Dark blue circles represent the six clinical measures, the medium blue circle represents the one utilization measure, and the light blue circles represent the two SDOH measures.

Figure 8. Pediatric Recommended Measures Enhanced Primary Care Model



Note: Dark blue circles represent the three clinical measures, the medium blue circle represents the one utilization measure, and the light blue circle represents the two SDOH measures.

Additional Hybrid Model Components

In 2024, the PCRC and OVBHCD engaged HMA to address the goals of SB 120, particularly the considerations for and development of the SQI and CQI. HMA conducted a comprehensive scan of the national landscape to identify research on primary care spending methodologies and payment model approaches in other states. The report can be found here.

Standard Quality Investment

As noted above, the SQI is a bundled payment for a defined set of services based on a known set of procedure codes, and any services outside the procedure code set will be billed and paid as traditional FFS claims. At the direction of DHCC, HMA's SQI and CQI recommendations apply only to the fully insured commercial population in Delaware, although expansion of this initiative into other populations is possible in future years.

The prospective nature of this payment system requires an estimate informed by the historical use of these defined services. HMA worked with the Delaware Health Information Network (DHIN) to receive historical claims data for primary care services to estimate a per member per month (PMPM) prospective payment.

The PMPM estimate depends largely on the chosen attribution logic and panel size (i.e., the number of providers and the number of attributed patients) that were discussed at previous PCRC meetings. For example, the 2025 projected SQI PMPM should be between $10 and $30 PMPM. Assuming an effective attribution logic, a single provider would deliver all primary care services, and the SQI paid to a provider would be at the higher end of the $10–$30 PMPM range. On the other hand, with limited attribution, more than provider would likely deliver primary care services. Consequently, the same volume of SQI dollars must be allocated to multiple providers, and the prospective SQI PMPM would fall at the lower end of the range. Given sample size limitations, instances of smaller panels require more detailed consideration and evaluation based on population and contract details.

Continual Quality Investment

Though SQI payments are tied to a known set of services and corresponding procedure codes, CQI payments are more generally defined as being used to advance value-based care. Practices can allocate CQI dollars toward several uses, including:

- Integrating SDOH
- Behavioral health integration
- Improved care coordination with patient navigators
- Preventive wellness and health literacy
- Technology investments
- Improved medication adherence
- Increased use of patient surveys
- Infrastructure improvements
- Recruiting, retaining, and training staff

A mechanism for practices to track and report CQI spending consistently and reliably needs to be developed. Because the list of possible uses for CQI is open-ended and non-exhaustive, the spending of CQI dollars by practices should be reviewed to avoid fraud and abuse, and practices should attest that CQI funds have been used appropriately to initiate or enhance value-based care.

National Scan

HMA's comprehensive scan of the national landscape and analysis of the findings offered insights into promising practices and lessons learned through other efforts to establish quality metrics, alternative payment models (APMs), prospective payments, and quality improvement programs for primary care. The national scan examined APM models in four states: Colorado, Maryland, Oregon, and Rhode Island. In addition, HMA researched prospective payments and quality improvement programs in Maryland, Michigan, Minnesota, Mississippi, New York, Oregon, Rhode Island, and Washington. A brief overview of the national scan follows.

Colorado

Colorado is developing two multi-payer statewide APMs and intends to tie 50 percent of Medicaid payments to value-based arrangements in 2025.

Oregon

Oregon Health Care Authority developed a VBP toolkit for coordinated care organizations to ensure that by 2024 at least 70 percent of their payments would be in a VBP model.

Rhode Island

The Health Care Cost Trends Steering Committee created a compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island, which developed a set of recommendations for accelerating the adoption of VBP models.

The Neighborhood Health Plan of Rhode Island QI (quality improvement) program targets clinical quality of care and member and provider experience. The QI program covers all Neighborhood product lines and offers incentives to providers that achieve improved quality of care.

Maryland

The Maryland Total Cost of Care model has three main components: (1) global budgets, (2) the care redesign program, and (3) the Maryland Comprehensive Primary Care Program.

Washington

Washington State is working to implement a multi-payer primary care VBP model that uses prospective comprehensive primary care payment to cover myriad services.

Minnesota

Minnesota was awarded the State Innovation Model testing grant in 2013 and used the funds to develop the Minnesota Accountable Health Model to enhance patient experience, improve population health, and reduce costs.

The Capital District Physician Health Plan – New York

Launched the Enhanced Primary Care program, which is a medical home program that provides prospective payments for primary care services.

TrueCare Mississippi

Coalition of Mississippi hospitals and health systems developing innovative programs to improve outcomes, equity, access to care, member engagement, and collaboration with community-based organizations.

Blue Cross Blue Shield of Michigan QI Program

The Blue Cross Blue Shield of Michigan QI program includes a physician group incentive program, which allows physicians across the state to collaborate on initiatives that offer incentives based on performance improvement and program metrics.

Recommendations

Based on the analysis, HMA recommended that, to achieve the SB 120 goal of directing 11.5 percent of total healthcare spending in 2025 toward primary care, the new SQI and CQI PMPM payments should be balanced with traditional payment models, such as FFS, care management, and other risk settlements. In addition, the amounts from the CQI PMPM for advancing VBC should be reviewed. For example, if a practice were to have a relatively lower SQI PMPM, it may present an opportunity to incentivize VBC, and the practice should receive a higher CQI PMPM. Conversely, practices that already have strong attribution and value-based care should

receive higher SQI PMPM payments and lower CQI PMPM reimbursement. This approach should produce PMPM amounts that allocate payments tailored toward improved effectiveness and efficiency to achieve the 11.5 percent threshold.

Conclusions and Next Steps

As this report demonstrates, Delaware has continued to build a strong framework for primary care reform through the work of the PCRC, its collaboration with the OVBHCD, and efforts to analyze primary care investment and implement affordability standards and primary care spending targets with an emphasis on VBC. Though the current measures have not yet produced the desired impact, the PCRC will continue to work on achieving high-quality primary care, with a focus on payment reform. A Primary Care Scorecard may be a useful measure of the progress of primary care reform within the state.

The PCRC's work will continue through the currently established workgroups and their priorities, as well as explore feasible pathways for the Delaware Enhanced Primary Care Model. In addition to advancing a hybrid payment model, which has prospective payment as a transition from an FFS payment model, other areas of focus include multi-payer alignment regarding such payment models and opportunities to increase primary care investment overall—promoting investment in practice transformation for providers to participate in value-based care and adoption of a standard set of quality metrics within VBP models.

The legislative history of the PCRC is evidence that the Collaborative will need to seriously consider supporting the use of the legislative and regulatory process as the most effective mechanism to make significant progress. The members of the PCRC represent a range of stakeholders and may need to participate with a greater level of engagement and collaboration to achieve these goals and produce consensus recommendations for effective policy.

Appendices

Appendix A. National Academy of Science and Engineering Medicine (NASEM) Survey Results

The survey results were summarized as follows:

If there is an increase in the total cost of care, the cost should not be passed onto the consumer/patient

- 11 responses: 72.7 percent agree>>>unrealistic

With the information provided by the OVBHCD and through the Department of Health and Social Services Benchmarking and CostAware data, there should be an effort to decrease inpatient costs, even for those health plans not covered under SB120 (Medicaid, self-insured plans)

- 11 responses: 90.9 percent agree>>> not feasible due to cost factor

If this is a STRONG RECOMMENDATION from the PCRC, should there be a recommendation for an established regulatory body regarding healthcare systems and their contracted payment schedules with carriers, such as a set schedule for annual increases in service payments, similar to what is in SB120?

- 10 responses: 90 percent agree

If establishment of a regulatory body is NOT a STRONG RECOMMENDATION, then should the PCRC recommend that those health plans that are excluded from SB 120 mandates contribute to a statewide Primary Care Investment Safety Net, which may cover, but is not limited to, costs associated with practice transformation for practices to reach PCMH quality of care; infrastructure costs to establish resources for patients and providers alike regarding primary care access; patient and provider education regarding the benefits of primary care, behavioral health, as well as social determinants of health (SDOH).

- 10 responses: 70 percent agree

The PCRC should recommend telehealth services, which would need to be defined, be included as an essential service of primary care.

- 11 responses: 100 percent agree

The Delaware Primary Care Delivery Model (aka Value-Based Model) should be incorporated in all health plans, either through regulation or legislation

- 11 responses: 72.7 percent agree

The PCRC should recommend that the certification of PCMH level of care not be limited only NCQA certification and can qualify for higher reimbursement if the practice meets certain parameters.

- 11 responses: 54.9 percent agree, 36.4 percent not sure (i.e., need to know the qualifying parameters)

Appendix B. Strategic Priority Environmental Scan Overview

State	Authority/ Governance	Cost Containment	Payers Included	Primary Care Investment Strategy	Aligned Quality Measures
CT	Office of Health Strategy (OHS)	Cap Total healthcare spending at 10% by 2025.	Public and private payers	Directs OHS to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021–2025	Yes, mix of HEDIS • Hypertension • HbA1c
MD	Department. of Public Health – Program Management Office	Saving $300 million in annual total Medicare spending by the end of 2023.	Medicaid, Medicare	Multi-payer PCMH program	Yes, mix of HEDIS • Hypertension • HA1c
MA	Massachusetts Health Policy Commission	Increase primary care spending approximately 12–15% of overall healthcare expenditures by 2029.	Commercial	FFS to a monthly prospective payment	Yes, mix of HEDIS • Hypertension • HbA1c
NJ	Governor's Office of Health Care Affordability and Transparency	Decrease how much health care costs grow each year (3.2% value).	Medicaid	Set benchmark performance criteria and conduct a cost-driver analysis	Yes, HEDIS and CAHPS • Hypertension • HbA1c
OR	Oregon Primary Care Reform Collaborative	Increase investment in primary care. Track spending allocated to primary care carriers, PEBB, OEBB, and (CCOs).	Multi-payer: Medicaid, commercial	Patient-centered Primary Care Home (PCPCH)	Utilization • Hypertension • HbA1c

RI	Office of the Health Insurance Commissioner (OHIC)	At least 9.7% of total healthcare spending must go toward direct primary care spending.	Multi-payer, Medicaid, Commercial	Alternative payment model; PCMH	Yes – mix of HEDIS • Hypertension • HbA1c
VT	Green Mountain Care Board	Track healthcare spending between 2018–2023 to keep average increase in costs between 3.5%–4.3%.	Commercial, Medicaid, Medicare	PMPM	Yes – mix of HEDIS • Hypertension • HbA1c

Appendix C. PCRC Workgroup Members

Name/Affiliation	Stakeholder Representation	Workgroup
Lori Ann Rhoads **The Medical Society of Delaware**	Provider Group	Value-Based Care Model
Anthony Onugu **United Medical**	ACO	Value-Based Care Model
Kathy Willey	ACO	Value-Based Care Model
Andrew Wilson **DHSS – Division of Medicaid and Medical Assistance**	DHSS Representation/ Payer	Value-Based Care Model
Dr. William Ott **Aetna**	Payor	Value-Based Care Model
David Cruz **Nemours**	Health System	Value-Based Care Model
Megan McNamara Williams **Delaware Healthcare Association**	Provider Group	Value-Based Care Model
Brendan McDonald **Highmark Health**	Payor	Value-Based Care Model
Cristine Vogel, Chair **OVBHC**	DOI Representation	Value-Based Care Model
Cari Miller, Chair **LabCorp**	Health Information Technology	Quality Measures and Provider Benchmarks
Lara Brooks **CVS Health/Aetna**	Payor	Quality Measures and Provider Benchmarks
Dr. Michael Bradley	Provider	Quality Measures and Provider Benchmarks
Donna Gunkel **United Medical**	Provider/ ACO	Quality Measures and Provider Benchmarks
Vacant	Payor	Quality Measures and Provider Benchmarks
Vacant	DHSS Representation	Quality Measures and Provider Benchmarks
Dr. Diane Bohner, **ChristianaCare**	Employer Physician/Provider	Practice Model
Dr. Robert Monteleone **St. Francis**	Provider	Practice Model
Lisa Adkins **Nemours**	Health Care System	Practice Model
Dr. Susan Conaty-Buck	Independent Nurse Practitioner	Practice Model
Dr. James Fletcher **MedNet**	MSD/Independent Practice	Practice Model
Mark B. Thompson, MHSA	Medical Society of Delaware	Communications
Maggie Norris-Bent, MPA	Communications Officer	Communications

Appendix D. PCRC Meeting Minutes – 2024

Below are the links to the approved 2024 PCRC Meeting Minutes:

- January 22, 2024
- February 12, 2024
- March 18, 2024
- April 15, 2024
- May 13, 2024
- July 15, 2024
- October 7, 2024, minutes were awaiting approval at the time of this report

Appendix E. Enhanced Primary Care Model - Quality Measure Descriptions

Measure Title	Measure Category	Measure Description	Population
Colorectal Cancer Screening	Preventive Health	Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Patients 50–75 years of age
Breast Cancer Screening	Preventive Health	Percentage of female patients 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	Female patients 50–74 years of age
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (< or =9%)	Chronic Disease	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c < or = 9.0% during the measurement period. *Recommend payers connect with DHIN for A1c results.	Patients 18–75 years of age
Controlling High Blood Pressure	Chronic Disease	Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period. *Based on current clinical guidelines. These may change and should be updated accordingly. *The group identifies the administrative burden of this metric and recommends not only using CPT codes as a matter of reporting. This metric is not recommended if the only manner of monitoring is CPT coding.	Patients 18–85 years of age
Body Mass Index (BMI) Screening	Preventive Health	Percentage of pediatric patients ages 3–17 and adult patients ages 18 and older who had an outpatient visit with a PCP or OB/GYN with a BMI percentile documented once per performance period.	Pediatric Patients: 3-17 Adults Patients: 18 years and older
Depression Screening	Preventive Health	Percentage of patients ages 12 and older screened for depression during the performance period using an	Patients ages 12 years and older at the

		appropriate standardized depression screening tool. Process measure.	beginning of the measurement period
Tobacco Screening and Cessation Intervention	Preventive Health	Percentage of patients ages 18 and older who were screened for tobacco use at least once or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.	Patients ages 18 and older
Child and Adolescent Well-Care Visits (WCV)	Preventive Health	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Patients 3–21 years old
ED Utilization	Utilization	Annualized rate of ED visits per 1,000 members. ED visits are limited to those visits that do not result in an inpatient admission, observation stay, or an outpatient surgery. The metric is calculated as the COUNT(of ED visits) / SUM (member months YTD)* (12* 1,000). This measure does not include urgent care. Exclusive of OB-related ED visits.	All ages (including pediatric populations)
Collection and Reporting of Race/Ethnicity Data	SDOH	The Collection and Reporting of Race/Ethnicity Data will strictly be for reporting in the first year. If a practice does not already collect race/ethnicity data or does not have an electronic system to produce reports for this, the first year will focus on identifying how to collect and store this information.	All ages (including pediatric populations)
Identification of one SDOH measure of the practice's choosing	SDOH	This metric is intended as a forward-thinking measure that we would like practices to begin identifying in Year 1 to implement in Year 2. A specific SDOH measure has not been identified for this, as we would like practices to indicate their patient-specific needs on their own. We also do not want to box in practices by looking at only one SDOH measure when many more may better fit the	All ages (including pediatric populations)

		needs of their specific patient population.	