PRIMARY CARE REFORM COLLABORATIVE (PCRC) MEETING

JUNE 23, 2025

WELCOME

AGENDA

I. Call to Order
II. Introductions
III. Review and Approve PCRC March 2, 2025, Meeting Minutes
IV. Office of Value-Based Health Care Delivery Update
V. PCRC Workgroup Updates
VI. Review PCRC End of Year Report (*PCRC vote*)
VII. Public Comment
VIII. Adjourn

CALL TO ORDER

- Dr. Nancy Fan, Chair
- Senator Bryan Townsend, Senate Health & Social Services Committee
- Representative Nnamdi Chukwuocha, Chair House Health & Human Development Committee
- Andrew Wilson, Division of Medicaid and Medical Assistance
- Jason Hann-Deschaine, MD, Medical Society of Delaware
- Dr. Rose Kakoza, Delaware Healthcare Association
- Michelle Devern, Delaware Nurses Association
- Kevin O'Hara, Insurance Carrier
- Steven Costantino (Designee for Cabinet Secretary Josette Manning)
- Stephanie Hartos, State Employee Benefits Committee
- Deborah Bednar, Insurance Carrier
- Maggie Norris-Bent, FQHC
- Cristine Vogel (Designee for Insurance Commissioner Trinidad Navarro)

INTRODUCTIONS

REVIEW AND APPROVE PCRC MARCH 3, 2025, MEETING MINUTES

OFFICE OF VALUE-BASED HEALTH CARE DELIVERY UPDATE

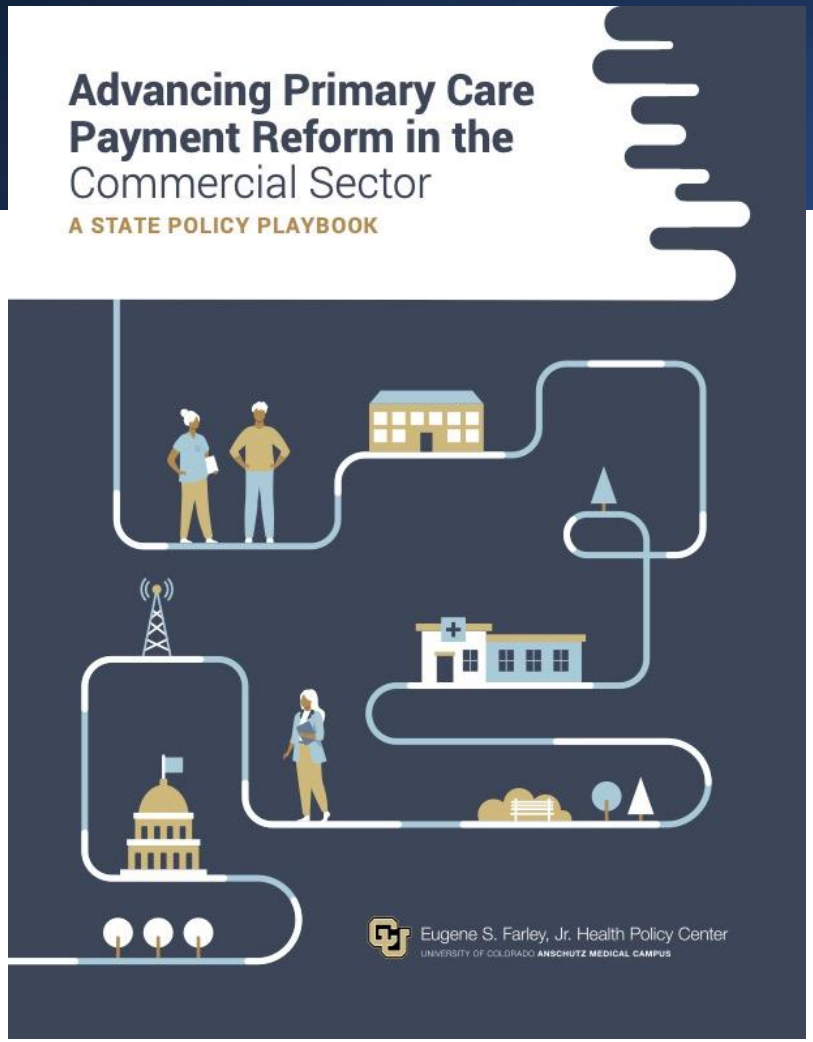
Cristine Vogel, MPH, CPHQ
Director

Primary Care Investment: 2024 Progress Update

Cristine Vogel, MPH
Director, Office of Value-Based Health Care Delivery
June 2025

Agenda

- Highlights and Challenges
- 2024 Primary Care Investment Results
- 2024 Non-claims payments by health systems and ACOs
- What's Next



Key Findings from States (AR, CO, **DE**, RI, and WA):

Advancing primary care payment reform must:

- Provide ***meaningful amounts*** of payment delivered through non-FFS mechanisms, including prospective payments
- ***Increase*** investment in primary care
- Have ***multi-payer alignment*** both within the commercial sector, and across all sectors of payers (Medicaid, state employees, etc.)

Advancing Primary Care Payment Reform in the Commercial Sector A STATE POLICY PLAYBOOK
University of Colorado

Highlights

- Delaware successfully increased primary care investment in 2023 and 2024 in the commercial, fully insured market
- The commercial market also has experienced increases in primary care reimbursement because of the “Medicare parity” rule implemented
- Delaware continues to be a leading state with its consistent definition, data collection, tracking and reporting processes
- Although Delaware is reporting increased primary care spending, it is too soon to start seeing reduction in overall healthcare costs – this is the long-term goal!

Challenges

- Access to primary care remains a challenge for Delaware so we must keep moving this program forward
- Carriers are reporting that many individuals are not seeking PCP visits (practices and carriers have outreach programs with little take up), this impacts attribution, primary care spend, and health outcomes
- High-cost claimants are drove up the Total Medical Expenses which exceeded carrier projections
  - About 300 members (or 1% of total), annual spending > $250,000
- Value-based “contracts” continue with the same health systems and ACOs

2024 Primary Care Investment Results

Carriers invested over $59.6 million into the primary care system in 2024 for commercial, fully insured Delawareans up from $43.9 million in 2023

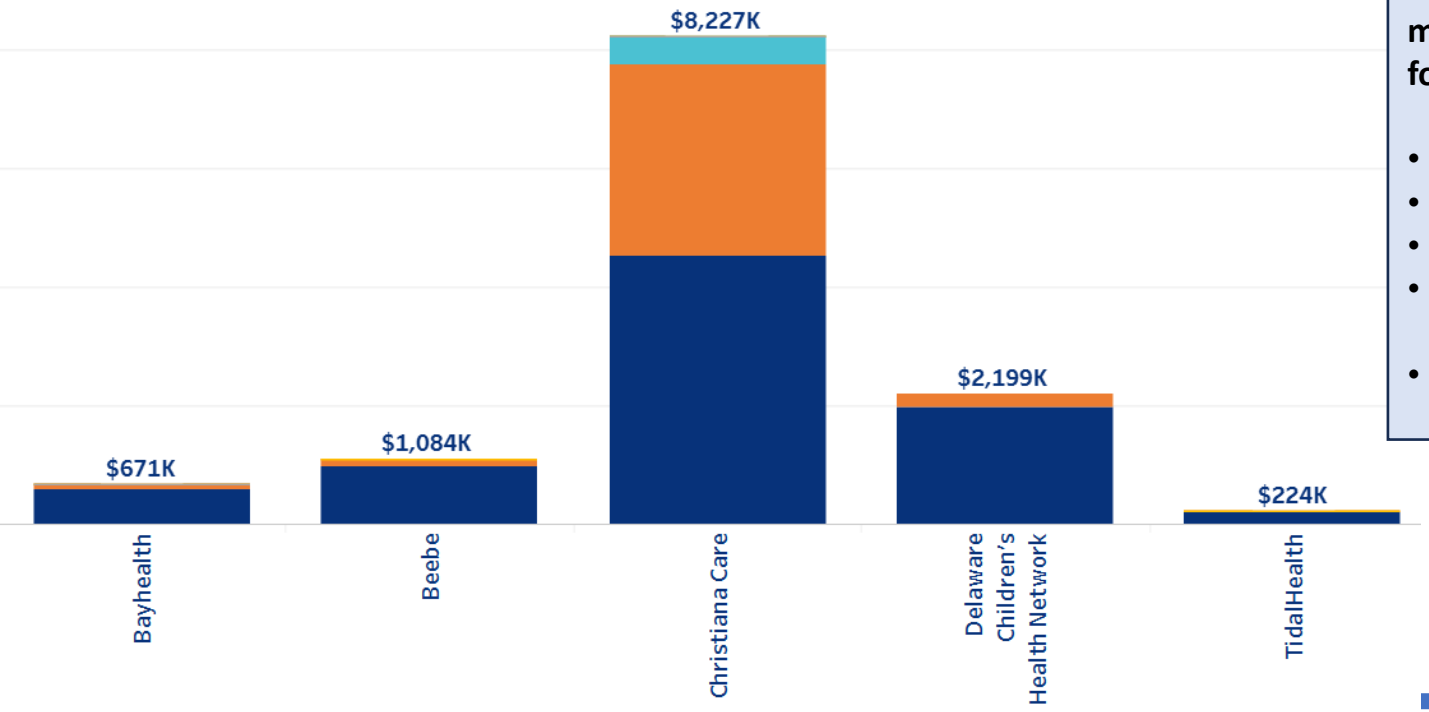
For providers engaged in value-based care programs, they received $35.7 million of the $59 million

- Prospective, care management payments totaled $13.6 million up from $7.1 million in 2023
- On a per member per month basis, care management payments increased from $3 PMPM (2022), $19 PMPM (2023), and $26 PMPM in 2024
- These increases resulted in an aggregate Primary Care Investment of 8.6%, falling short of the 10% requirement

2024 Primary Care Investment Results

	2024 Primary Care Investment (Attributed to Care Transformation Programs)				
	Primary Care Spend %	**Primary Care Payments**	**Total Primary Care Spend PMPM**	**Care Management PMPM**	**DE Members (Attributed)**
Aetna	**6.6%**	$4,277,800	$70	$9	5,080
Cigna	**10.9%**	$1,381,700	$69	$2	1,670
Highmark	**9.5%**	$28,885,200	$76	$34	31,600
UnitedHC	**3.6%**	$136,800	$51	$8	220
New to Market, Year 1 Implementation					
AmeriHealth	**3.8%**	$1,094,100	$5		5,800
Delaware First	**2.0%**	$5,000	$16		86
		$35.7 Million			**44,456**

2024 Non-Claims Payments by Health System

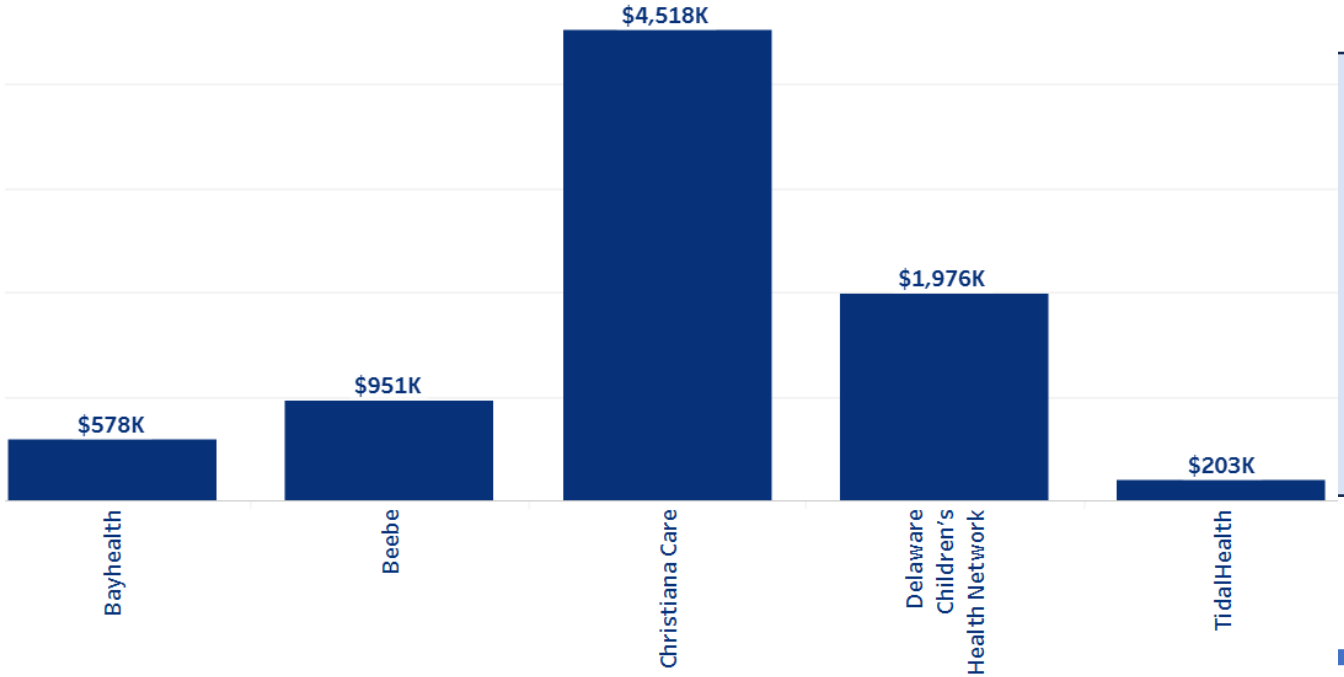


Health systems collected $12.4 million with PMPM payments for providers engaged in VBC:

- **Bayhealth $22 PMPM**
- **Beebe $30 PMPM**
- **Christiana Care $43 PMPM**
- **DE Children Health Network $39 PMPM**
- **TidalHealth $24 PMPM**

2024 Care Management Payments by Health System

Health systems collected $8.2 million in prospective care management payments in 2024.

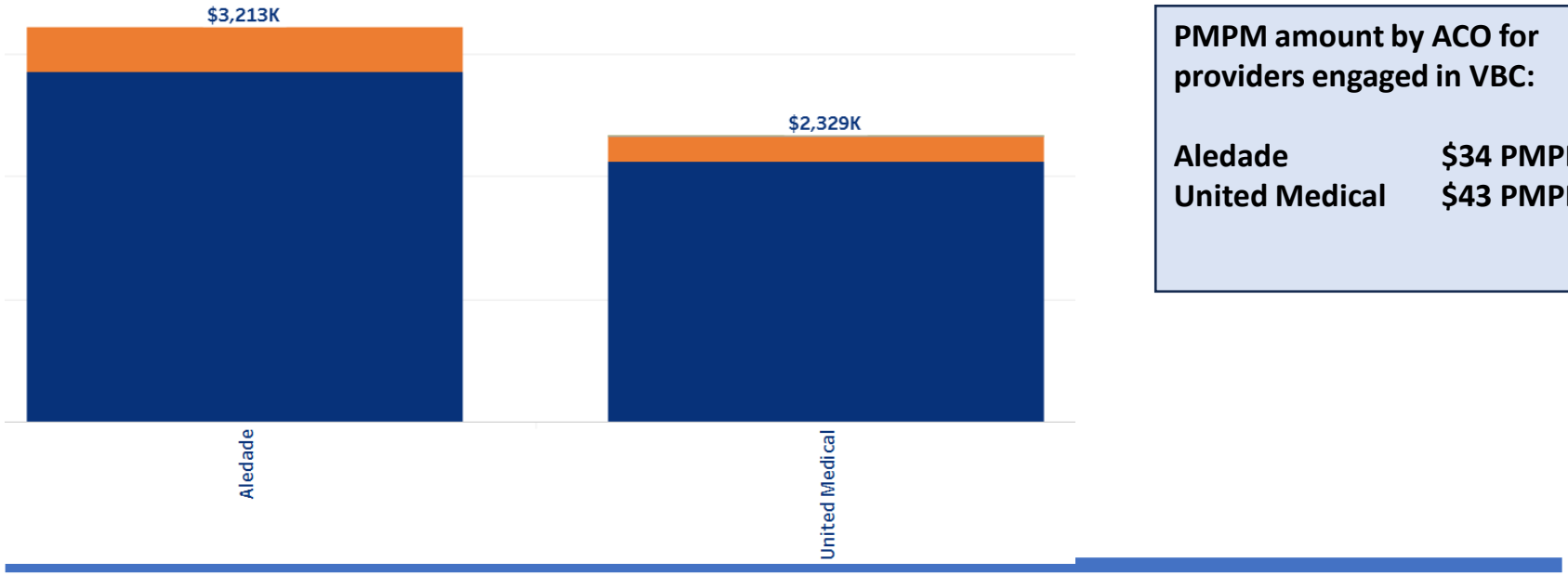


PMPM payments for providers engaged in care transformation:

- **Bayhealth $19 PMPM**
- **Beebe $26 PMPM**
- **Christiana Care $24 PMPM**
- **DE Children Health Network $35 PMPM**
- **TidalHealth $22 PMPM**

2024 Non-Claims Payments by ACO

The two ACOs (non-affiliated) collected $5.5 million in non-claims payments in 2024

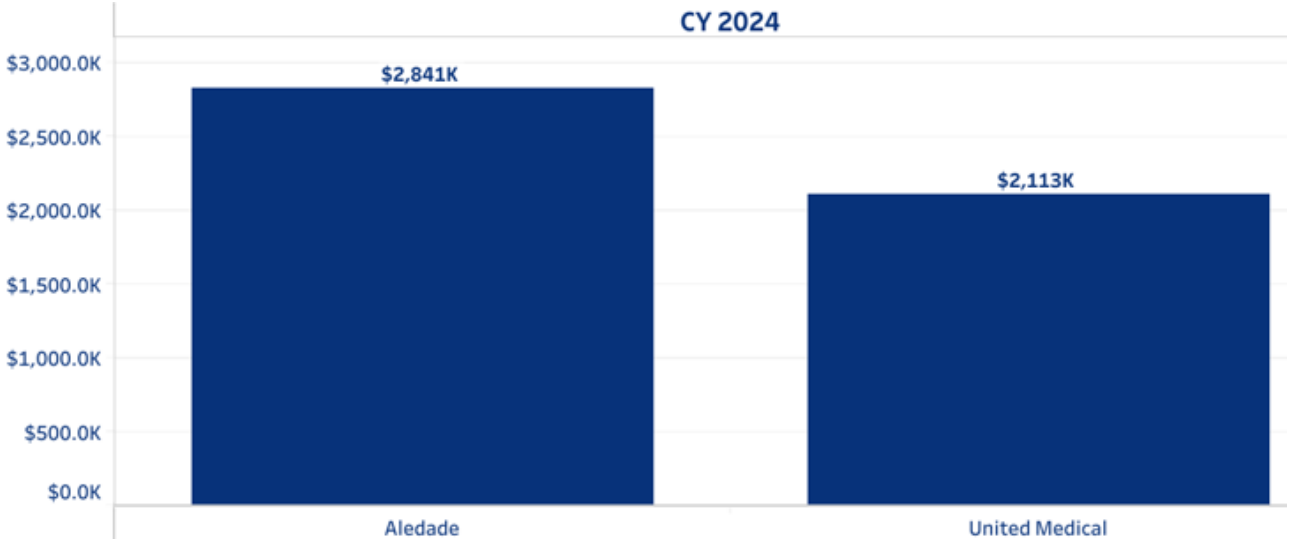


PMPM amount by ACO for providers engaged in VBC:

Aledade	**$34 PMPM**
United Medical	**$43 PMPM**

2024 Care Management Payments by ACO

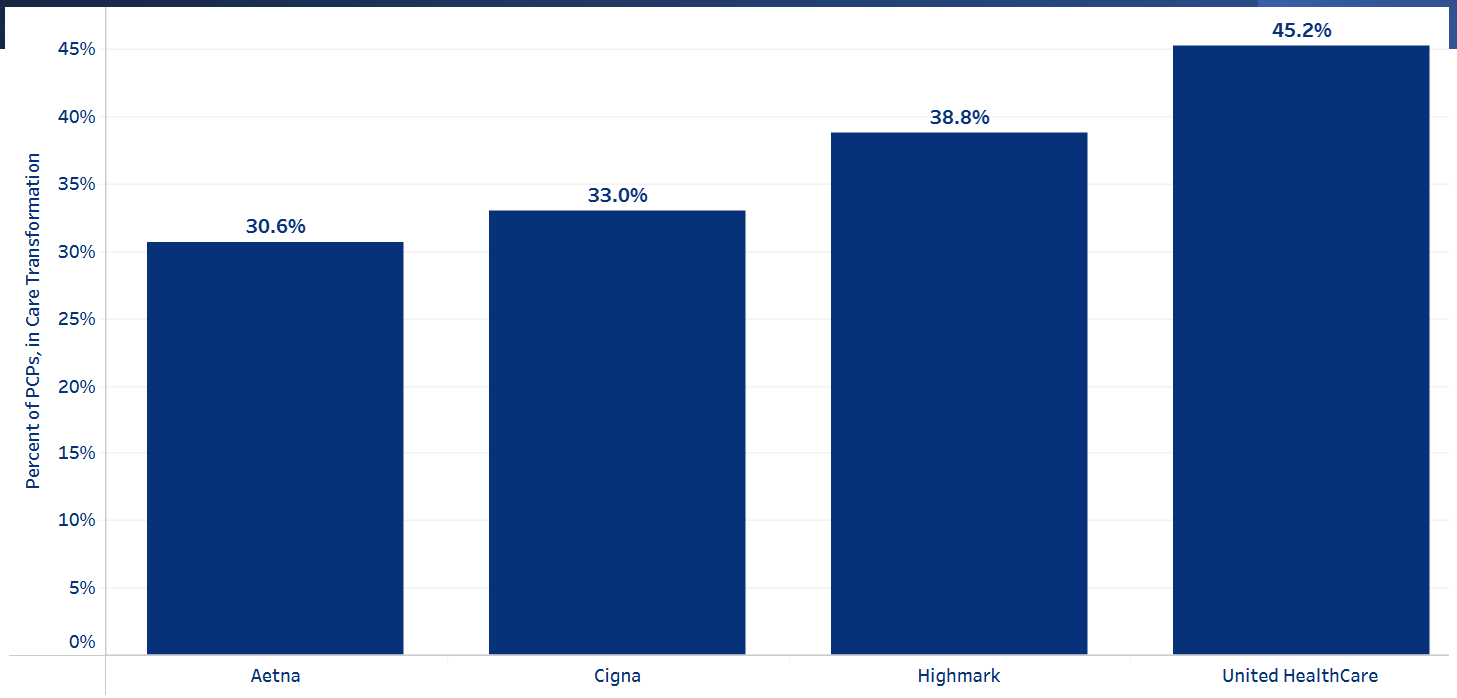
The two ACO (non-affiliated) collected $4.9 million in prospective care management payments in 2024



PMPM amount by ACO for providers engaged in VBC:

Aledade	**$30 PMPM**
United Medical	**$39 PMPM**

2024 Progress with Providers in Care Transformation



Carriers reported their progress towards achieving 75% of providers participating in care transformation by 2026

What's Next for OVBHCD?

- Analyzing pharmacy spending data (including rebate information) and will be reporting results
- Analyzing GPL-1 data, along with rebate information, to better understand utilization and costs, including co-pays for these high-cost medications
- Requested primary care utilization and cost data from DHIN to understand fee-for-service spending across payer types
- Continue working toward payer alignment strategies to reduce provider administrative burden and improve performance

PCRC WORKGROUP UPDATES

INTER-WORKGROUP MEETING (MAY 27, 2025)

Second Inter-Workgroup Meeting on May 27, 2025.

Purpose: Align workgroups, share updates, and prepare for the June 23 PCRC meeting

Main Takeaways:

- **Quality Metrics Alignment**: Year-one measures finalized for both adult and pediatric populations, with a focus on claim-based metrics to reduce reporting burden. Implementation may shift to 2027 due to payer timelines. More payer input is needed to streamline and align measures.
- **Value-Based Care (VBC) Strategy**: Identified 20+ attribution and process pain points with 40+ proposed solutions. Emphasis on active patient panel management, simplified contracts, and a tiered prospective payment model to support provider readiness.
- **Practice Model Innovation**: Advocated for flexible metric "menus" and community-based support for small practices. Explored interoperability with DHIN and discussed funding challenges for transformation efforts.
- **Cross-Workgroup Themes**: Strong support for prospective payments tied to quality outcomes. Concerns raised about payer portal fragmentation, attribution errors affecting quality scores, and clawbacks on advance payments.

Value-Based Care Workgroup Goals

The **Value-based Care Workgroup** is committed to advancing sustainable transformation through strategic collaboration and innovation in primary care. The group's key goals include:

- Strengthening multi-payer alignment
- Securing stakeholder buy-in
- Aligning attribution and payment models
- Driving policies that support primary care investment

Three Categories:

I. Recommendations
II. Considerations
III. Common Themes

Note: not all stakeholders support/endorse all recommendations and considerations

I. Proposed Recommendations

1. Opportunities for Enhanced Collaboration & Education

Improved Panel Management Support

- Payers and providers should leverage their resources to provide more accurate, timely, and actionable roster lists and support efficient panel management processes.

Education on Financial and Quality Metrics

- There is a need for clearer education and transparency regarding shared savings models, risk scoring methodologies, trend factors calculations, and the importance of on-going monitoring and interpretation of these metrics.

I. Proposed Recommendations

2. Enhancing and Standardizing an Active Panel Management Process

- VBC Working Group will establish a process to address patient attribution when (1) patients are receiving care elsewhere, (2) when their provider relocates, and (3) consider using a shorter look-back. This process should be endorsed across commercial payers and adopted across other payers.

3. Standardizing and Aligning Attribution Across MCOs

- VBC Working Group and DMMA to develop a standardized process that is used across each of the MCOs, and/or full delegation of assignment/attribution logic that is used.

II. Considerations:

- Encourage alignment between payers and providers on more frequent and predictable payment schedules, such as quarterly payments, to enhance financial sustainability and planning.

- Recognize that smaller/independent provider groups may lack the scale, systems, and staffing to fully participate in value-based care. Explore:
    - Practice aggregation strategies, or
    - Incentives for joining Accountable Care Organizations (ACOs)

II. Considerations:

- Consider a two-tiered, population-based, payment reform program:
  - Tier 1: measures, requirements, and incentives that enable small/independent practices to participate, and increase the requirements over time to provide a glidepath to greater capacity for VBC.
  - Tier 2: designed for practices farther along in value-based care (likely health system and ACOs)

III. Common Themes

Phased Implementation with Future Alignment

- Programs may initially launch with fully insured commercial plans, but must be strategically designed to align with other payers such as Medicaid and State Benefits Office (SBO) to ensure long-term scalability and consistency.

Clear ROI for Care Coordination Payments

- A mutual understanding of return on investment (ROI) is essential to justify prospective care coordination payments, ensuring financial sustainability and stakeholder support.

III. Common Themes

- **Simplified, Aligned Contracts**
    - Streamlining contracts to reduce administrative burden
    - Aligning metrics and incentive structures across payers
    - Designing for measurable success for both providers and patients
- **Mutual Accountability**
    - Emphasize that both payers and providers must be held to clear expectations, reinforcing shared responsibility for outcomes and performance.

PRACTICE MODEL WORKGROUP

Strategic Priority: 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.

Priority for Workgroup: focused on common challenges with value-based payment models:

- Decreasing Administrative burden -
  - data collection, analysis, integration
  - asking to do "more" with less>>>having the adequate practice resources (transformation) to be successful in VB payment
- Demonstrating the "value" of the practice and patient care

PRACTICE MODEL WORKGROUP

Comments regarding Attribution work from VBC Workgroup:

- More flexibility working with practices regarding attribution list - helping them be successful
- streamlining with standardized reporting cadence
- appropriate feedback

Meeting with DHIN regarding greater interoperability and networking of information for practices

- Nemours present and useful information regarding their experience with their specialists and primary care offices
- Essentially for DHIN, rate limiting is data is only as good as the input/participation

PRACTICE MODEL WORKGROUP

Meeting with DHIN regarding greater interoperability and networking of information for practices

- What is the “ask” - help with workflow. Possible “push” report regarding missing data, e.g. CRS, mammo, etc
- FUNDING
- DHIN is interested in working with PCRC and can continue discussion, but these two areas need more details.

PRACTICE MODEL WORKGROUP: QUESTIONS:

What are the concerns/decisions/preferences regarding a primary care payment reform from the Practice Model Workgroup perspective?

- *Practices participating in quality programs need to be paid an enhanced per member per month fee at least quarterly to fund the staffing needed to participate and succeed in quality programs.*

What support would PCPs need to succeed in the payment model, and how does this vary by practice model type?

- *PCPs would need to have staff and educational support to succeed in the payment model. Simple and clear incentives need to be rolled out that the PCPs can understand and get excited about. I think this is true for all practice model types.*

PRACTICE MODEL WORKGROUP: DRAFT RECOMMENDATIONS

1. While practices want more flexibility than a standardized set of “metrics” which may not really reflect the quality of care they provide, that need is offset by the reality that in our small patient population with an outsize effect of limited payors, limited leverage to increase flexibility v. standardization
    a. consideration for a “menu” compromise, which has a limited set of metrics and practices only need to meet “X” # of metrics to qualify for ?prospective/ retrospective payments

PRACTICE MODEL WORKGROUP: DRAFT RECOMMENDATIONS

2. How to “small” practices be successful:
    a. reality of cost of running small practices>>>consideration for “community” networking/coalescing practices for economies of scale and shared resources
    b. Always ? of funding: ?grants to participate in community approach for VBC. *possible public/private collaboration*
        i. *challenges of any funding in this current federal environment*

3. Increasing Awareness of PCRC work and possible opportunities for practices>>>work with Communications workgroup on maybe standalone PCRC roundtable (last one before COVID) or with larger event, such as Healthcare Workforce Summit

QUALITY METRICS WORKGROUP

Goals and Purpose:

- Promote and advocate for quality measures aligned across payers based on the highest cost of care drivers.

Propose the following measures for the next performance year opportunity:

Adult Measures for Year One

1. Controlling high blood pressure (CBP)
2. Hemoglobin A1c (≤9%) (GSD)
3. Colorectal cancer screening (COL)
4. Breast cancer screening (BCS)

Pediatric Measures for Year One

1. Child Well-Care Visits (only 3-11) (WCV)
2. Well-child Visits for Age 15 months-30 months (W30)
3. Lead screening (LSC)
4. ***Consideration:*** Immunization Combo-7 (if payers want to include an immunization measure).

Appendix: Adult Measures

Measure	Description	Numerator	Denominator	Steward	Data Source
Controlling high blood pressure	The percentage of adults 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.	Patients 18-85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.	NCQA	Claims, Electronic Health Data
Hemoglobin A1c (≤9%) ***NCQA measure is 8%, however adjusted to 9% for DE commercial market**	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <9.0%* during the measurement year.	Patients whose most recent HbA1c level is less than 9.0%* during the measurement year.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year.	NCQA	Claims, Electronic Health Data
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Women who received a mammogram to screen for breast cancer.	Women 50-74 years of age.	NCQA	Claims, Electronic Health Data
Colorectal Cancer Screening	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Patients who received one or more screenings for colorectal cancer according to clinical guidelines.	Patients 51–75 years of age	NCQA	Claims, Electronic Health Data

Appendix: Pediatric Measures

Measure	Description	Numerator	Denominator	Steward	Data Source
Child and Adolescent Well-Care Visits (3-11 years of age)	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	One or more well-care visits (Well-Care Value Set) during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.	The eligible population.	NCQA	Claims, Electronic Health Records
Well-Child Visits for Age 15 Months–30 Months	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.	The Rate 2 eligible population.	NCQA	Claims, Electronic Health Records
Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday	The eligible population (see HEDIS specs)	NCQA	Claims, Electronic Health Records
Childhood Immunization Status (CIS): Combination 7	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.	Eligible population (see HEDIS specs)	Eligible population (see HEDIS specs)	NCQA	Claims, Electronic Health Records

REVIEW PCRC END OF YEAR REPORT

(PCRC VOTE)

2025 PCRC Recommendations Report

Summary of Key Takeaways

Presented by:

Health Management Associates (HMA)

- **Craig Schneider, Principal**
- **Berkley Powell, Consultant**

Purpose and Outline

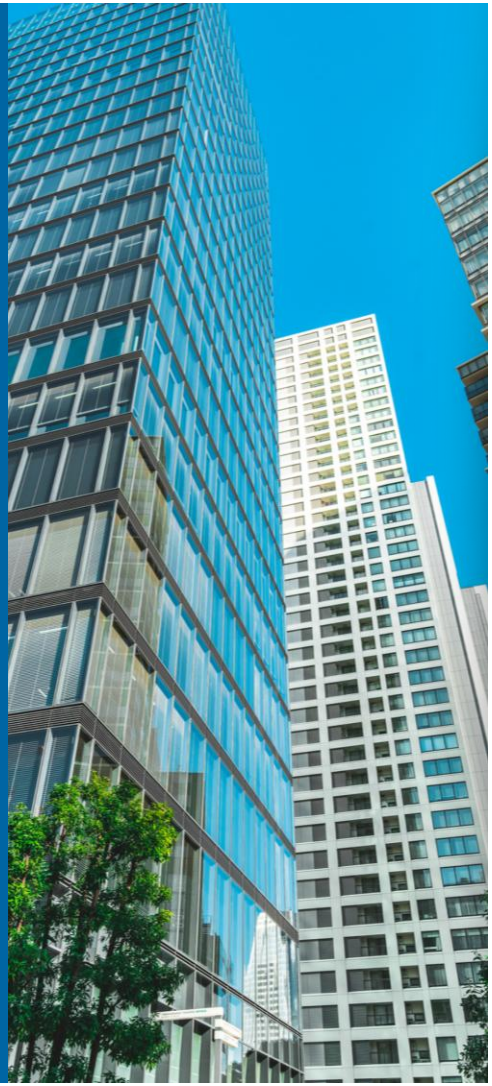
OF THE RECOMMENDATIONS REPORT

- **Purpose:** Summarize PCRC workgroups discussions, identify decisions to be made, and propose a timeline to advance primary care payment reform in Delaware.

- **Outline:**
  - Brief history and overview of the PCRC and its mission
  - Alignment with SB120 and broader health system goals
  - PCRC workgroup discussions
  - Other state and CMS models
  - Strategic considerations, recommendations, and timeline for implementation of a primary care payment model

Model Development Next Steps

Key decisions to continue momentum and stakeholder commitment



Key Decisions for Implementation

- Payment Approach
- Comprehensiveness
- Pilot test or full roll out
- Governance structure and legislation/ regulatory approach
- Analytical/actuarial modeling
- Role of quality measures in the payment model
- Operational needs and oversight
- Evaluation
- Communications plan

Operational Considerations

Multi-payer alignment

Innovation Zone

Align with neighboring states or position Delaware as an "innovation zone"

Leverage existing initiatives

Leverage Delaware's cost transparency platform (CostAware) and benchmarking tools such as the Benchmark Trend Report Dashboard for statewide alignment. Collaboration with Diamond State Hospital Cost Review Board's efforts.

Expanding to additional payers

SEBP, Medicaid, and ERISA plans not subject to legislative mandate under SB120. In Delaware, the fully insured market segment is relatively small (~10%).

Operational Considerations

Incentive Alignment

Adoption of mutually defined VBC contracts

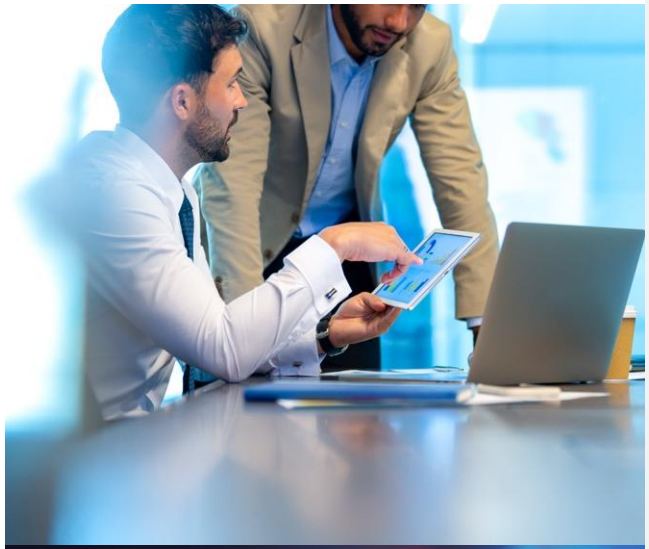
Collaboration between commercial and public payers to adopt shared VBC frameworks

Data sharing

Determine procedures for data collection and reporting across participating payers. Consider if the PCRC will recommend an aligned approach for promoting data sharing, transparency, performance management, and benchmarking.

Incentives

Determine incentives for providers and payers to adopt mutually defined VBC models



Operational Considerations

Performance Measures

Quality Metrics Workgroup Measures

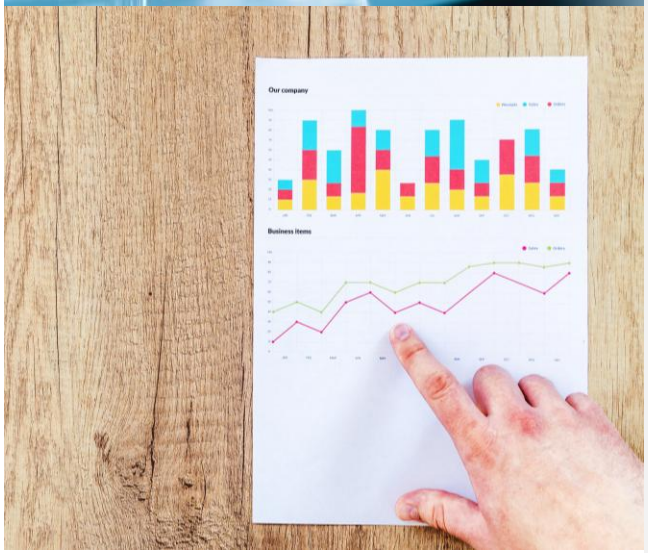
Finalize and adopt the measures for Year 1 with proposed rollout approach.

Reporting Timelines

Consider implementation timeline and coordination with payer timelines to avoid misalignment.

Benchmarks

Establish performance benchmarks. Measures should align with Delaware's broader health care benchmarking process.



Operational Considerations

Primary Care System Sustainability

Risk and Participation

Consider how to structure incentives to encourage provider participation:
•Reward-only models may lead to voluntary opt-outs and limited uptake.
•Penalty-based models may increase participation but risk provider dissatisfaction or attrition

SQI & CQI Payment Structures

Evaluate the proposed Standard Quality Investment (SQI) and Continual Quality Investment (CQI) recommendations previously proposed.

VBP Parameters

Determine the primary care value-based payment parameters needed to encourage provider participation and grow the workforce

Additional Considerations

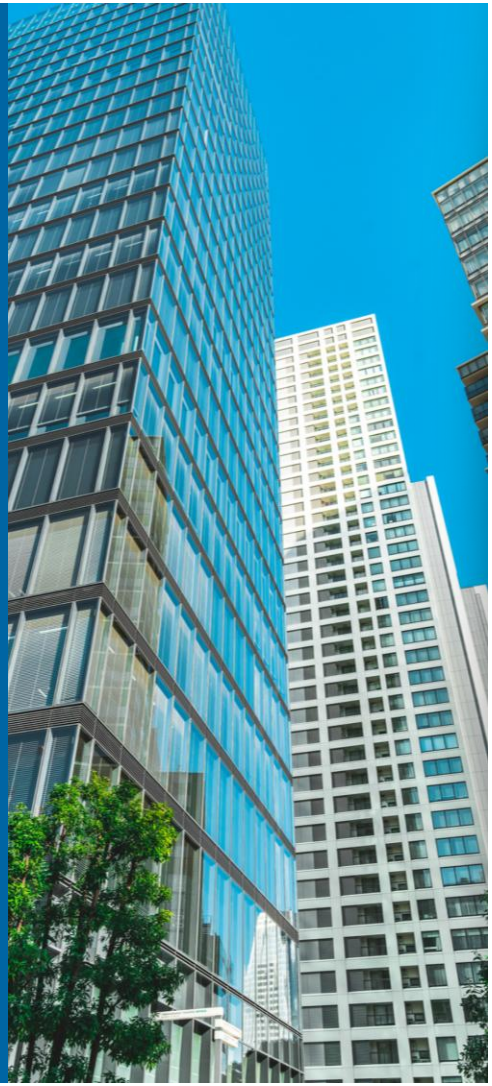
Attribution Methodology
Attribution methodology for reimbursements

Provider and Consumer Education
Provider and patient education on the payment model can influence overall model success.

Expansion Considerations
Operational capacity to expand and timeline for expansion.

Model Development Next Steps

Recommendations



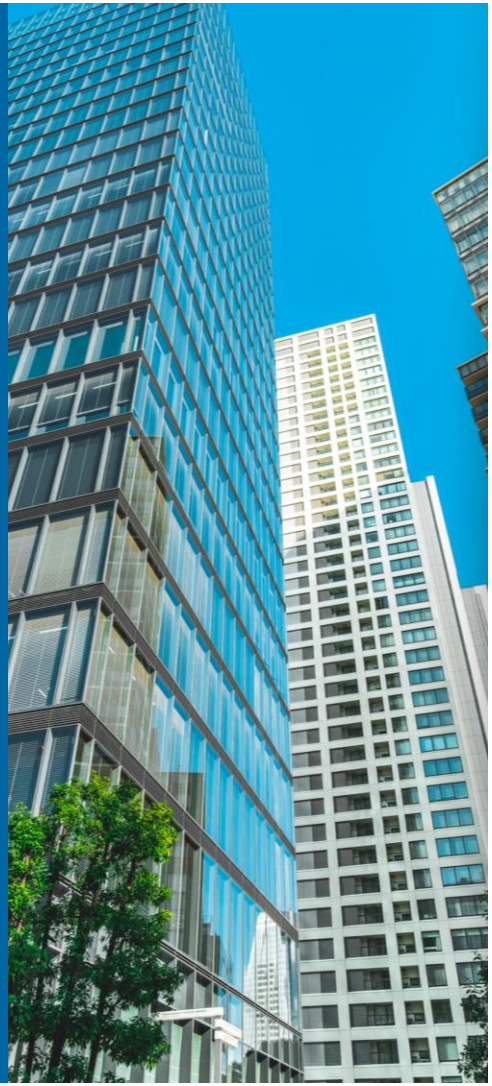
Key Decisions for Implementation

Overview of Proposed Model

- ❑ Multi-tiered hybrid payment structure
  - ❑ Combines prospective capitation with retrospective performance-based payments
  - ❑ Allows practices to participate based on readiness
  - ❑ Encourages progression towards advanced value-based care
- ❑ Hybrid Payment Mechanism
  - ❑ Prospective payments to support care delivery
  - ❑ Retrospective performance-based payments (calibrated to each tier)

Model Development Next Steps

Recommendations



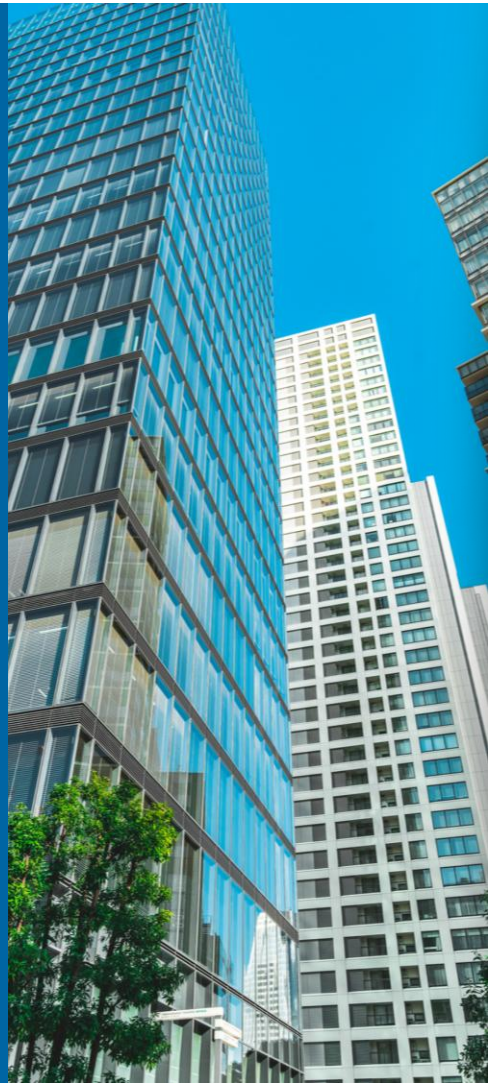
Key Decisions for Implementation

Comprehensiveness Across Payers and Providers

- ❑ Multi-Payer Alignment
  - ❑ Commercial fully insured plans
  - ❑ Marketplace Qualified Health Plans
  - ❑ Medicaid managed care and fee-for-service programs
  - ❑ Consider inviting Medicare Advantage plans and engage self-insured employers on a voluntary basis
- ❑ Inclusive Provider Participation
  - ❑ All eligible primary care practices
  - ❑ Practices would select tiered payment options

Model Development Next Steps

Recommendations



Key Decisions for Implementation

Statewide Rollout

- ❑ Launch a full statewide rollout for providers, starting with three-year performance period
- ❑ Phased approach for payers, starting with commercial plans

- ❑ Pursue state legislation and regulatory action to authorize and implement the program
  - ❑ Seek CMS waiver to enable Medicaid participation.
  - ❑ Ask CMS about the feasibility of re-opening AHEAD model

- ❑ Conduct actuarial and revenue scenario modeling to help primary care practices understand how the payment model may affect different practice types

Model Development Next Steps

Recommendations

Key Decisions for Implementation

Quality Measures

- ❑ Finalize and approve Year 1 quality measures proposed by the Quality Metrics workgroup by the end of 2025
- ❑ Task the workgroup with developing additional measures for Years 2 and 3 by March 2026
- ❑ Ensure performance benchmarks for Year 1 are proposed by June 2026
- ❑ Finalize benchmarks for Years 2 and 3 by September 2026
- ❑ During the first half of 2026, evaluate the inclusion of cost, efficiency, and/or utilization measures and determine their role in the overall measure set and payment model.

Model Development Next Steps

Governance Structure

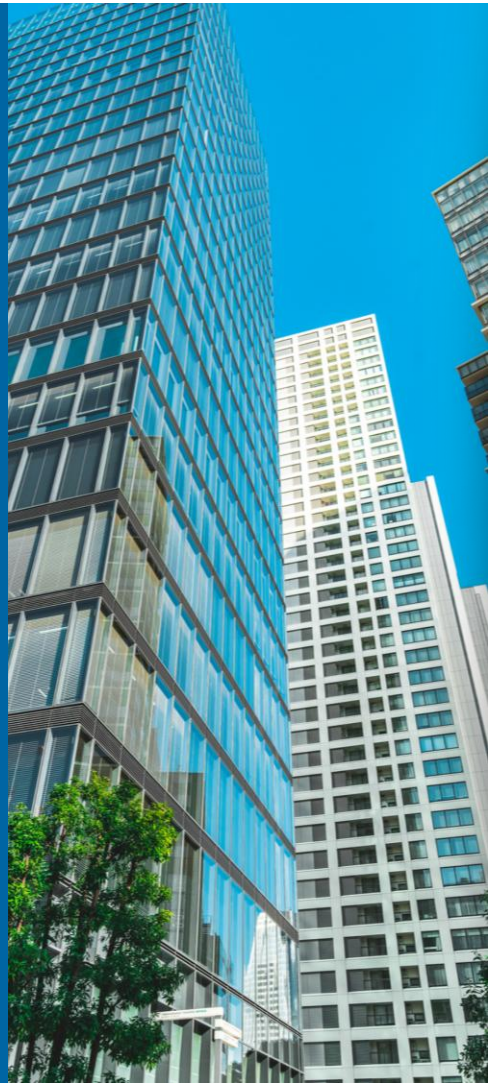
Key Decisions for Implementation

- **PCRC modify current four-workgroup structure**

Current Workgroup Name	Name Beginning SFY26	Responsibilities
Communications	Communications	Develop and implement a communications plan
Practice Model	Analysis & Monitoring	Define and oversee analytic needs and monitor program's impact on primary care practices and access to primary care in the state
Quality Metrics	Program Performance	Determine measure set for future program years, recommend benchmarks, consider whether and which potential cost measures to include
Value-Based Care	Payment Model Design	Recommend scope and specifics of payment model design, including which payers and providers are included and the pace for expansion
N/A	Implementation	Identify operational challenges, troubleshoot any issues, develop solutions to any challenges, oversee development of any legislation or regulations, or federal waivers, and plan and conduct stakeholder engagement efforts.

Model Development Next Steps

Recommendations



Key Decisions for Implementation

Operations, evaluation, stakeholder engagement, and communications

- ❑ DHCC conduct an internal assessment of staffing and computer systems needs and capabilities by December 31, 2025. Determine additional staffing or procurement needs.
- ❑ Conduct an evaluation determined by the new Implementation workgroup which will define the parameters of the evaluation.
- ❑ Implementation Workgroup to develop a stakeholder engagement plan by end of September 2025.
- ❑ Communications Workgroup to develop a strategic outreach effort with specific activities.

Proposed Implementation Timeline

Activity	Proposed Timeline
PCRC to recommend payment model approach to DHCC	September 2025
Develop implementation roadmap	October 2025
Draft legislation or regulation	December 2025
Create marketing and communications plan	January 2026
Establish implementation governance structure	March 2026
Determine operational needs	March --June 2026
Phase 1 of payment model launch	July 2026
Phase 2 of payment model launch	July 2027
Complete evaluation of first 2.5 years of payment model	December 2028

Discussion

APPENDIX:

National Model Comparisons

Prior reports and discussions focused on additional models (see 2024 report and 2024 strategic plan).

- **Maryland:** Global hospital budgets via HSCRC; informs CMS AHEAD model.
- **New Mexico:** Medicaid hybrid model VBP initiative, with bonus payments, three tiers, and risk-sharing contracts with Medicaid MCOs. Discussing multi-payer alignment soon.
- **CMS Models:**
  - **BPCI Advanced:** Voluntary bundles for 90-day episodes
  - **ACE:** Voluntary inpatient episodes
  - **TCPI:** Reduced ED use with transformation
  - **ACO REACH, ACO Primary Care Flex, Primary Care First:** Newer primary care-focused models that have not been formally evaluated.
  - **AHEAD:** State multi-payer model that addresses hospital and primary care settings.

PUBLIC COMMENT

ADJOURN