PRIMARY CARE REFORM COLLABORATIVE (PCRC) Meeting
June 23, 2025
3:00 p.m. - 5:00 p.m.

Meeting Attendance and Minutes

In-Person Collaborative Members Attending:

Name	Appointment
Dr. Nancy Fan, Chair	Delaware Health Care Commission
Steven Costantino	Department of Health and Social Services
Stephanie Hartos	Chair, State Employee Benefits Committee
Cristine Vogel	Department of Insurance
Dr. Rose Kakoza	Delaware Healthcare Association
Representative Nnamdi Chukwuocha	House Health & Human Development Committee
Jason Hann-Deschaine	Medical Society of Delaware
Michelle Deveren	Delaware Nurses Association

Virtual Collaborative Members Attending:

Name	Appointment
Andrew Wilson	Division of Medicaid & Medical Assistance
Kevin O'Hara	Insurance Carrier (Highmark Delaware)
Deborah Bednar	Insurance Carrier (Aetna)
Senator Bryan Townsend	Senate Health & Social Services Committee
Maggie Norris-Bent	Federally Qualified Health Center (Westside Family Healthcare)

Meeting Facilitator: Dr. Nancy Fan, PCRC Chair and Dr. Neil Hockstein, incoming PCRC Chair

Delaware Health Care Commission Staff: Elisabeth Massa (Executive Director)

Anchor Location:

Department of Health and Human Services (DHSS)
Herman M. Holloway Sr. Health and Social Services Campus
The Chapel
1901 N. DuPont Highway
New Castle, DE 19720

Call to Order

Dr. Fan called the meeting to order at approximately 3:00 p.m. A quorum was present. Dr. Fan reviewed the housekeeping items, and the attendees introduced themselves.

Review and Approve March 3, 2025, Meeting Minutes

Dr. Fan asked Collaborative members if there were any edits or comments for the March 3, 2025, meeting minutes. Hearing none, a motion was made to approve the minutes by Steven Costantino, seconded by Cristine Vogel. All members were in favor. The approved minutes are available on the Delaware Public Meeting Calendar.

Office of Value-Based Health Care Delivery (OVBHCD) Update

Cristine Vogel, Director of the OVBHCD presented an update on Delaware's primary care investment. First, she shared the University of Colorado issued a report, "Advancing Primary Care Payment Reform in the Private Sector." Delaware was included, along with Arkansas, Colorado, Rhode Island, and Washington.

Ms. Vogel next shared the 2024 progress update for primary care investment results. Delaware successfully increased primary care investment in 2023 and 2024 in the commercial, fully insured market. Delaware continues to lead in primary care investment among states. Discussed that Delaware having a consistent definition for primary care, data collection, tracking and reporting process contributes to the state leading in primary care investment. The commercial market also has experienced increases in primary care reimbursement because of the "Medicare Parity" rule implemented. Although Delaware has seen an increased primary care investment in 2023 and 2024, it is too soon to see if there is a reduction in overall healthcare costs. Cristine noted that overall healthcare cost reduction is a long-term goal.

Despite progress, several challenges remain. These include low rates of primary care provider (PCP) visits, and the disproportionate impact of high-cost claimants on total medical expenses (TME). Value-based care (VBC) contracts are still concentrated among a limited number of health systems and accountable care organizations (ACOs). Carriers have expressed concern over low patient engagement, noting that both payers and providers have invested considerable resources into outreach and incentives, yet continue to face difficulties ensuring patients attend their initial visit and access primary care services.

Carriers have invested $59.6 million in primary care for the commercial fully insured market ($35.7 million of these funds were associated with those providers participating in care transformation. Primary care investment is 8.6% (the target was 10%). Of the five health systems, ChristianaCare earned the most non-claims payments ($8.2 million) and the range of non-claims PMPM amounts was from $22 to $43.

Care management payments, a subset of non-claims payment, ranged from $19 to $35 PMPM. For ACOs, Aledade received $3.2 million and United Medical $2.3 million in non-claims payments (their respective PMPM figures are $34 and $43 and respective care management fees total $2.8 million and $2.1 million). Plans need to accomplish 75% in care transformation by 2026 – the highest is currently at 45%.

Ms. Vogel pointed out that AmeriHealth and Delaware First are new to the commercial, fully insured market and 2024 is their implementation year. A PCRC member mentioned that in the 2026 performance period, there may be about 50,000 more uninsured because of federal changes, and these plans are sensitive to changes in the calculation of primary care investment due to lower enrollment.

Next steps for OVBHCD are to analyze prescription drug spending including GLP-1; data from Delaware Health Information Network (DHIN) on fee-for-service spending across payer types; and multi-payer alignment strategies.

PCRC feedback and discussion about the OVBHCD Update:
Several PCRC members raised concerns and questions about the following from the OVBHCD update:

- Discrepancies between reported PMPM payments from carriers and what providers receive—funding is not flowing to PCPs.
- Ms. Vogel noted the numbers are driven by total medical expenses, which are high overall, and this increases the amount of primary care investment.
- Members raised concerns that the reported payments are not comparable if the methodology differs across payers. Overall, there is a lack of transparency in methodology and attribution.
- Ms. Vogel noted that OVBHCD does not have the authority to tell insurers what amount of payment can be distributed among the categories of non-claims payment (care management, risk, etc.). Currently, she always strongly encourages more money in the prospective payment category.
- Out-of-pocket expenses are not included in the spending figures. Ms. Vogel will confirm that pharmacy medications covered under medical coverage in outpatient and inpatient settings are included in the spending figures.
- Outliers are also skewing the data and therefore the data must be normalized.
- Potential need for broader inclusion of Medicaid and state employee plans to influence outcomes.
- Acknowledgement of the difficulty of retaining primary care physicians in Delaware. Only 2 of the last 24 primary care graduates have stayed in Delaware.

<u>PCRC Workgroup Updates</u>

The workgroup chairs provided updates on their respective workgroups' recent meetings. However, due to time constraints, not all updates could be presented during the meeting. Dr.

Fan encouraged members of the PCRC to review the full set of presentation slides following the meeting to ensure they are informed about all workgroup activities and progress.

The second Inter-Workgroup meeting took place on May 27, 2025, with the primary goal of aligning workgroup efforts, sharing progress updates, and preparing for the June 23rd PCRC meeting. A key takeaway from the session was the strong consensus in favor of implementing prospective payments tied to quality outcomes. The Quality Metrics Workgroup has been actively developing a standardized set of measures and exploring how these could be integrated into a unified payment model across payers. Additionally, several cross-theme concerns emerged from the workgroups, including fragmentation across payer portals, the impact of attribution methodologies on quality metrics, and the risk of clawbacks on advance payments.

Value-Based Care (VBC) Workgroup: The Value-Based Care Workgroup has been meeting bi-weekly over the past several months and has developed a series of proposed recommendations organized into three key focus areas. In addition to the proposed recommendations, the workgroup has also identified broader considerations for the PCRC and recurring themes that emerged throughout their discussions. The three primary areas of recommendation include:

1. Opportunities for Enhanced Collaboration & Education
    a. 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 process.
    b. 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.
2. Enhancing and Standardizing an Active Panel Management Process
    a. VBC Workgroup will establish a process to address patient attribution (1) when 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.
3. Standardizing and Aligning Attribution Across MCOs
    a. VBC Workgroup and Division of Medicaid and Medical Assistance (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.

The members discussed the next steps for advancing the VBC workgroup's recommendations. Ms. Vogel, the VBC chair, estimated that approximately 50% of the proposed work could be accomplished through direct collaboration with payers and providers. However, completing the remaining 50% (particularly efforts related to standardizing attribution) may require legislative action. While the idea of payers voluntarily signing a Memorandum of Understanding (MOU) was raised, it was noted that other states have struggled to achieve effective multi-payer alignment through voluntary agreements alone. The PCRC must determine which elements should be pursued through legislation. The VBC Workgroup has been talking through the

challenges for several months since it is the workgroup's responsibility to do research for the PCRC, but the PCRC needs to make the decisions for implementation. Dr. Hockstein highlighted the urgency of this decision, noting that only two to three PCRC meetings remain before the next legislative session begins.

Practice Model Workgroup: The Practice Model Workgroup has prioritized addressing common challenges clinicians face within value-based payment models, with a focus on reducing administrative burden and demonstrating the value of both clinical practice and patient care. As the only clinician-led workgroup (comprising physicians and nurses) it has faced engagement challenges due to participants' schedules.

Despite this, the workgroup held a productive meeting with the DHIN to explore opportunities for improved interoperability and information sharing among practices. Additionally, the group has developed several draft recommendations aimed at supporting practice transformation and enhancing participation in value-based care based on recent discussions:

1. **Provider flexibility:** Practices express a desire for greater flexibility than what a standardized set of metrics typically allows, especially if such metrics may not capture the quality of care they deliver. Given the state's relatively small patient population and the outsized influence of a limited number of payers, there is a constrained leverage to prioritize flexibility over standardization.
    a. **Consideration:** One potential compromise under consideration is the adoption of a "menu-based" approach. It would offer a curated set of core metrics from which practices could select a subset—meeting a defined number of these metrics would qualify them for prospective or retrospective payments. This structure aims to preserve some degree of provider choice while maintaining consistency and accountability across the system. Next steps would include collaboration between the Practice Model and Quality Metrics Workgroups.
2. **Independent provider challenges**: Small practices face significant financial and operation challenges that can hinder their ability to participate effectively in value-based care models.
    a. **Consideration:** proposed strategy to address small practices challenges by fostering "community-based" networks, encouraging small practices to collaborate, share resources, and achieve economies to scale.
    b. **Challenge:** to enable small practices to engage in collaborative models, there is a need to explore targeted funding mechanisms (such as grants) that support this initiative. However, securing funding is increasingly difficult in the current federal environment.
3. **Education and awareness:** Across workgroups there is a focus on more education and the need for increased transparency which would help practices be more successful.
    a. **Consideration:** Increasing awareness of PCRC work and possible opportunities for collaboration. Restart the Communications workgroup and attend larger events such as the Healthcare Workforce Summit.

Quality Metrics Workgroup: The Quality Metrics Workgroup aims to promote and advocate for the adoption of quality measures that are aligned across payers. The group has focused on identifying a core set of metrics designed to reduce administrative burden while still making improvements in health outcomes. These measures were selected based on their prevalence among Delaware's commercial payers. To support implementation, the workgroup has proposed a phased approach, beginning with approximately eight measures in the first year, with additional metrics to be introduced in subsequent years. The goal of starting with a smaller number of measures in Year One is to ensure that all providers can participate, regardless of their readiness for value-based care. The proposed Year One measures are:

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).

Review PCRC End of Year Report (*PCRC vote*)

Craig Schneider and Berkley Powell from Health Management Associates (HMA) presented the 2025 PCRC recommendations report which was submitted to the PCRC members the previous week. The purpose of the report was to synthesize the work of the PCRC and the PCRC workgroups, propose a series of key decisions for the PCRC to move the initiative forward and propose a timeline for implementing a new payment reform initiative.

The report included specific recommendations for the PCRC which included:

1. Overview of proposed model:
    a. **Multi-tier payment model** (two-tier) structure that works both for integrated delivery systems and small independent practices. A tiered approach would allow practices to participate based on level of readiness and encourage progressions towards advanced value-based care.
    b. **Hybrid payment mechanisms** both prospective to support care delivery and retrospective performance-based payments.
2. Comprehensiveness across payers and providers
    a. **Multi-payer approach** for alignment and standardizations. Advised to start with commercial, fully insured plans and over time add additional payers. Payers to

engage include commercial plans, Marketplace Qualified Health Plans, and Medicaid managed care and fee-for-service programs. Consider inviting Medicare Advantage plans and engage self-insured employers on a voluntary basis. Discussed that it will take time to get CMS approval for Medicaid waivers.

3. Statewide roll out
    a. **Statewide approach** for providers, starting with three-year performance period and phased approach for payers, starting with commercial payers.
    b. **Pursue state legislation and regulatory action** to authorize and implement the program. Would need to seek CMS waiver to enable Medicaid participation.
    c. **Actuarial and revenue scenario modeling** to help primary care practices understand how the payment model may affect different practices.
4. Quality measures
    a. **Finalize and approve the Year 1 quality measures** proposed by the Quality Metrics workgroup. The workgroup would be tasked with developing additional measures for Years 2 and 3 by March 2026. Ensure that performance benchmarks for Year 1 are proposed by June 2026. Finalize benchmarks for Year 2 and 3 by September 2026. During the first half of 2026, the workgroup should evaluate the inclusion of cost, efficiency, and/or utilization measures and determine their role in the overall measure set and payment model.
5. Governance structure
    a. Proposed restructuring the current PCRC four-workgroup structure to the following to better support the model:

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.

6. Operations, evaluation, stakeholder engagement, and communication
    a. **Conduct an internal assessment** of staffing levels and IT system capabilities to identify any additional personnel or procurement needs.
    b. **Evaluation plan** determined by the implementation workgroup that will define the parameters of the evaluation.
    c. **Stakeholder engagement plan**
    d. **Strategic outreach efforts** developed by the Communications workgroup.

7. 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 of recommendations report:
Questions were raised about how the Delaware Enhanced Primary Care (EPC) Model, a hybrid payment framework originally introduced to the PCRC two years prior, could fit into the recommendations or if they are the same model. The recommendation from the 2025 report is not the EPC model. The discussion focused on how components of the EPC model could align with the recommendations outlined in the report and potentially serve as a foundation for value-based care reform.

Participants acknowledged that while the EPC model was conceptually adopted in 2023, its implementation stalled due to the absence of formal regulations. Without a regulatory structure, health plans were not required to offer the model, limiting its reach and impact. Despite this, members agreed that the model contains valuable elements that could support broader participation and scalability.

The conversation then turned to the challenge of multi-payer alignment. While SB120 mandates apply to commercial fully insured plans, they exclude Medicaid and state employee plans. Members emphasized the need for a more inclusive approach to ensure sustainability and equity across the healthcare system. There was discussion about whether to pursue a phased implementation strategy or to engage additional payers voluntarily or through new regulatory mechanisms.

In parallel, the group explored the coexistence of hybrid payment models and global budgeting. Delaware is currently piloting a pediatric global budget model within Medicaid. While promising, this model is not multi-payer (although there is potential to expand). Members debated whether such models could operate alongside hybrid models and ultimately agreed that they are not mutually exclusive. Different models may be appropriate for different populations, and both could contribute to the overarching goal of expanding access and improving outcomes.

The group also discussed a single fee schedule across all markets similar to Rhode Island. Without such a multi-payer fee schedule, there is pressure on publicly funded health insurance. Another participant commented that the insurance fee schedule is not the driver of cost increases; the cost drivers are added costs and lack of return on investment.

Concerns were raised about the short-term costs of investing in primary care versus the long-term benefits. While primary care spending has increased, overall healthcare costs continue to rise, and access to care has not significantly improved. This highlighted the need for a long-term commitment and robust evaluation mechanisms to assess the effectiveness of reforms. Overall, there needs to be commitment to improving access and sustainability in primary care. Discussed that multi-payer alignment could be a flexible approach to improve primary care access.

The group also discussed the potential for Delaware to participate in CMS's AHEAD model, which supports multi-payer VBC initiatives at the state level. Although the application window has closed, members suggested that Delaware could request reconsideration, given the alignment of its goals with the model's objectives.

The meeting concluded with a call to action. While no vote was taken on payment model adoption, members agreed to reconvene within 4–6 weeks to make decisions on the payment model and implementation timeline due to time constraints. There was support for adopting the proposed governance structure and workgroup framework, even if the specific payment model remains under discussion. The session closed with recognition of Dr. Fan's leadership and a shared commitment to advancing primary care reform in Delaware.

Public Comment

David Cruz and Michael Bradley expressed concerns about data reconciliation and lack of financial impact on independent practices.

Adjourn

The meeting adjourned.

In-Person Public Meeting Attendees:

Michael Bradley	MSD/MedNet
Margaret Hegerman	AmeriHealth
Kristin Dwyer	Nemours
Carling Ryan	Delaware Healthcare Association
David Cruz	Nemours
Suzane Lefadgo	DFH/AmbetterHealth DE
Cari Miller	Labcorp
Anthony Onugu	UMACO

Virtual Public Meeting Attendees:

Donna Pugh	DHSS
Sarah Owens	Health Management Associates
Christina Haas	DOI
Ainsley Ramsey	Health Management Associates
Brendan McDonald	Highmark
Faith Dyson-Washington	Health Management Associates
Megan Werner	Westside Family Healthcare