PRIMARY CARE REFORM COLLABORATIVE (PCRC) Value Based Care Workgroup Meeting
August 18, 2025
3:00 p.m. - 5:00 p.m.

Meeting Attendance and Minutes

Name	Representation
Cristine Vogel	Department of Insurance (DOI)
Christine Donohue-Henry, MD, MBA	ChristianaCare
Sarah Mullins, MD	Aledade
Anthony Onugu	United Medical

Virtual Work Group Members Attending:

Name	Representation
Michelle Adams	Westside Family Healthcare
Michael Bradley, MD	Dover Family Practice
Christina Bryan (for Brian Frazee)	Delaware Healthcare Association
Laura Hudson	Bayhealth
William Ott, MD	Aetna
Angela Perry, MD	AmeriHealth
Lori Ann Rhoads	Medical Society of Delaware
Andrew Wilson	DMMA
David Cruz	Nemours
Brittany Danoski	Mercy Health/St. Francis
James Trumble, MD	Tidal Health

Work Group Members Absent:

Name	Representation
Kate Masino	Highmark

Meeting Facilitator: Cristine Vogel (DOI)

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

Cristine Vogel, Workgroup chair, called the meeting to order at approximately 3:02 p.m. After a roll call, a quorum was present.

Review and Approve Meeting Minutes

This is the first PCRC Value-Based Care Workgroup meeting, there are no prior meeting minutes to review.

Delaware Faces Challenges

Ms. Vogel described the unique challenges that Delaware faces. Physician reimbursement and access to primary care in Delaware is ranked lowest in the nation. However, outpatient and inpatient hospital spending ranked 4th and 7th highest, respectively, in the nation. The goal is to improve access and encourage more providers in Delaware as well as retain providers currently practicing. Delaware would like to start seeing curbing healthcare costs overall.

Value-Based Care Workgroup Goals

Ms. Vogel reviewed the goals of the Value-Based Care (VBC) workgroup and noted this is the first meeting of the "new" VBC workgroup with additional members. The previous focus was on attribution and other policies related to primary care investment and value-based payment model. The new focus broaden the scope to develop new VBC strategies.

Previously Proposed Recommendations

Ms. Vogel reviewed the previously proposed recommendations from the June PCRC meeting which included the following:

- Opportunities for Enhanced Collaboration & Education
    - *(Panel management support, education, better collaboration)*
- Enhancing and Standardizing an Active Panel Management Process
- Standardizing and Aligning Attribution Across MCOs (Medicaid)
- Consider a two-tiered, population-based, payment reform program

SB120: Overview of Sunset Impact

Ms. Vogel reviewed an overview of the impact of SB120 if it sunsets as shown in the figure below.

SB 120: Overview of Sunset Impact

Statute		Statutory Requirements	Regulatory 1322 Requirements	Sunset
Section 1	Duties of DHCC	Ability to adopt regulations (a)(2)	n/a	No
Sections 2 & 3	PCRC	Composition, adopt rules	n/a	No
Section 4	**Price Growth Limit**	**Rate filings may not include aggregate unit price growth for nonprofessional services that exceed >2% or Core CPI+1%**	**Sec. 7 mirrors statute**	**YES 1/1/27**
Section 4	HCP-LAN	Plans >10,000 members reflect progress; 50% of total cost of care tied to APM, etc.	Sec. 8: Details similar to statute, for 2025 program qualifications specify certain shared savings requirements, etc.	No
Sections 5 & 6	**Primary Care Spend Requirements**	**By 2025 spend at least 11.5% of its total cost of medical spend on primary care**	**Details of data reported, compliance toward 75% providers participating in care transformation by 2026; eligible activities**	**YES 1/1/27**
Sections 7 & 8	OVBHCD	Shall adopt regulations, mandatory min. for payment innovations, APMs, collect data, collaborate with PCRC	Regulations include definitions, Medicare "parity", incentive program, p.c. spend, eligible activities, price growth limits, HCP-LAN, and enforcement	No

Delaware Department of Insurance - Office of Value-Based Health Care Delivery

Ms. Vogel clarified SB120 itself remains active, however, key components (sections 4, 5, and 6) are to sunset after 2026. Ms. Vogel expressed interest in understanding the original reasoning behind the sunset clause, especially given the ongoing discussion about whether to let it expire. Ms. Vogel invited others to share insights.

Dr. Mike Bradley shared the sunset provision had been a compromise to help pass the bill, which was a new initiative for Delaware. The idea had been to test the program's viability without committing to it indefinitely. Reflecting on its impact, Dr. Bradley believed the program had not succeeded, particularly in supporting primary care physicians. He noted that: (1) the bill affected less than 10% of patients, and (2) the financial support promised (e.g., $24 per member per month) was not reaching individual primary care providers and might instead have been going to hospitals.

Senator Bryan Townsend agreed with Dr. Bradley that the sunset clause in SB120 was part of a political compromise and a way to test a new system. He explained that not all parts of the bill were subject to sunset—only those that some stakeholders preferred to keep temporary. He elaborated that the intent was to gather about three years of data to evaluate the program's effectiveness. If the program was clearly working, lifting the sunset clause should not be controversial. However, he noted that the program didn't work as intended, not necessarily because of the bill's design, but due to external factors such as:

- High inflation, which disrupted timelines.
- Lack of participation from key healthcare sectors, such as Medicaid and the state employee health benefits plan.
- Use of flexibility within the framework to meet numerical goals without achieving meaningful outcomes.

He concluded that the sunset was meant to allow for course corrections based on clear results, but now the group must consider how much clarity they actually have on the program's impact.

Dr. Neil Hockstein Opening Remarks

Dr. Hockstein apologized for arriving late, explaining he had been meeting with federally qualified health centers (FQHCs), which are currently facing significant pressure, especially from federal-level challenges. He expressed appreciation for the group's engagement and efforts to reinvent the system.

He acknowledged that the value-based care component of SB120 did not unfold as expected. However, he emphasized that the bill's introduction of Medicaid parity for primary care—making it a legally entrenched principle—was a major advancement, as was the establishment of the Office of Value Based Health Care Delivery (OVBHCD). He noted that while this may now seem commonplace, it was a significant step forward when the bill was first introduced. He encouraged the workgroup participants to not dwell on the past and to think big – investments will yield returns in the future.

SB120 Section 334

Ms. Vogel reviewed SB120 Section 334:

> *Section 334(c) … establish regulations under this section, mandatory minimums for payment innovations, including APMs, provider price increases, carrier investment in primary care, and other activities deemed necessary to achieve the purpose of this section, to support a robust system of primary care by January 1, 2026.*

Ms. Vogel highlighted an opportunity under SB120 that allows OVBHCD to establish regulations related to the current discussions until January 1, 2026. She emphasized that while some changes may require legislation, others could be implemented more quickly through regulation. This flexibility could help expedite certain proposals, either in part or in full, depending on their relevance to regulatory authority.

She expressed confidence in the group's ability to find common ground and develop programs that stakeholders can support, aiming to swiftly improve value and access for patients. Ms. Vogel also mentioned that she had requested strategy submissions in advance to help guide the group's upcoming discussions.

Principles for New Value-Based Care Strategies

Ms. Vogel outlined guiding principles for the new value-based care strategies, emphasizing the need to both enhance healthcare quality and lower costs. A central focus is transitioning primary care away from fee-for-service models and increasing access to high-value services. She

also pointed out that the sunsetting provisions in SB120, particularly those tied to primary care investment and cost containment, remain essential areas for continued attention.

Key priorities include:

- Improve quality while reducing healthcare costs
- Continue to move primary care away from fee-for-service payment
- Expand access to high-value primary care services

Proposed Strategy and Discussion

Ms. Vogel noted the group had an hour-plus discussion and proposed starting with a review of the eight advanced recommendations received the previous Friday, along with several principle-based comments. These comments, while not fully developed strategies, reflected important considerations that should have informed future planning.

Strategy: Align Program Designs Across Payers

Ms. Vogel introduced a draft strategy focused on alignment across payers, which she believes remains a central and ongoing priority. The strategy aims to:

- Align program designs across payers, including performance measures, payment structure, payment schedule, reporting, and other key components, to drive better performance of quality and utilization, reduce provider administrative burden, and move toward high-value care delivery.

Ms. Vogel emphasized that the VBC workgroup has already begun identifying activities to support this alignment and plans to propose legislation and regulations by October 31, 2025. She encouraged the group to consider whether this alignment strategy is still relevant and achievable, framing it as a visionary but attainable goal that may take several years to implement.

Discussion:

Lara Hudson emphasized the importance of mandatory participation by all insurance payers, warning that without a nearly all-payer system, value-based care strategies would fail to reach the majority of patients in Delaware. She shared that only 10% of her patient population is currently covered under such programs, making the effort feel ineffective. This lack of broad support, she noted, contributes to early retirements and practice sell-offs among primary care providers. Lara urged the group to consider legislation or regulation with enforceable provisions to ensure payer participation.

Dr. Mike Bradley emphasized the urgent need for a nearly all-payer system in Delaware, noting that current value-based care programs only impact about 10% of his patient population. He expressed frustration over the limited reimbursement and administrative burden, which he believes contributes to early retirements and practice closures among primary care providers. He urged the group to consider legislation or regulation with enforceable provisions to ensure

all insurers participate. Without such measures, he warned, the system cannot meaningfully improve care for the majority of patients.

Dr. Neil Hockstein highlighted the challenges associated with rate filings and the difficulty of compelling payers with smaller populations to adjust their systems. He observed that less-represented payers often decline to participate, which has hindered progress over the past decade. Dr. Hockstein described this lack of engagement as an unfortunate reality that must be acknowledged in future planning.

Lori Ann Rhoads echoed the concerns raised by Ms. Hudson and Dr. Bradley, drawing on her experience serving on six to ten committees over the past 18 years focused on similar issues. She stressed the importance of legislative action, noting that voluntary and consensus-based approaches have repeatedly failed to produce meaningful change. Lori Ann supported the idea that any new strategy must have regulatory "teeth" to be effective and sustainable.

Dr. Angela Perry began by sharing her background, noting that she started a private practice in an underserved area in Chicago and later moved to Delaware. She highlighted the challenges of entering the Delaware market as a smaller payer with only Medicaid and Exchange plans, and no commercial component. From her dual perspective as a former provider and current insurer, she emphasized the need for a national-level investment in primary care, not just a Delaware-specific solution. Dr. Perry stressed that not all stakeholders have been meaningfully engaged, making it difficult to have productive conversations about value-based care. Dr. Perry suggested that a two-part solution may be necessary—one tailored for independent practices, which face unique financial and staffing challenges, and another focused on workforce development, especially in a state with limited medical education infrastructure. Dr. Perry also called for shared responsibility across the healthcare system, including hospitals and insurers, to invest in improving access. She expressed concern about the lack of provider participation in current programs and the difficulty of recruiting providers under current conditions. Looking ahead, she warned that without broader inclusion, the system risks stagnation, as it has over the past decade, and noted that HR1 will likely result in loss of members.

In response to a question about whether she supports alignment across payers or prioritizes primary care investment, Dr. Perry clarified that both are essential. She advocated for alignment on quality measures across Medicare, Medicaid, and exchange plans, while also emphasizing the need for increased investment. She described the challenge of joining the market late in the value-based care glide path and noted that many providers were unaware they were being reimbursed below Medicare rates. Dr. Perry concluded by pointing out that hospital costs in Delaware are higher than in other states, reinforcing the need for a more inclusive and comprehensive strategy to improve access and equity.

Ms. Hudson added context from her organization, noting they currently manage 13 value-based contracts with a total of 88 performance metrics, which she described as unsustainable and unmanageable. She emphasized that while her organization has implemented these independently, it would be nearly impossible for smaller practices to do the same. Ms. Hudson

pointed to the success of Medicare Shared Savings Program accountable care organizations (MSSP ACOs), which use standardized metrics, as evidence that it is possible to align the number of measures. She urged Delaware stakeholders to take advantage of the opportunity to deliver care differently by getting all payers to agree on a unified approach, which she believes would yield significant results.

Dr. Christine Donahue agreed with Ms. Hudson's concerns about the overwhelming number of metrics and shifted the conversation to the role of self-insured employers in Delaware. She questioned how these employers might be impacted by alignment strategies and whether there is a way to engage them. Ms. Vogel referenced efforts in other states like California, where self-insured employers are beginning to collaborate on cost and quality strategies. She asked whether such engagement is legally feasible in Delaware due to federal law and noted that employer representation is currently lacking in the PCRC and DHCC.

Dr. Hockstein responded by acknowledging that while self-insured employers cannot be legally compelled to participate due to the federal Employee Retirement Income Security Act of 1974 (ERISA) protections, there is potential to socialize alignment strategies with them over time. He suggested that demonstrating success with other populations could encourage voluntary participation and offered to help promote the effort through outreach.

David Cruz from Nemours briefly noted that different payers have varying performance programs too.

Ms. Vogel clarified that the current focus is primarily on Medicaid and the State Employee Health Benefits Plan, which have historically been the two additional payers considered for multi-payer alignment because state agencies administer these programs. She emphasized that alignment of quality measures and contract language could reduce administrative burden for providers by streamlining workflows.

Lori Ann Rhoads provided historical context, explaining that self-insured employers are protected under ERISA which prohibits states from regulating these plans. However, she expressed optimism that state-level legislation might offer pathways to engage these employers, noting that other states appear to be making progress despite the federal constraints.

Ms. Vogel acknowledged that some states are making progress on value-based care, even without direct government involvement.

Dr. Bradley emphasized that including state employees and Medicaid in value-based care efforts would cover approximately 50% of Delaware's population, making it a strong starting point for broader reform. He also advocated for standardizing quality measures across all insurers, noting that the current variation (30 to 40 different metrics per insurer) is overwhelming and counterproductive. A unified scorecard, he suggested, would greatly improve consistency and reduce administrative burden.

Senator Townsend reflected on past efforts to engage the ERISA self-insured plans, noting that while business representatives initially participated in the PCRC, they eventually disengaged due to misalignment with state policy discussions. He stressed the need for government influence to support primary care and supported the idea of a harmonized, consistent framework for quality metrics and program design. He identified the Office of Value Based Health Care Delivery as a suitable entity to lead these efforts to renew a partnership with the self-insured plans, ensuring clarity and sustainability across the healthcare system.

Anthony Onugu offered his view on alignment, stating that from his experience managing commercial, Medicaid, and Medicare contracts, there is already considerable alignment in quality measures and program design between Medicaid and commercial coverage. He identified Medicare Advantage as the area with the most variability due to the older population. Anthony emphasized that the limited scope of value-based programs, particularly the exclusion of Medicaid and state employees, is a major barrier. He also highlighted attribution challenges as a key issue affecting alignment and program effectiveness.

Ms. Vogel noted that while multi-payer alignment has been discussed, there has been no direct recommendation to extend primary care investment beyond the sunset clause. She emphasized the need for strategies that explicitly address investment in primary care.

Mr. Onugu responded that only about 8.5% of patients in his organization are covered by the state's value-based programs, leaving over 90% outside the scope of investment. He highlighted the limited reach of current initiatives and the need for broader inclusion and multi-payer alignment.

Dr. Mullins acknowledged that value-based care has demonstrated success in improving quality and reducing costs across various organizations and patient populations. However, she noted that despite the potential, many practices (including the 48 independent practices she represents) received no payments in 2025 which makes it difficult to move away from fee-to-service models. She advocated for broader participation in VBC and enforcement of existing laws.

Dr. Bradley supported removing the sunset from SB120 and continuing efforts to incrementally increase primary care investment. He reiterated that most practices have not received the promised per-member payments and emphasized the need to push forward with improvements.

Dr. Perry discussed challenges specific to exchange plans, noting that members often use coverage only for catastrophic events, making it difficult to meet care thresholds. She warned that high penalties and risk pool requirements could drive plans out of Delaware, citing recent exits by Aetna and other carriers. She advocated for better support to improve access and participation. Christina Haas (DOI) clarified that Aetna's exit was part of a national withdrawal and not solely due to Delaware's legislation. She noted that three new carriers have entered the market since SB120 was enacted and that enrollment has doubled. Ms. Haas emphasized the

importance of considering inflation and hospital cost controls when evaluating the effectiveness and cost of primary care investment and offered DOI's support in developing improved regulatory approaches.

Senator Townsend clarified that it is not an either/or; lifting the sunset on SB120 should not mean maintaining the status quo and precluding other changes. He called for modifications across multiple areas, including attribution clarity, ramp-up flexibility for new entrants, and adjustments to the 11.5% investment threshold. He emphasized the need for legislative, regulatory, and operational changes to improve the system without starting over.

Ms. Vogel concluded the discussion by committing to drafting a revised strategy that incorporates member feedback. She proposed a multi-layered approach that reconsiders the framework for primary care investment and multi-payer alignment, aiming to simplify care structures and improve quality. The draft will be circulated via email for further input.

Strategy: Lower Healthcare Costs

Ms. Vogel transitioned the group to the next proposed strategy, which had been shared in advance, and invited open conversation to explore its purpose and goals.

- Lower healthcare costs by targeting high-cost and high-risk/not well managed claimants
    - Develop a coalition of state, payers, and providers to identify high-cost chronic care patients and develop incentives to reduce costs of caring for these patients.
    - By reducing total costs of care (denominator), the percentage associated with primary care will increase.
    - Providers are looking to partner with payers on these efforts rather than working in silos, but providers need access to timely information from the payers.

Ms. Vogel noted that this strategy was provider-driven and emphasized her preference for freeform discussion to better understand stakeholder perspectives. She welcomed anyone familiar with the proposal to share background and insights to help guide the conversation.

<u>Discussion:</u>

Christina Bryan introduced the topic by emphasizing the importance of collaboration in addressing rising healthcare costs. She noted that Delaware faces unique challenges due to its aging and increasingly ill population, with higher rates of chronic conditions like diabetes and obesity. Ms. Bryan framed the proposal as a way to work together to manage care and reduce high-cost areas, rather than as a replacement for existing efforts.

Dr. Mullins responded by noting that the proposal closely resembles the work already being done by ACOs. She explained that ACOs partner with payers to identify and manage high-cost, high-utilization patients, but stressed that success depends on having willing payer partners. Without that collaboration, value-based care efforts can falter.

Michelle Adams from Westside Family Healthcare agreed, stating that her organization participates in ACOs specifically to help manage high-risk patients. She highlighted the need

for adequate infrastructure and reimbursement to support care management. Ms. Adams also pointed out that Delaware's growing and aging population will naturally drive-up costs, and that many chronic conditions are already advanced by the time patients seek care. She emphasized the importance of addressing social determinants of health early on.

When asked by Ms. Vogel whether FQHCs can identify and manage high-cost patients, Ms. Adams confirmed that they can identify patients through ACO partnerships but lack the resources to effectively engage and address barriers to care. She expressed concern about the future viability of FQHCs, especially given current pressures by HR1 and uncertainties about their capacity beyond 2026.

Danielle Socrates expressed strong support for the discussion, noting that the goal of identifying and managing high-cost patients aligns closely with the mission of ACOs. She emphasized the need for infrastructure investment in predictive analytics, pointing out that much of the current work is reactive—patients are flagged as high-cost only after issues arise. Ms. Socrates advocated for a more proactive approach, using data to anticipate rising risk and understand patient behaviors before costs escalate. Danielle highlighted that while many organizations perform well on quality metrics, the real challenge lies in managing a small number of high-risk, high-cost patients who can disproportionately affect performance outcomes. Ms. Socrates called for stronger partnerships with payers, and a coalition-based approach to better support these patients and reduce overall healthcare costs.

Andrew Wilson echoed earlier points about care management and noted that in Medicaid, managed care organizations (MCOs) play a similar role as ACOs in managing high-cost patients. He suggested that MCOs could be invited to share insights about their care management strategies.

Ms. Adams responded to a question about practices not belonging to ACOs, stating that while ACOs offer significant value, individual practices should have the flexibility to choose what works best for them. She emphasized that non-ACO agreements also include incentives for cost and utilization reduction.

Dr. Donahue supported the idea of a tiered system that could accommodate both ACO-affiliated and independent practices. She highlighted the importance of direct support at the practice level, especially for FQHCs, where patients face language and other barriers. She advocated for funding to reach practices directly to help navigate care.

Dr. Mullins explained that payments currently only flow through advanced payment models, meaning providers outside of ACO or SIN arrangements are not eligible for reimbursement. She emphasized that before expanding eligibility, the system must first ensure that those already participating under the legislation are being paid appropriately. Dr. Mullins highlighted a lack of alignment in payment timing and structure across organizations, which creates confusion and undermines the effectiveness of value-based care efforts.

Ms. Vogel explained that the Office of Value-Based Healthcare collects data from carriers on which providers are receiving payments but does not track whether providers are aware that these payments are tied to increased primary care investment. Although millions of dollars have been paid out, many organizations report not seeing the funds, likely due to a lack of transparency in how payments are distributed. She clarified that SB120 does not mandate equal distribution—only providers with value-based contracts are eligible for the investment, and payments are based on total medical costs per market segment. Ms. Vogel suggested that improved data collection and verification may be needed to ensure providers understand and receive the intended funds.

Mr. Onugu confirmed that some carriers do identify payments tied to specific patient segments, which is a positive development toward transparency.

Senator Bryan Townsend cautioned against letting semantics derail progress, stressing that whether the strategy involves improving SB120 or starting anew, substantial change is needed. He advocated for building a coalition of the willing and emphasized the importance of clarity, consistency, and commitment in reform efforts. He also supported carving out high-cost patients from performance metrics to ensure that primary care efforts are focused on preventive and front-end care.

Ms. Vogel redirected the group's attention to the proposed strategy on screen, expressing uncertainty about whether there was consensus to move forward with it. She questioned whether the strategy was truly aligned with the broader goals of value-based care or if it represented a separate initiative focused on high-cost patients. Ms. Vogel emphasized the need for clarity before proceeding, noting that several additional strategies still needed to be reviewed.

Dr. Mullins agreed that the targeted patient population is important but echoed Ms. Vogel's concern that there was no clear consensus on advancing the strategy.

Ms. Hudson responded that the proposal aligns with existing care management fee structures and appears to support the broader strategy outlined earlier in the meeting. She suggested that the current proposal fits under the umbrella of program design aimed at addressing high-cost populations. Lara agreed with Cristine's assessment that the strategy is necessary but not sufficient.

Ms. Haas added that the Department of Insurance has been evaluating the impact of high-cost claims on total medical expense (TME) calculations. She noted that some claims—such as those from severe accidents—can distort primary care investment rates. Ms. Vogel emphasized the importance of distinguishing between acute high-cost events and chronic conditions that are poorly managed, suggesting that this distinction is critical for designing effective strategies to manage high-cost patients.

Final Strategy Discussion and Next Steps

Ms. Vogel transitioned the group toward the final portion of the meeting by setting aside one of the proposed strategies for future consideration and moving the discussion forward. She reminded participants that, as this is a public meeting, time must be reserved for public comments.

Ms. Vogel invited members to share any additional proposed strategies, especially those not yet submitted or discussed. She encouraged the group to think strategically and ambitiously, referencing Dr. Hockstein's earlier comments about moving beyond tactical steps toward long-term solutions that can advance Delaware's transition to high-value care. She previewed the focus for the next meeting: designing a value-based program that can be implemented across carriers and includes a tiered approach. This topic, which has been the subject of recent recommendations, will serve as the starting point for the next VBC workgroup meeting.

Discussion:
Dr. Bradley raised a question about whether there is a separate group focused on primary care workforce development, such as offering tuition and living expense support for medical students in exchange for service commitments in Delaware. He emphasized that recruiting and retaining physicians is essential to improving care quality and cost-effectiveness.

Ms. Vogel confirmed that the Workforce Committee of the DHCC is addressing these issues and that access-related workforce concerns fall under their purview. She clarified that the current group is focused specifically on value-based care strategies.

Ms. Adams expressed confusion about the group's focus, believing there had been a shift toward access issues rather than value-based care. She emphasized that access and value-based care are interconnected, particularly in terms of funding and team-based care. Michelle also voiced concern about the lack of control over payer decisions, questioning how the group's work would lead to meaningful progress.

Ms. Vogel clarified that team-based care is a core component of value-based care, not a separate issue. She encouraged the group to continue submitting strategies, even if they hadn't done so by the initial deadline.

Ms. Hudson shared that her team submitted a strategy modeled after the CMS Innovation Center's Comprehensive Primary Care Plus model (CPC+), which involves upfront payments to support infrastructure for care redesign. Cristine acknowledged the submission and offered to follow up for more strategic framing.

Dr. Donahue requested that all submitted strategies be shared with the committee. Ms. Vogel agreed but noted that contributors hadn't been informed their submissions would become public, so she would anonymize them before distribution. Ms. Vogel also asked whether anyone had implemented the 2025 CMS advanced primary care management codes. Lara Hudson

confirmed that Bay Health had begun testing them but noted that actual reimbursements may be lower than expected, despite promising projections.

Ms. Vogel concluded by stating she would compile and redistribute all submitted strategies anonymously. She encouraged additional proposals ahead of the September 8th PCRC meeting, noting the urgency of developing a strategic plan.

Public Comment

No public comments in person.

Response from Elyse Pegler (in the virtual meeting chat):

> *Hi, I participate in many state and federal efforts to align payers in multi-payer efforts. Some of the challenges each effort has encountered are that the core sets of measures that payers are accountable for differ from each other. And the key driving force in Value-Based Care is aligning incentives, so payers typically flow down their measures to providers. MSSP, ACO REACH, MA Stars, CMS Universal Set, Medicaid minimum reporting set, each Medicaid program, self-funded plan sponsors - they all have different measures. The LAN did several side-by-side's if folks are interested.*

Adjourn

Dr. Bradley motioned, and Senator Townsend and Ms. Vogel seconded. The meeting adjourned at 4:57 PM.

In-Person Public Meeting Attendees:
None

Virtual Public Meeting Attendees:

Mary Jo Condon	Freedman HealthCare
Pam Price	Highmark BCBS
Deb Bednar	Aetna VBC
Elyse Pegler	Aetna VBC
Lauren Graves	ChristianaCare
Carling Ryan	Delaware Healthcare Association
Senator Bryan Townsend	Delaware State Senate
Wyatt Patterson	
Brian Greenlee	
Douglas Doyle	
Catherine Cardillo	Trinity/St. Francis
Sheila Saylor	DHSS
Tyler Blanchard	Aledade
Brendan McDonald	Highmark
Craig Schneider	Health Management Associates
Berkley Powell	Health Management Associates