Delaware Health Care Commission Retreat

November 7, 2025

Welcome Remarks

Neil Hockstein, M.D.

DHCC Chair

Delaware Health Care Commission

Delaware Medical Orders for Scope of Treatment (DMOST)

Health Care Benchmarks

Diamond State Hospital Cost Review Board

Diamond State Hospital Cost Review Board

Reinsurance Program 1332 Waiver

Health Workforce Subcommittee

Health Resources Board (HRB)

Delaware Institute for Medical Education and Research (DIMER)

Delaware Institute for Dental Education and Research (DIDER)

Delaware Provider Loan Repayment Programs

CostAware

Delaware's State Health Care Costs

CostAware

Primary Care Reform Collaborative (PCRC)

Rural Health Transformation Program (RHTP)

An Overview of Delaware's Application

Rural Health Transformation Program

- A $50 billion Rural Health Transformation Fund created as part of H.R. 1.
- Half of the money to be “equally distributed” across states with an approved application. Remaining half to be distributed by CMS at its discretion based on need and rural population.
- All states must submit a $200 million budget for each year (5 years total). Delaware likely to receive less based on rural population (~$120M - $150M/yr).
- Funds distributed annually FY 2026 - FY 2030. Needs to be spent by FY 2031 (9/30/31).
- Awards are expected by December 31, 2025.

Program at a Glance

State Applications Must Include Initiatives that Address Five CMS Strategic Goals:

- **Preventive Care –** improve disease prevention, chronic disease management, BH and prenatal care
- **Sustainable Access –** improve access, coordinate operations, improve efficiency and sustainability
- **Workforce Development –** attract and retain a high-skilled workforce
- **Innovative Care –** innovative care models to improve outcomes, provide incentives
- **Tech Innovation –** innovative tech to improve health, make delivery more efficient, data sharing

Program at a Glance

State Applications Must Cover 3 of 11 Permissible Uses

Prevention and chronic disease: evidence-based interventions to improve prevention and chronic disease management

Provider payments: payments to healthcare providers for the provision of health care services

Consumer tech solutions: consumer-facing tech for the prevention and management of chronic disease

Training and technical assistance: training and tech assistance for providers to use technology

Workforce: Recruiting and retaining clinical workforce to rural areas, with 5-year commitment

IT advances: Tech assistance, software/ hardware for IT advances to improve outcomes

Appropriate care availability: Right-sizing health care delivery system by identifying needs

Behavioral health: Supporting access to SUD treatment services and mental health services.

Innovative care: innovative models like value-based care

Capital expenditures and infrastructure: Investing in existing buildings and infrastructure, minor building alterations or renovations and equipment upgrades

Fostering collaboration: Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other health care providers

DE's RHTP Application Covers All 11 Permissible Uses

Program at a Glance

Funding Restrictions and Limitations

Category	Restrictions and Limitations
Capital Expenditures	• 20% maximum • Cannot include construction, building expansion, or major improvements to buildings that will increase their value substantially
Provider Payments	• 15% maximum • Cannot include reimbursable services
Catalyst Fund	• 10% maximum
Administrative Expenses & Oversight	• 10% maximum
Technology	• 5% maximum for replacing a EMR system if one that's HITECH certified exist

Overview of Delaware RHTP

- **Unites 15 integrated initiatives** designed to expand access, strengthen the workforce, modernize technology, and improve population health in rural Sussex and Kent Counties.

- Together, these **projects directly impact approximately 400,000 rural residents—representing 38–40% of the state's population**—by building sustainable, community-based healthcare capacity.

- The **total estimated cost is $1,000,000** with direct costs equaling $935.5 million and an indirect cost rate of 6.45% applied to ensure statewide oversight and coordination.

Summary of Key Performance Objectives

- **Expand access** to comprehensive rural healthcare and behavioral health services.
- **Strengthen the sustainable workforce pipeline** through new medical and clinical education programs.
- **Drive innovation** through improvements in for telehealth, data integration, and care coordination.
- **Improve outcomes** through improvements in nutrition and chronic disease prevention and management.

Initiatives Included in Delaware's RHTP

Expand Access

- Establish Hope Centers for homeless populations
- Bring care to rural communities with more mobile health units, school-based health center and library-based health services

Strengthen Workforce

- Create Delaware's first medical school with a Primary Care-Rural Health track
- Establish "Train Here, Stay Here" programs with education awards for medical students, residents, and other healthcare professionals
- Expand training programs for nurse practitioners, physician assistants, community health workers, and other healthcare roles

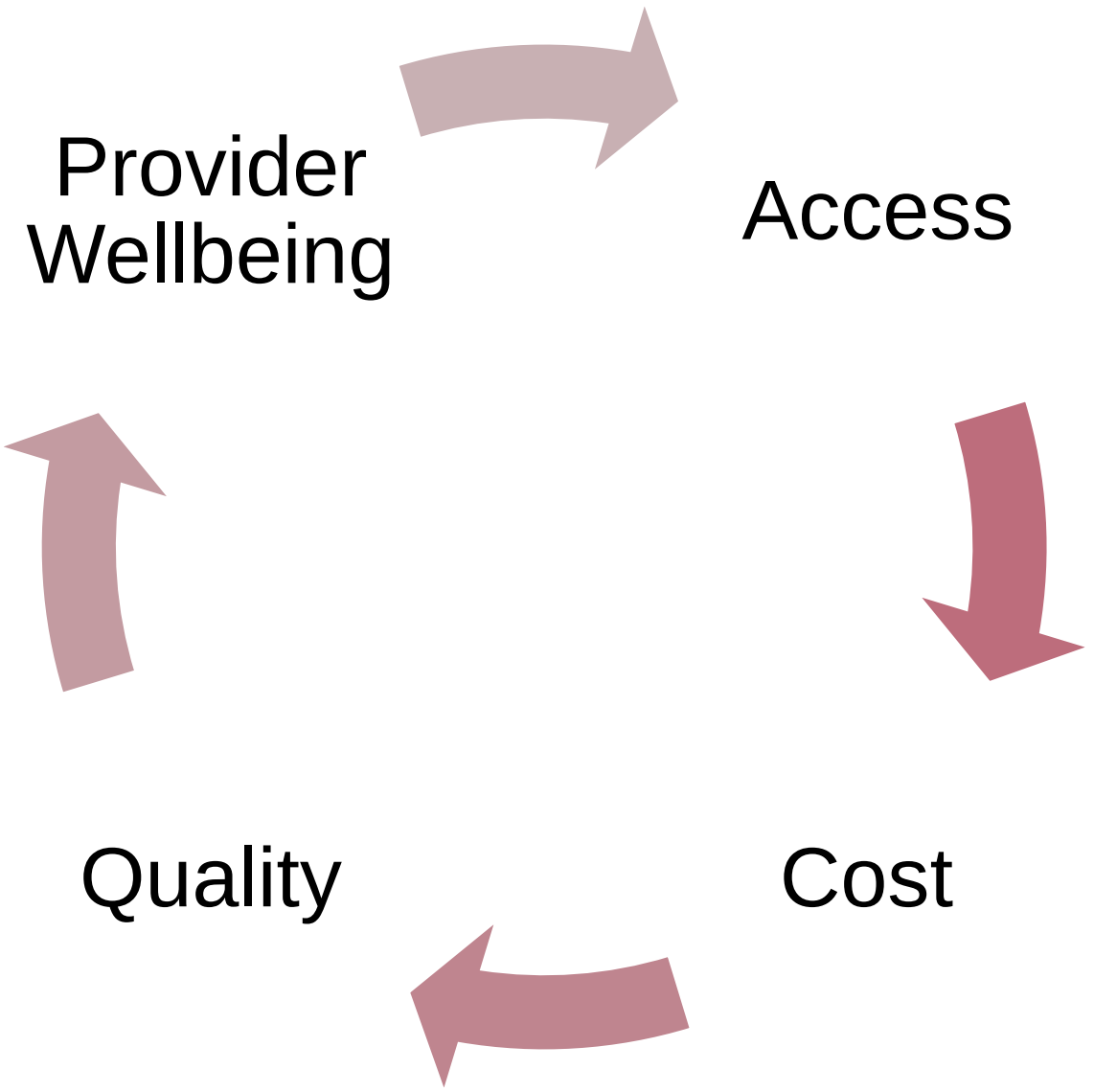
Drive Innovation

- Create a comprehensive health IT infrastructure for real-time insurance verification and prior authorizations
- Launch a Catalyst Fund for telehealth and remote monitoring technologies
- Implement a diabetes wellness pilot integrating continuous glucose monitoring with care management.

Improve Outcomes

- Deploy a Food is Medicine infrastructure with billing mechanisms and workforce development
- Establish value-based care readiness programs for rural providers and FQHCs
- Create a Healthcare Workforce Data Center for real-time tracking of progress

Delaware Medical School


Access
Cost
Quality
Provider Wellbeing

Agenda

- Session 1: Access
- Session 2: Quality
- Break
- Session 3: Cost
- Session 4: Provider Wellbeing
- Wrap-Up/Next Steps/Adjourn

Session 1: Access

Facilitator – DHCC Commissioner, Kathy Matt, Ph.D.

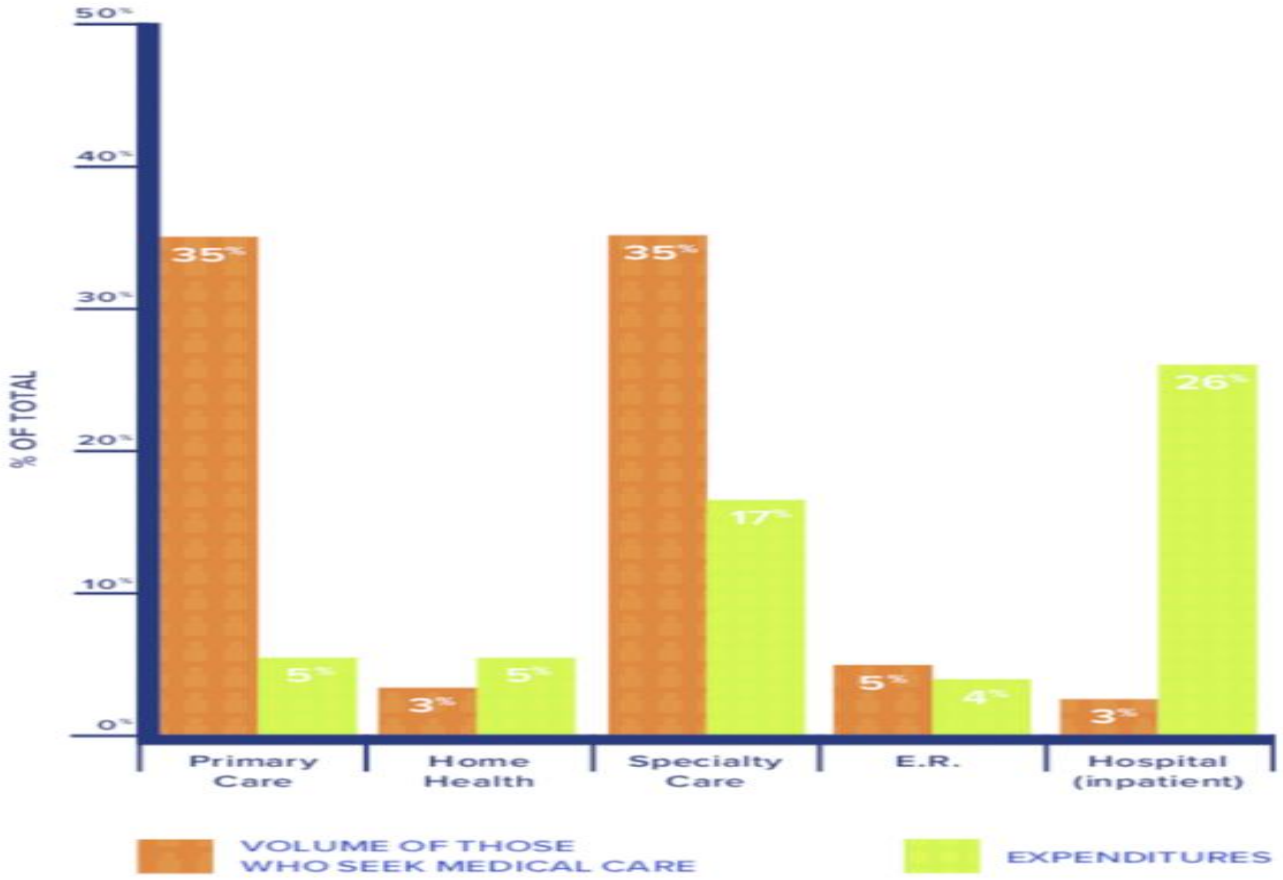
Challenges

Access to healthcare is limited due in part to:

- Health Care Workforce Shortages
- Maldistribution of Practitioners
- Aging of our current workforce
- Aging of our Health Professional Educators
- Health Professional Burnout

Health Care Visits vs. Expenditures

Primary care has been historically underfunded in the United States. Less than 5% of total health care spending is focused on primary care.



Source: National Academies of Sciences, Engineering, and Medicine

Recommendations from the DHCC Health Workforce Subcommittee

1. Data/Surveys/ Licensure
2. Clinical Training / Preceptors/ Enhancing Healthcare Workforce Pipelines
3. Health Care Professional Shortages
4. Long-term Care
5. Delivering Care to Rural and Underserved populations

Recommendations from the DHCC Health Workforce Subcommittee

1. **Data/Surveys/ Licensure –** Need to refine the data further to provide more information on the current workforce and their statewide distribution as well as information to enable forecasting of the future workforce needs.

    - SB 122 passed and Health Care Workforce Summit

* Statements in blue are steps already taken

Recommendations from the DHCC Health Workforce Subcommittee

2. **Clinical Training / Preceptors/ Enhancing Healthcare Workforce Pipelines –** Need to work out financing and partnerships of hospitals and educational institutions, high schools, and middle schools to create health care career pipeline. Also need mechanisms to grow the next generation of health care workforce educators and fill the ever-expanding demand.

- Health Care Education Round Table
- Link clinical training at clinical sites to commitments to work in health system and link to scholarships and loan repayment programs
- Increase Preceptor Slots through incentives to Health Professionals

* Statements in blue are steps already *Statements in red are future action steps

Recommendations from the DHCC Health Workforce Subcommittee

3. **Health Care Professional Shortages –** Need to solve shortages of physicians, dentist and dental hygienists, nurses, specialists, behavioral health specialists, etc.. How do we grow our own in the state, and recruit and retain the workforce needed in our state.

   - SB 122, Health Education Round Table
   - Participation in Compact agreements
   - Health Workforce Innovation and Initiative Fund

* Statements in blue are steps already *Statements in red are future action steps

Recommendations from the DHCC Health Workforce Subcommittee

4. **Long-term Care Needs for Aging Populations –** We need health professionals such as CNAs to work in long term care facilities, but it is also the idea of encouraging some students to start as CNAs and get experience. This experience then can help them move up the health care career ladder to higher level health care professional positions.

   - Enhance training programs for CNAs as part of a health care career ladder

*Statements in red are future action steps

Recommendations from the DHCC Health Workforce Subcommittee

5. **Delivering Care to Rural and Underserved Populations –** Need to work on geographic distribution, and telehealth options, etc. Can we establish more clinics in underserved areas that we can then recruit health care professionals to establish practices there.

   - Mini Med in Sussex by DIMER Rural Health Committee
   - State supported Primary Care and Rural Health Residency Programs

* Statements in blue are steps already *Statements in red are future action steps

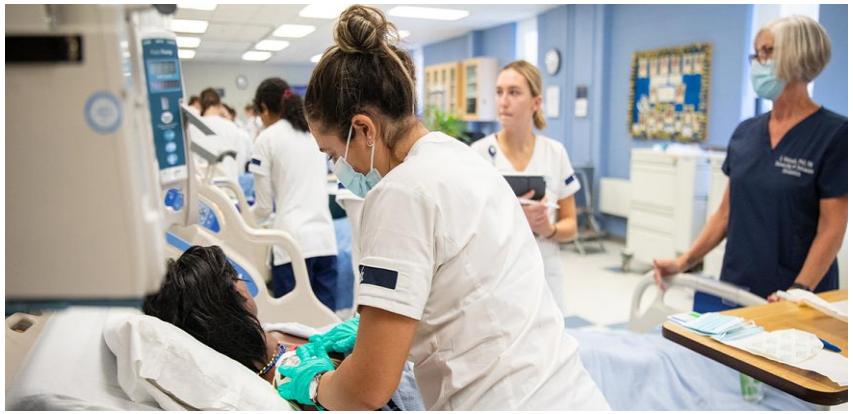
Approaches to Growing the Primary Care Workforce

- **Scope of practice**
  - Nurse Practitioners, Physician Assistants, Pharmacists, and Dental Hygienists
- **Funding more residency programs**
  - Requirement for a five-year commitment of service in underserved areas
  - Support relocation funding
- **Expand interstate licensure compacts**
- **Develop education programs**
  - High School and College
  - Increase scholarships and loan repayment

State	Strategy	Why It Works	Delaware Opportunity
Montana	Rural residency programs + tax credits for rural providers	Boosts retention in underserved areas	Fund rural rotations in Kent/Sussex + offer housing stipends
North Carolina	AHEC-supported rural training + mentorship	Builds local workforce and supports students	Partner with AHEC-like model for rural outreach and training
Michigan	Behavioral Health Workforce Center	Centralizes recruitment, training, and credentialing	Create a Delaware Behavioral Health Hub
Oregon	Stipends and tuition aid for behavioral health students	Attracts diverse candidates to high-need fields	Offer scholarships for psychiatric NPs and counselors
California	Health Workforce Data Dashboard	Enables real-time planning and investment decisions	Build a public-facing dashboard with licensure and employment data
Massachusetts	Employer reporting mandates for workforce data	Improves forecasting and regional planning	Require health systems to report workforce metrics
Colorado	Career ladder programs for CNAs → LPNs → RNs	Supports retention and advancement	Launch bridge programs with wraparound supports
Washington	Apprenticeships for medical assistants and behavioral health techs	Combines paid work with training	Develop apprenticeship tracks for entry-level roles
Arizona	License reciprocity for out-of-state professionals	Reduces onboarding time for relocating clinicians	Expand reciprocity and streamline onboarding
Minnesota	Pathways for internationally trained clinicians	Taps into underutilized talent pool	Create supervised practice and language support programs

Expand Health Sciences Education

- All levels across the State of Delaware (Middle School, High School, Technical Schools, and Universities)
- Create distinct career pathways
- Incentivize clinical preceptorships



Nichole Moxley

Division of Public Health

Thank you for your many years of service to the State of Delaware!!

Session 2: Quality

Facilitator – DHCC Commissioner, Nick Moriello

Quality: Value Based Care

Value-Based Care Contracts Overview

Value-based care contracts shift reimbursement from fee-for-service to performance-based payments, aligning provider incentives with quality, cost efficiency, and patient experience metrics. [1]

- **Shared Savings:** Providers earn a percentage of cost savings when spending falls below pre-set benchmarks. [2]
- **Bundled Payments:** A single, predefined payment covers all services for an episode of care across multiple providers. [3]
- **Capitation/Population-Based Payments:** Fixed monthly per-member payments covering a broad set of services within a population.
- **Pay-for-Performance/Quality Bonuses:** Incentives tied to meeting or exceeding agreed-upon clinical and patient-experience targets. [3]
- **Accountable Care Organizations (ACOs):** Networks of providers collectively responsible for total cost and quality outcomes for a defined patient cohort. [3]

Considerations:

- **Contract Negotiation:** Define achievable quality and financial benchmarks to ensure fair risk-reward balance. [2]
- **Risk Exposure:** Evaluate the level of downside risk versus potential shared-savings upside. [2]
- **Infrastructure Needs:** Strengthen data analytics, care management, and reporting capabilities to track performance.

1 www.physiciansadvocacyinstitute.org 2 Perr&Knight 3 MD Clarity 4 Centers for Medicare & Medicaid Services 5 Milliman 6 United States of Care 7 American Hospital Association

Quality: AHEAD Model

The **AHEAD Model—Achieving Healthcare Efficiency through Accountable Design –** is CMS's voluntary, state-total-cost-of-care initiative designed to curb health care cost growth, improve population health, and advance equity by aligning Medicare, Medicaid, and commercial payers. [4]

- **State Collaboration:** Multi-payer alignment across participating states to set unified cost-growth and quality targets. [5]
- **Primary Care Focus:** Incentivizes investments in primary care capacity and preventive services to reduce total cost of care. [6]
- **Population Health Accountability:** Mandates state plans for chronic disease prevention, health equity promotion, and choice/competition policies. [7]
- **Timeline & Scope:** Announced September 2023; cohorts onboarded by readiness level; operational changes start January 2026; model concludes December 2035. [4]
- **Financial Incentives:** States earn shared savings for reducing per-capita cost growth below CMS-defined benchmarks. [4]

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Break

Session 3: Cost

Facilitator – DHCC Commissioner, Cheri Clarke Doyle

Cost

- Transparency
  - All Payer Claims Database (APCD)
    - Current State – CostAware website – consumer facing
    - Goal – to create dashboard to help inform policy

Dashboard Measure (Examples)

Evidence-Based Decision Making

- By aggregating data from multiple sources (claims, EHRs, public health databases), dashboards help policy makers base decisions on actual evidence rather than assumptions.
    - Identifying areas with high chronic disease rates for targeted interventions.
    - Allocating resources to regions with rising emergency visits.

Trend Analysis

- Dashboards can visualize historical and predictive trends, enabling policymakers to:
- Forecast healthcare demand.
- Evaluate the impact of previous policies.
- Plan long-term strategies for workforce and infrastructure.

Equity and Access Monitoring

- They can highlight disparities in care by demographic, geography, or socioeconomic status. This supports policies aimed at reducing health inequities.

Performance Measurement

- Dashboards track KPIs like readmission rates, cost per patient, and preventive care uptake. Policymakers can use these metrics to assess whether programs are meeting goals.

Cost

- Health Resources Board (HRB)
    - Is it efficient?
    - Is it harming access?
    - What is the cost (time/money)?

Certificate of Need (CON) Implications

- **Higher Costs in CON States**
  Studies consistently find that states with CON laws have higher patient spending per service and overall healthcare costs. These laws restrict competition by requiring providers to obtain state approval before expanding facilities or purchasing equipment, which creates artificial scarcity and drives up prices. [standtogether.org], [pacificlegal.org]
- **Impact of Repeal**
  Evidence from states that repealed CON laws suggests that removing these regulations tends to reduce healthcare spending, primarily through lower prices. Preliminary difference-in-differences analyses indicate that repeal improves competition and may also enhance quality (e.g., lower mortality and readmission rates), though quality improvements are less consistently significant. [clemson.edu]
- **Access and Capacity**
  States with CON laws often have fewer hospitals, surgical centers, and imaging facilities, especially in rural areas. For example, rural communities in CON states have about 30% fewer hospitals and 13% fewer surgical centers, which can lead to longer travel times and reduced access to care. [pacificlegal.org]
- **Cost Estimates**
  One analysis estimated that repealing CON laws in Washington, D.C., could save $459 per capita annually in healthcare costs.

Session 4: Provider Wellbeing

Facilitator – DHCC Commissioner, John Powell, M.D., MHCDS, FACEP

Cement Delaware as a Healthcare Talent Destination

Discussion:

- Payer Credentialling
  - Transparency and efficiency
- Expansion of Positive Prior Authorization Changes.
- Ensuring Top of License Work & Efficient Clinical Practices
- Targeted improvements
  - Create initial licensure visibility
  - Reimaging education & CME requirements

Streamline Payer Credentialing

- Opaque process, with prolonged wait for completion
- Medicare covers care retroactive to full application submission
  - Non-governmental payers may cover care at time of credentialling
    - Not retroactive to full application submission
- Visibility of clinicians who are appropriately credentialled
  - Medical Staff/Payer Cred offices have difficulty obtaining information
  - Payer websites may not be updated nor accurately reflect the payer's in-network clinicians
- Payer information accuracy:
  - Payers may inappropriately send patients notices of out-of-network status for clinicians who are credentialled and confirmed in-network

Delaware Department of Insurance

Discussion of Uniform Credentialing Proposal

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Legislative Goals

- **Enhance onboarding and provider speed-to-market**
- Uniformity in application to reduce administrative burden
- **Require retroactive reimbursement**
- Provisional credentialing
- **Create access to processes, appeals, and a regulator**

Widespread Benefits

- **Improve consumer access to care**
- Enable provider movement and growth
- **Assist in provider and system efficiency**
- Create insurer accountability
- **Enhance access to reimbursement**

… without sacrificing patient safety, data accuracy, or network management.

Expand Positive Prior Authorization Changes

- Recent changes
  - Speed & standardize health insurance prior authorizations
    - Electronic processing
  - Utilization Review
    - Clinical criteria only applies upon reauthorization of the health care service
    - 6-month notice to insurance holders prior to UR terms change

- Ideas for future updates
  - Medication dosing changes
  - Expanded timeframe for chronic medications
  - Acute inpatient psychiatric care

Ensure Top of License Work & Efficient Clinical Practices

- Provide patient care to the top level of training and competency
  - Team-based care models
  - Administrative tasks managed by office staff
    - Chart preparations
    - In-box tasks
    - Prior authorizations / setup
  - Practice managers managing the office team
- Total Workforce Development: Beyond Docs & Nurses

Create Transparency for Progress Status in Initial Licensing

- First experience with licensing process can set a positive tone
- Transparency of steps complete or missing on application
  - Decreases administrative burden of:
    - Clinicians
    - DPR personnel
    - Medical Staff Office members
- Create a secure means to see application status?

Reimagine Required Education

- Mandatory education requirements may not have intended effects
  - Child Abuse initial training and repeat licensing options:
    - Abusive head trauma
    - Pediatric drug exposures
    - Sentinel injuries
  - Controlled substances reporting
  - *Key stakeholder requests*
- Explore other targeted options?
  - Change periodicity of mandatory lessons
  - Codify resource page – easily searchable
  - Focused podcasts sent to clinicians (OEMS example - medetomidine)
  - CRISP – frequent clinical updates

Wrap-up/ Next Steps/Adjourn

THANK YOU

Slides will be posted on the DHCC website,

https://dhss.delaware.gov/dhcc/home-2/dhcc_presentations2025/