PRIMARY CARE REFORM COLLABORATIVE (PCRC)
Value-Based Care Model Workgroup
September 8, 2025
3:00 p.m. - 5:00 p.m.

Meeting Attendance and Minutes

In-Person Work Group Members Attending:

Cristine Vogel	Department of Insurance (DOI)
Sarah Mullins, MD	Aledade

Virtual Work Group Members Attending:

Christine Donohue-Henry, MD, MBA	ChristianaCare
Anthony Onugu	United Medical
Michelle Adams	Westside Family Healthcare
Michael Bradley, DO	Dover Family Practice
Christina Bryan (for Brian Frazee)	Delaware Healthcare Association
Laura Hudson	Bayhealth
William Ott, MD	Aetna
James Trumble, MD	TidalHealth
Angela Perry, MD	AmeriHealth
Lori Ann Rhoads	Medical Society of Delaware
Andrew Wilson	DMMA
David Cruz	Nemours
Kate Masino	Highmark

Work Group Members Absent:

Britanny Danoski	St. Francis/Mercy Health

Meeting Facilitator: Cristine Vogel, Work Group Chair

Delaware Health Care Commission Staff: Elisabeth Massa

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

Introductions

Cristine Vogel called the meeting to order at approximately 3:03 p.m. After a roll call, a quorum was present.

Review and Approve Minutes

Dr. Mullins made the motion to approve the August 18, 2025, workgroup meeting minutes, and Drew Wilson seconded the motion. Minutes are approved.

Summary of August 18th Meeting

Ms. Vogel provided an overview from the August 18th meeting which included:

- Sunset was included because stakeholders took the position that once the "Delaware Model" was implemented and working, that primary care spending would be increasing within the program design and total cost of care would stabilize.
- Stakeholders strongly support multi-payer alignment (of primary care investment and performance measures)
- Need a solution that is focused on independent practices
- Need a program design that has tiers based on practices' capabilities

Value-Based Workgroup Overview, Purposes, and Goals

Next, Ms. Vogel provided an overview of what the workgroup is "solving" which included:

- High healthcare costs in Delaware; and primary care is underfunded
- Commercial market is <100,000 residents – how can we increase the population covered by the new program
- Current regulations include value-based care (VBC) contracted providers to count toward primary care investment (40,000)
- Carriers with <5,000 members in Delaware are challenged with implementing value-based care programs
- Small-size/independent practices may not have resources to pursue VBC
- Delaware Model was never implemented; therefore, SB120 must be extended until a new program is established

Ms. Vogel reminded the workgroup that the new value-based strategies should aim to:

- 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

Goals of the workgroup are to implement Value-Based Care through collaboration, legislation and regulation as shown below (noting that the graphic should not imply that these topics are sequential).

Align Existing Value-Based Programs	Offer Pathway for Rural and Independent Providers	Launch New Program Model to Expand Value-Based Care
•Extend SB120 until New Program Model is in operation •Replicate most effective payment models •Address frequent barriers to success	•Develop framework that rural and independent providers can "access" care team support •Fund critical infrastructure with Rural Health Transformation dollars (interop, EHR, FQHC, workforce, Mobile Units)	•Create sustainable multi-payer model that reflects Delaware market, population, lessons learned •Use tiered approach to include interested providers •***Consider AHEAD Model***

Discussion:

Rural Health Funding:
Dr. Neil Hockstein cautioned against relying heavily on the new federal Rural Health Transformation Program (RHTP)funding for primary care, especially since the definition of "rural" is still unclear and may exclude much of New Castle and Kent Counties. While some parallel programs may support primary care and value-based care, they should be considered separately. Funding details for the RHTP are expected in early September, but it's likely that only small portions of New Castle County will qualify. Dr. Hockstein also cautioned that missteps in the application process could risk losing significant federal funding, emphasizing the need for careful strategies and compliance with HHS criteria.

Align Existing Value-Based Programs:
Dr. Michael Bradley emphasized the importance of multi-payer alignment for existing value-based care programs and advocated extending or removing the sunset clause on SB120, which he believes offers strong foundational value. He also highlighted the need for unified quality measures across all insurance companies, noting that the current variability is burdensome for

providers. A simple, standardized approach in the upcoming legislative session would be highly beneficial.

Dr. Hockstein raised concerns about the stability of Delaware's insurance marketplace, noting that if smaller payers with limited presence are pressured with state-specific quality measures, they may exit the market (something already seen with Aetna leaving the individual market). Ms. Vogel clarified that while Aetna exited the ACA marketplace, it remains active in the large group market. Chris Haas (DOI) confirmed that for the upcoming year, the ACA marketplace will include Ambetter (Centene), AmeriHealth, and Highmark, and emphasized that Aetna's departure was not linked to current legislation. Dr. Hockstein concluded by urging a pragmatic approach to policy, warning that overreaching could result in further payer exits and dissatisfaction.

Christina Bryan followed up on Dr. Michael Bradley's comments by acknowledging the value of SB120 but also raising concerns about its limitations, particularly the caps on hospital growth, so it might not be appropriate to extend all of SB120's provisions. She emphasized the need for collaboration to ensure any legislative extension works effectively for Delaware. A major barrier to advancing value-based care, Ms. Bryan noted, is the lack of timely data, which hinders decision-making and program implementation—suggesting that improved data sharing, including access to payer data and the all-payer claims database, would be crucial.

AHEAD Model:
Tyler Blanchard from Aledade shared insights from his organization's experience with Maryland's AHEAD model, which supports value-based care through partnerships with primary care-focused entities. Aledade began its care transformation efforts in 2019 and has found the program to be well received, especially during its earlier MDPCP phase that focused on Medicare and included some alignment with other lines of business. Recently, Maryland launched Medicaid participation in the AHEAD model, with Medicare expected to go live in January 2026. However, commercial payer alignment remains unclear, though Mr. Blanchard suspects work is underway in that area. He noted that Delaware's SB120 has historically focused on commercial markets, and as the state explores AHEAD, it should be mindful of this distinction. Overall, he expressed optimism about the model's potential, particularly its ability to align quality measures across payers, which is a frequent request from physicians.

When asked by Ms. Vogel about upcoming changes from CMS, Mr. Blanchard explained that negotiations between Maryland and CMS are ongoing, and each state has flexibility in shaping its version of the program. He mentioned a newly released 40-page methodology document that may contain further details, though he hadn't reviewed it fully yet.

Dr. James Trumble added that a key component of the AHEAD model is the collection and use of data analytics to provide feedback to practices. He emphasized the importance of consistent, non-redacted data from all payers, echoing earlier comments. Dr. Trumble concluded that regardless of the specific path Delaware takes, access to meaningful data will be vital to the

success of any value-based care initiative, and that the direction being discussed aligns closely with Maryland's approach.

Dr. Christine Donohue-Henry responded to the discussion about the AHEAD model by expressing that, while it's a promising option for Delaware's future, it's not feasible in the short term. She noted that CMS has opened applications for additional states to join in 2026, but has concerns that Delaware would not be able to meet that timeline. Dr. Donohue-Henry emphasized the importance of building a reliable and consistent foundation before pursuing such a model and suggested that AHEAD could be considered as part of a longer-term roadmap.

Ms. Vogel asked whether the AHEAD model should still be proposed to the PCRC, acknowledging the challenges of meeting the 2026 application timeline and the heavy lift required from hospital systems and Medicaid agencies. Dr. Donohue-Henry responded that if included, it should be framed as a potential option for 2028 rather than a near-term solution. Dr. Trumble and Danielle Socrates agreed, emphasizing that while the model could be part of a long-term strategy, the infrastructure demands make it unrealistic for implementation by 2026.

Andrew Wilson (Division of Medicaid and Medical Assistance) acknowledged that while Medicaid would aim to move at the pace requested, implementing models like AHEAD presents technical challenges, especially in light of evolving federal regulations and guidance. He noted that many existing models may not yet fully align with current law, making the process a moving target even for CMS. Despite these complexities, he expressed readiness to support implementation. Ms. Vogel responded by suggesting that the AHEAD model could still be discussed at the upcoming PCRC meeting, but with clear disclaimers about its feasibility and timeline. Participating in AHEAD would add Medicare and Medicaid and could generate $12 million in federal funding.

Dr. Sarah Mullins expressed support for including the AHEAD model on Delaware's future roadmap, emphasizing that Senate Bill 120 currently operates as a single-pronged approach without broader payer participation. She highlighted the significant success Delaware has seen in other models, particularly the Medicare Shared Savings Program, where all Delaware ACOs reported positive results in 2024 and none experienced losses, one even achieving over $26 million in savings. Dr. Mullins cautioned against limiting the state's strategy to a narrow focus and advocated for building on proven successes, while acknowledging the implementation challenges that would need to be addressed for AHEAD to succeed.

SB120 Extension

Dr. Hockstein urged the group to shift focus toward actionable next steps, particularly around SB120, to ensure they have a clear recommendation for the General Assembly. He emphasized the need to decide whether to preserve the current allocation of medical spending toward primary care and, if so, whether to include adjustments like excluding high-cost claimants or physician-administered drugs. Dr. Hockstein warned that without alignment and timely action, the group risks losing payer engagement and potentially allowing SB120 to sunset without a replacement, which would jeopardize primary care funding. He encouraged the group to aim for

both short- and long-term success, centered on improving patient outcomes and supporting value-based care. Ms. Vogel responded by suggesting the extension of SB120, and Dr. Hockstein clarified that all options should be considered, urging the group to unify their recommendation to strengthen its impact in legislative discussions.

Ms. Vogel proposed extending SB120 until a new program model is operational, aligning with the original intent of the bill. She suggested removing the sunset clause and opened the floor for discussion on whether to maintain or revise the current 11.5% primary care spend requirement. Dr. Angela Perry (AmeriHealth Caritas) raised concerns about how the percentage is applied—whether to all PCPs or a defined population—and asked for clarification on which components of SB120 are under review. Ms. Vogel clarified that the group could revisit the percentage and other elements through a new bill or regulatory changes, emphasizing the importance of collective input to guide PCRC recommendations.

Dr. Donohue-Henry supported the idea of strengthening SB120 to avoid future legislation that may not serve stakeholders well, but noted the challenge of aligning a diverse group within a tight timeline. Ms. Vogel acknowledged the difficulty of virtual collaboration and reiterated the urgency of meeting the PCRC's deadline. Dr. Hockstein suggested a dual approach: a short-term fix to prevent SB120 from sunsetting and a longer-term strategy to develop a new model, possibly with a one-year extension. Ms. Vogel agreed and explained that her proposed strategy slide was meant to reflect overlapping efforts—extending SB120 while designing a new tiered model that accommodates varying practice capabilities. She encouraged the group to refine the language and structure of their recommendations to ensure clarity and consensus.

Dr. Bradley recommended extending SB120 by one year, through the end of 2027, rather than eliminating its sunset entirely. He expressed frustration that the current law affects too few patients to justify the effort required and emphasized the need to bring more insurance companies into the program—either voluntarily or through regulation. He also highlighted broader concerns about workforce sustainability and reimbursement disparities between independent practices and hospital-employed physicians, urging the group to develop a more impactful and inclusive value-based care model.

Ms. Vogel raised concerns about the feasibility of a one-year extension for SB120, noting that carriers would need to submit rate filings by June 2026 to implement changes by 2027 (which would be a tight timeline). Tanisha Merced (Department of Insurance) agreed, emphasizing that expanding the program to include more populations like Medicaid and self-insured groups would require more time and infrastructure than a single year allows. She also noted that previous efforts to remove the sunset clause failed due to lack of stakeholder alignment. Dr. Perry and Kate Masino (Highmark) echoed these concerns, citing the complexity of regulatory filings, CMS coordination, and pricing challenges. Mr. Wilson added that Delaware Medicaid has fixed timelines, such as the 2027 quality strategy update, which could serve as natural opportunities to align and implement changes. He suggested leveraging these existing deadlines and processes to guide the committee's planning and avoid relying solely on arbitrary timeframes.

Ms. Vogel proposed summarizing draft changes to SB120 that the Office of Value-Based Healthcare Delivery and the Department of Insurance (DOI) had identified as areas for improvement. Dr. Perry and Dr. Mullins expressed interest in understanding the available policy levers.

Ms. Haas provided a detailed overview of the proposed changes, which include shifting regulatory authority from the PCRC to DOI, maintaining a 10% primary care investment with a focus on prospective payments, and ensuring broader provider participation by requiring insurers to accept any provider meeting standard model criteria. Additional proposals include excluding excessively high-cost claimants from cost calculations, integrating Medicaid and statewide benefits into the model, and gradually ramping up primary care spending.

Ms. Haas also addressed the need for flexibility in adjusting total cost of care targets and discussed the potential for regulatory authority to make future changes without requiring new legislation. Dr. Donohue-Henry raised concerns about downside risk and the feasibility of achieving cost reductions below national trends, especially given Delaware's aging and chronically ill population. Ms. Bryan echoed these concerns, noting the potential strain on Medicaid and hospital systems, and emphasized the importance of aligning with existing models and stakeholder input.

Finally, Ms. Merced clarified that the DOI's intention is to develop a long-term, adaptable solution rather than a short-term fix. She emphasized that the proposed changes were informed by extensive stakeholder engagement and aimed at preventing disruption from SB120's sunset clause.

Next Steps

Ms. Vogel emphasized that having proposed models and strategies in place could help build a more realistic timeline for SB120 reform—especially if the sunset clause is removed. She suggested compiling a summary document of draft legislative changes from the Office of Value-Based Healthcare Delivery and DOI to help stakeholders visualize the available policy levers and areas for improvement. Dr. Donohue-Henry confirmed interest in seeing the details of that proposal, and LoriAnn Rhoads added that while sharing the document is a good strategy, expecting full consensus from such a broad stakeholder group is unrealistic. Rhoads argued that the lack of agreement is what stalled SB120 previously and urged the group to move forward with a sunset mitigation plan, even if not every detail is resolved, to avoid continued delays.

Dr. Mullins raised a concern about whether the DOI's proposed changes to SB120 included improved transparency in payer reporting, specifically asking if there would be more than just attestations from payers and whether providers would have better access to data. Ms. Vogel responded that while the Office of Value-Based Healthcare Delivery could request information, it would need regulatory authority to collect standardized data. Ms. Merced clarified that the current proposal does not change reporting requirements and that while DOI has broad authority to collect data from carriers, it lacks authority over providers. She emphasized that

although DOI supports enhanced data collection, it may not be the appropriate agency to analyze provider-level data, especially given its limited analytical capacity.

Dr. Hockstein supported extending SB120 for several years and suggested incorporating improvements to attribution, a concern raised frequently over the past year. Dr. Bradley revised his earlier recommendation, now advocating for the complete removal of SB120's sunset clause or extend to the end of 2028 to allow for continuity while new programs and legislation are developed to eventually supersede it. Anthony Onugu offered assistance with drafting language to address the attribution component, reinforcing the importance of refining that aspect as part of the extension effort.

Recommendations for PCRC

Ms. Vogel proposed refining the group's strategy by removing the middle column (see graphic below) from a planning slide and instead focusing on a tiered approach to support independent practices—an idea previously discussed and included in the proposed strategies. She suggested updating the strategy language in the first column to explicitly state "modify SB120" with the specific bullet points discussed, rather than referring vaguely to "existing value-based programs." The goal is to present a clear, actionable proposal to the PCRC that reflects the group's intent to prevent SB120 from sunsetting while acknowledging that details still need to be finalized.

Ms. Vogel emphasized that while full consensus may not be achievable, a broadly supported draft could still be valuable for PCRC discussions. She committed to redrafting the proposal and sharing it via email, marked clearly as a draft for discussion.

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Ms. Vogel is to send a modified table via email to the workgroup and will propose recommendations to the PCRC for the meeting on September 22nd. Dr. Hockstein noted that at the September 22nd PCRC meeting there should be something to vote on. The September PCRC meeting is the last meeting for the year. Dr. Hockstein suggested that this workgroup should be involved in the next steps for recommendations on legislation.

If another workgroup meeting is needed before September 22nd, the workgroup will need to wait 7 days for it to be publicly posted.

Public Comment

No public comment.

Adjourn

The meeting adjourned at 4:48 PM.

Virtual Public Meeting Attendees:

Chris Haas	DOI
Tanisha Merced	DOI
Mary Jo Condon	Freedman Healthcare
Kristen Dwyer	Nemours
Carling Ryan	Delaware Healthcare Association
Meredith Stewart Tweedie	ChristianaCare
Phylicia Edmonds	
Tyler Blanchard	Aledade
Pamela Price	Highmark
Ceil Tilney	
Gary Swan	Freedman Healthcare
Craig Schneider	Health Management Associates
Berkley Powell	Health Management Associates
Donna Pugh	DHSS