Maryland Commercial Fully-Insured Market Alternative Payment Model Arrangements

A Report to the Senate Finance Committee and the House Health and Government Operations Committee

December 2024

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Executive Summary

This report, prepared by the Maryland Health Care Commission (MHCC), provides a comprehensive analysis of Alternative Payment Model (APM) adoption for Maryland residents in the State's commercial fully-insured market, tracking progress from 2022 to 2023. In alignment with Chapters 298/297, Senate Bill 834 and House Bill 1148, *Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization* (2022), MHCC addresses key outcomes, including the number and types of value-based arrangements, quality outcomes, complaints, cost-effectiveness, and the effect of two-sided incentive arrangements on health care practitioners' fee schedules.[1] The findings in this report reflect data submitted by three payors—CareFirst, Aetna, and Cigna—representing over 1.5 million member months in value-based arrangements in 2023.

Key Findings:

The Number and Types of Value-based Arrangements:

- APM adoption in Maryland increased significantly on a population basis, with member-month participation growing 80% from 2022 to 2023, this equates to approximately 57,000 new members in 2023, totaling approximately 128,000 members. This is largely driven by CareFirst's expansion into APMs that include comprehensive upside gainsharing and downside risk, (Health Care Payment Learning & Action Network) HCPLAN Category 3B payment models.[2]
- The percent of Total Medical Expenditures (TME) attributed to value-based APMs rose from 13% to 21% of overall TME, reflecting a substantial shift toward value-based care. The percentage of TME referred to above includes all fee-for-service medical expenses for the member in addition to incentive payments made through the APM.
- Growth was primarily in population-based models, with CareFirst adding four new provider organizations to its HCPLAN Category 3B, APMs built on FFS (Upside Gainsharing/Downside Risk) arrangements, which accounted for most of the increase.
- Episode-based APMs also showed growth, particularly in HCPLAN Category 3B, with large increases in the number of pregnancy episodes.

Complaints and Health Care Practitioners' Feedback:

- Providers highlighted challenges including administrative burdens, lack of transparency in quality measures and shared savings calculations, and fee schedule adjustments that disincentivized APM participation.

Cost-effectiveness:

- While participation in APMs increased, actual non-claims payments to providers, a critical component of advanced APMs, remain minimal in Maryland, representing only 0.18% to 0.20% of TME in 2022 and 2023, respectively.
- Maryland's APM adoption trends align with those nationally, though the percent of payments at-risk and moving through non-claims payments remains lower when

[1] Maryland General Assembly. Senate Bill 834: Maryland Health Equity Resource Act. Maryland General Assembly, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0834?ys=2022RS. Accessed 2024.
[2] See Appendix - HCPLAN Category Definitions.

compared to states like Delaware and Massachusetts, which report 1 - 2% of TME as non-claims payments. However, both Delaware and Massachusetts operate in different market environments and have been actively promoting these types of payments for a longer period.

Quality Outcomes:

- MHCC is using payor-submitted data to calculate quality performance across APMs, leveraging the Medical Care Data Base (MCDB) MHCC expects to calculate quality outcomes based on data matching by February 1, 2025.

Recommendations:

- Data Standardization: MHCC recommends continued refinement of its data collection process, and the adoption of the national Non-Claims Payment (NCP) Framework, and its enhanced classification methods to improve data accuracy and comparability. Current data reconciliation reveals challenges in drawing comparisons across payment arrangements, particularly among episode-based payment arrangements. Maryland would be among the first states to adopt and implement the nationally endorsed NCP Framework.
- APM Adoption Insights: MHCC recommends continued investment in understanding provider-specific APM adoption and non-claims payments, especially for primary care models. The analysis in this report reveals a wide array of APM arrangements, impacting different provider types. This additional information will provide actionable insights to guide policy and program improvements.

This report underscores Maryland's progress toward value-based payment adoption while identifying areas for improvement to ensure sustained growth and effectiveness in APM implementation. Looking ahead, MHCC will continue to enhance its data collection and reporting capabilities, enabling better evaluation of APM outcomes and alignment with national trends.

Introduction

MHCC is an independent regulatory agency that provides information on the availability, cost, and quality of health care services in Maryland to policymakers, purchasers, providers, and the public. In 2022, Maryland's legislature enacted Chapter 298/297, directing MHCC to collect and report information on the adoption of APMs and their impact on Maryland. The first report was submitted to the Senate Finance Committee and House Health and Government Operations Committee in December 2023, covering a single year of data as a baseline for future analysis and policy development. In this report, MHCC now presents two years of data, tracking progress from 2022 to 2023.

Value-based Payment Adoption and National Trends

In the mid-2000s, Michael Porter and Elizabeth Teisberg argued that the inefficiencies in the U.S. health care system stem from competition focused on the wrong metrics, prioritizing the volume of services over patient outcomes.[3] To address these inefficiencies and realign market incentives, they proposed a shift toward value-based models that reward providers based on patient health outcomes rather than service volume. Adopted by Centers for Medicare & Medicaid Services (CMS) in 2010, value-based care (VBC) shifts the market dynamic, tying health care provider compensation to patient outcomes, focusing on quality, equity, and cost-effectiveness rather than the volume of services delivered. By aligning financial incentives with quality and patient-centered goals, value-based care encourages providers to deliver more coordinated, efficient, and equitable care.[4]

In 2015, CMS established the Health Care Payment Learning & Action Network (HCPLAN) to accelerate the shift from fee-for-service to VBC. In 2016, HCPLAN published an Alternative Payment Model (APM) Framework to standardize and categorize payment models, and help stakeholders assess progress in moving away from traditional fee-for-service (FFS) payment methods (Figure 1).[5,6] The APM Framework categorizes (HCPLAN Category) payments made to providers based on its linkage to quality and type of risk associated with the payment methodology.

In the context of moving to value, it is important to draw distinction between non-claims payments, value-based payments (VBPs), and Alternative Payment Models (APMs), these concepts are interconnected and are used throughout this report to describe progress on payment model adoption.

Non-Claims Payments are payments made to providers that are not tied directly to individual claims for services rendered. Instead, they may include care management fees, infrastructure investments, population-based payments, or episodic-based payments. Non-claims payments are often used in higher-tier HCPLAN Categories.

Value-Based Payments (VBP) are tied to the quality of care rather than the volume of services provided. VBPs reward providers for achieving better patient outcomes, improving care, and reducing costs. They

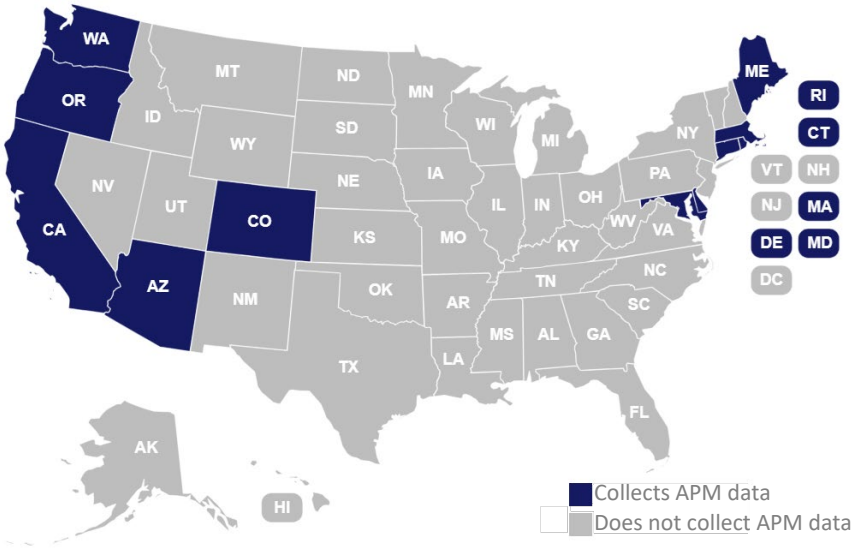
[3] Porter, Michael, and Teisberg, Elizabeth. Redefining Health Care: Creating Value-Based Competition on Results. Boston: Harvard Business School Press, 2006.
[4] Centers for Medicare & Medicaid Services. Medicare Quality Programs: Value-Based Programs. U.S. Department of Health and Human Services, https://www.cms.gov/medicare/quality/value-based-programs. Accessed 2024.
[5] See n. 2, Supra.
[6] Health Care Payment Learning & Action Network. Alternative Payment Model (APM) Framework Refresh White Paper. Health Care Payment Learning & Action Network, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf. Accessed 2024.

often rely heavily on non-claims payments to encourage providers to focus on long-term care improvements and preventive measures.

Alternative Payment Models (APMs) are payment approaches that go beyond traditional fee-for-service reimbursement. APMs do not necessarily need to be value-based and can range from shared savings models to capitated arrangements, where providers take on greater financial and clinical responsibility for patient care. As with VBP arrangements, as providers move to higher tiers of APMs, the reliance on non-claims-based payments typically increases.

Fee-for-service payments can incentivize provider organizations to increase the volume of services to increase revenues, even if those services do not add value. In contrast, APMs often use non-FFS or non-claims-based payments to compensate for health care services, linking payment amounts to the value of the care delivered. The HCPLAN Framework has become the foundation for implementing APMs and evaluating progress toward health care payment reform.

Figure 1. States Collecting APM Data



As of 2023, HCPLAN reported that nearly 60% of payments made by health plans, states, and traditional Medicare to providers fell under HCPLAN Category 2C or above, ranging from APMs built on FFS with a link to quality, such as programs that offer providers an additional payment for meeting certain quality thresholds, to APMs that share upside gains and full risk with providers. [7] Notably, approximately 40% of these payments included some level of upside gain sharing and/or shared risk with providers. It is also worth noting that HCPLAN reported nearly identical adoption rates in 2022.[8] Still, in most of these contracts, total payments tend to be only minimally impacted by the value of care received.

With increased standardization in recent years, states and the HCPLAN have begun to report their progress and year-to-year changes enabling comparisons across states. Currently, eleven states—Arizona, California, Colorado, Connecticut, Delaware, Maine, Maryland, Massachusetts, Oregon, Rhode Island, and Washington—monitor and collect data on value-based arrangement adoption (Figure 2). Of these eleven states, eight have published reports on APM adoption for payors in their state.

[7] Health Care Payment Learning & Action Network. APM Measurement: Progress of Alternative Payment Models - Methodology and Results Report 2023. Health Care Payment Learning & Action Network, https://hcp-lan.org/workproducts/apm-methodology-2023.pdf. Accessed 2024.

[8] Health Care Payment Learning & Action Network. APM Measurement: Progress of Alternative Payment Models - Methodology and Results Report 2022. Health Care Payment Learning & Action Network, http://hcp-lan.org/workproducts/apm-methodology-2022.pdf. Accessed 2024.

HCPLAN establishes APM adoption goals for the nation. In 2020, Oregon and Delaware set APM adoption goals for payors within their states. California set APM adoption goals in 2024. Both Delaware and California have adoption goals that are more aggressive than national adoption goals. Oregon's adoption strategy among the commercial market is voluntary. National APM adoption goals or benchmarks are listed in Table 1.

Table 1. HCPLAN National Commercial Market APM Adoption Goals, 2024-2030

HCPLAN Year	Adoption Goal*
2024	25%
2025	30%
2030	50%

**The adoption goal is only met through HCPLAN Categories 3B, 4A, 4B, and 4C.*

Background on health care market and changes in Maryland

In 2018, Maryland partnered with CMS to create the Maryland Total Cost of Care (TCOC) Model. It was targeted to save over $1 billion in Medicare spending by the end of 2023, building on decades of collaboration across Maryland and CMS to control costs and improve value in the state. The Maryland Primary Care Program (MDPCP) is a companion program that offers incentives to decrease the need for high-cost care by increasing prevention and chronic disease management while preventing avoidable hospital use.[9] These APMs include non-claims payments such as care management fees, performance-based incentive payments, and comprehensive primary care payments (CPCP).

Requirements in Maryland

In response to the national trend toward value-based payments, Maryland's 2022 legislature enacted Chapter 297 to allow commercial payors to design payment models with two-sided provider risk and capitation arrangements and encouraged the adoption of value-based payment arrangements. Unlike other states, previously restricted in Maryland.

MHCC is tasked with developing a collaborative data collection method with stakeholders to meet COMAR 10.25.06.14 requirements.[10] This involves creating a non-fee-for-service expenses report and updating the Commission's annual MCDB Submission Manual with relevant instructions. MHCC must report annually through December 31, 2032, on value-based care arrangements, specifically covering:

1. The number and type of value-based arrangements entered into;
2. Quality outcomes of the value-based arrangements;
3. The number of complaints made regarding value-based arrangements;
4. The cost-effectiveness of the value-based arrangements; and
5. The impact of two-sided incentive arrangements on the fee schedules of health care practitioners included in the target budget that are not eligible providers.

[9] Maryland Department of Health. Maryland Primary Care Program (MDPCP). Maryland Department of Health, https://health.maryland.gov/mdpcp/pages/home.aspx. Accessed 2024.
[10] Maryland Department of Health. COMAR Online: Maryland Regulations and Administrative Code. Maryland Department of Health, https://dsd.maryland.gov/regulations/Pages/10.25.06.14.aspx. Accessed 2024.

To support this initiative, MHCC collects data on APM arrangements as per COMAR 10.25.06.14, with all payors required to report their data using the APM Data Submission Guide.[11] As part of their requirements, MHCC reported out on data collection in December of 2023 on 2022 data. This report is the first year in which trend data is reported. Data reported here include 2022 and 2023 data.

Data Collection Methodology

Payors were required to return the APM Data Collection Template by September 30, 2024, including APM participation for the previous two years, 2022 and 2023. Since the law was passed in October 2022, there were few VBP arrangements in place during that year. Payors were instructed to assign members or episodes and TME according to HCPLAN Framework Categories. Members may be part of multiple APMs. Therefore, payors were instructed to assign all TME to the HCPLAN Category farthest along the continuum of clinical and financial risk to the provider. For example, if a member's TME could be counted under either HCPLAN Category 2C or 3A, the member's TME would be assigned to HCPLAN Category 3A. Upon receipt of complete Data Collection Templates, MHCC conducted a data quality review and worked with payors to address any questions and resubmit data as necessary.

Data was provided for population-based APMs and episode-based APMs, along with aggregate summary information, including non-claims payments. Non-claims payments were reported by HCPLAN Category. Data provided by payors focused on Maryland residents in fully-insured products, however, payors could also voluntarily report on other market information, such as Medicare Advantage, self-insured health plans, etc. Since payors only provided information on fully insured products, this report reflects reported information on fully-insured products only.

Kaiser and UnitedHealthcare offered APM programs in 2022 and 2023 that do not require data submission and received waivers for this reporting year. Data submitters included Aetna, CareFirst, and Cigna, which provided data to MHCC.

To calculate quality measures such as HEDIS, MHCC opted to use Maryland's Medical Care Data Base (MCDB) rather than relying on direct submissions from payors. This decision was driven by several factors including the ability to consistently report claims data across payors over time, and to reduce administrative burden on both MHCC and payors while still enabling quality measurement reporting.

Data Considerations

At times, it may be difficult for payors to determine the proportion of population-based and/or episode-based APMs to attribute to Maryland residents. Population based payments are calculated based on the performance of the entire population attributed to the provider, which may include patients from neighboring states. As such, payors are allowed to submit data for both Maryland residents and non-residents. Cigna elected to submit its data in this format. To attribute its data to Maryland residents, the ratio of Maryland residents to non-residents and Maryland-resident episodes to non-Maryland-resident episodes was used to approximate TME and non-claims payments.

It is also worth noting that several APMs were excluded from the tables and figures below due to either low Maryland resident member months or low per-member-per-month (PMPM). CareFirst's pediatric APM, accounting for approximately six members, was excluded. This APM crosses the border of Maryland and largely operates out of state. Additionally, CareFirst submitted data on an HCPLAN Category 2C APM.

[11] See n. 10, Supra

The PMPM for this APM was significantly lower than comparators due to the low number of risk-only Maryland residents reported. As this model represents less than 0.6% of CareFirst's members, this APM was included in summary membership data only (Tables 2 and 3).

Results

Summary of Submitted Data

Participation in APMs in Maryland totaled approximately 128,000 attributed members, and 21% of the market based on TME (Table 2 and Table 4). While other HCPLAN Categories experienced either a decrease in member participation or only a modest increase, most of the growth was driven by CareFirst, which expanded participation in its HCPLAN Category 3B model by adding providers and in turn, members, into upside gainsharing and downside risk arrangements linked to quality. This shift is marked by a decrease in overall FFS member months and an increase in member months for HCPLAN APMs linked to quality.

Membership in APMs increased 80% from 2022 to 2023, reflecting an overall market shift toward APM adoption.

In 2023, CareFirst accounted for 83% of the overall membership in APMs and engaged with five new provider organizations, establishing contracts under the HCPLAN Category 3B model (Table 3) with all of them. This is where the majority of the APM growth in Maryland occurred in 2023, representing approximately a 56,000 member increase over the previous year. The next largest payor, Cigna, saw only a modest increase in APM participation, all in its HCPLAN Category 3A models, which include upside gainsharing only. Aetna, the smallest payor, increased its APM participation in HCPLAN Category 3A by approximately 1,100 members. The decrease in HCPLAN Category 2C was largely driven by movement from 2C to 3A provider organizations.

Table 2. Member months for Population-based APMs

HCPLAN Category and Payor	2022	2023	Percent Change
HCPLAN 2C – FFS (Pay for Performance)	**9,209**	**5,810**	**-37%**
Aetna	9,209	5,810	-37%
CareFirst	0	11,812	N/A
HCPLAN 3A – APM built on FFS (Upside Gainsharing)	**519,244**	**538,136**	**4%**
Aetna	17,464	30,606	75%
CareFirst	275,762	279,516	1%
Cigna	226,018	227,472	1%
HCPLAN 3B – APM built on FFS (Upside Gainsharing/ Downside Risk)	**329,177**	**997,705**	**203%**
CareFirst	329,177	994,629	202%
Total	**857,630**	**1,541,651**	**80%**

In 2023, Aetna and CareFirst added several new provider organizations and established population-based APM agreements with each new provider organization. Cigna contracted with one new provider under an episode-based APM aligned with HCPLAN Category 3A, incorporating upside gainsharing (Table 3). While

modest, this increase in member months and provider participation demonstrates continued growth among HCPLAN APMs tied to quality.

Table 3. Provider Organization Participation in APMs

HCPLAN Category and Payor	2022 – Provider Organizations – Population-based	2023 – Provider Organizations – Population-based	2022 – Provider Organizations – Episode-based	2023 – Provider Organizations – Episode-based
HCPLAN 2C– FFS (Pay for Performance)	**6**	**7**	**N/A**	**N/A**
Aetna	6	5	N/A	N/A
CareFirst	0	2	N/A	N/A
HCPLAN 3A– APM built on FFS (Upside Gainsharing)	**17**	**21**	**7**	**8**
Aetna	4	6	0	0
CareFirst	3	4	2	2
Cigna	10	11	5	6
HCPLAN 3B – APM built on FFS (Upside Gainsharing/ Downside Risk)	**4**	**8**	**4**	**4**
CareFirst	4	8	4	4
Total	**27**	**36**	**11**	**12**

For 2023, spending associated with HCPLAN Categories 2C through 3B represented just under 21% of overall TME, up from 13% the year prior. This growth was driven by CareFirst's expansion among HCPLAN Category 3B.

Table 4. Aggregate TME Across HCPLAN Categories

HCPLAN Category	2022 Aggregate TME	2023 Aggregate TME	Percent TME Change 2022 to 2023
HCPLAN 1 – FFS	$3,237,011,009	$3,315,233,729	2%
HCPLAN 2C – FFS (Pay for Performance)	$4,426,405	$3,438,075	-22%
HCPLAN 3A – APM built on FFS (Upside Gainsharing)	$263,219,773	$291,585,797	11%
HCPLAN 3B – APM built on FFS (Upside Gainsharing/ Downside Risk)	$207,679,008	$581,093,667	180%
Total	$3,712,336,195	$4,191,351,269	13%

**Excludes CareFirst's HCPLAN Category 2C APM due to the low number of risk-only Maryland residents and CareFirst's 3A APM that consist mostly of non-Maryland residents. See Data Considerations for additional details.*

Not only was there growth in HCPLAN APMs 2C and above, but there was also a significant decrease in HCPLAN Category 1 - FFS. While HCPLAN Categories 2C and 3A remained largely consistent year to year, HCPLAN Category 3B grew nearly two and a half times over (Figure 3). As noted, this growth was driven by CareFirst's expansion, including the addition of providers and members to this category.

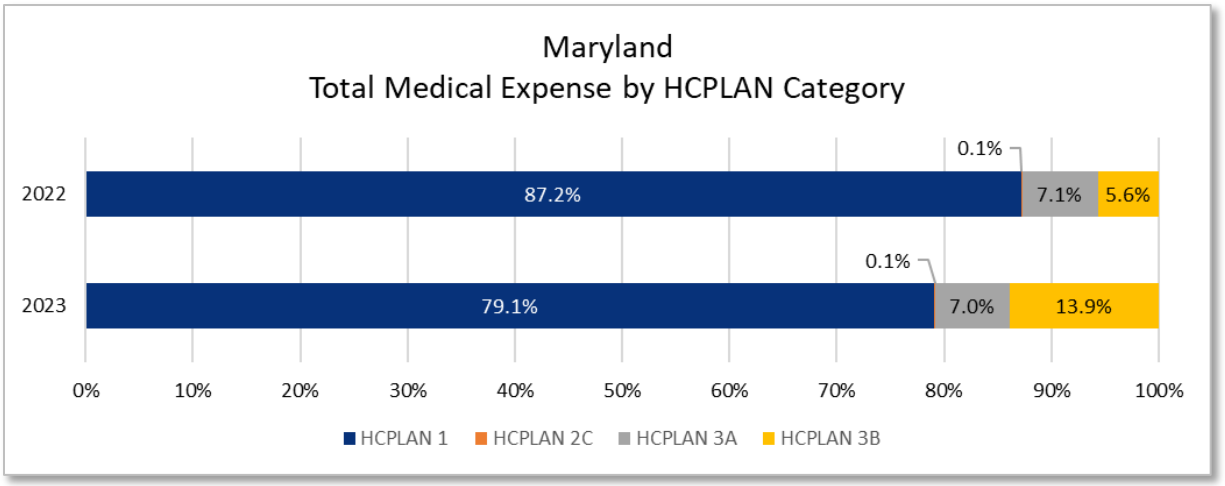
Table 5. PMPM Across HCPLAN Category

HCPLAN Category	2022 Aggregate PMPM	2023 Aggregate PMPM	Change in PMPM
HCPLAN 1 – FFS	$530.99	$564.11	$33.12
HCPLAN 2C – FFS (Pay for Performance)	$480.66	$591.75	$111.09
HCPLAN 3A – APM built on FFS (Upside Gainsharing)	$488.01	$527.33	$39.32
HCPLAN 3B – APM built on FFS (Upside Gainsharing/ Downside Risk)	$617.45	$569.85	-$47.59
Total	$515.07	$547.39	$32.33

**Excludes CareFirst's HCPLAN Category 2C APM due to the low number of risk-only Maryland residents and CareFirst's 3A APM that consist mostly of non-Maryland residents. See Data Considerations for additional details.*

When examining overall PMPMs, it is notable that while all other HCPLAN Categories experienced increases, HCPLAN Category 3B, which includes upside gainsharing and downside risk, showed a decrease in PMPM (Table 5). Conversely, HCPLAN Category 2C saw a significant PMPM increase between 2022 and 2023, potentially due to a 2022 participating provider with lower relative age/gender factors transitioning from HCPLAN Category 2C to 3A.

Figure 2. Percent of Total Medical Expense by HCPLAN Categories, 2022-2023



As additional context for Maryland's APM adoption, it is important to note that Maryland is unique in two ways. First, as it is focused primarily on care redesign, the APM data presented here for Maryland does not include the CMS Center for Medicare & Medicaid Innovation All-Payor Model as an APM. Since the 1970s, Maryland has partnered with CMS to set hospital rates under the Health Services Cost Review Commission. In 2014, Maryland received approval from CMS to implement a global budget model for Maryland hospitals. In recent years, this has expanded to broader care redesign and total cost of care models, with a greater focus on population health and care quality. As a result, the market and APM adoption in Maryland may look fundamentally different from other national comparators. As state-to-state comparisons are made, it's worth considering how to classify these payments.

Second, due to Maryland's unique rate-setting environment, Medicare, commercial, and Medicaid rates are different than in other states with rate disparities across payors being less pronounced than

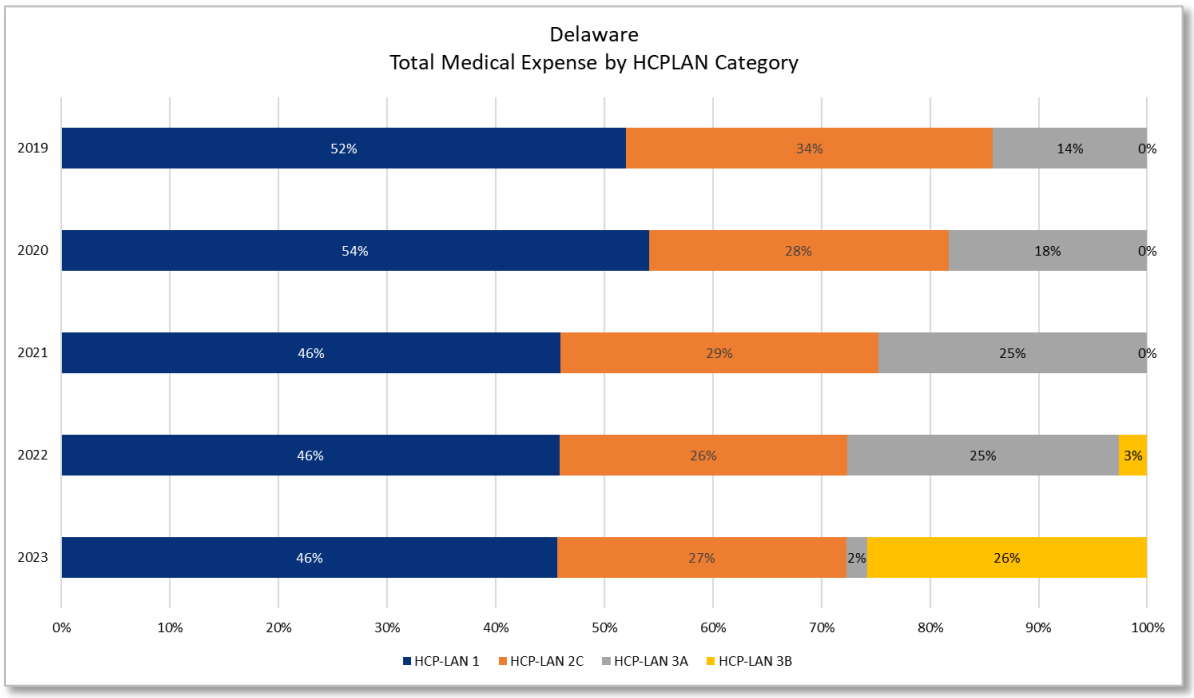
elsewhere. Maryland's rate setting environment has put downward pressure on commercial pricing, which may make it more difficult to drive value-based care investment in Maryland than in other states.

National Comparators

Delaware established the Office of Value-Based Health Care Delivery in 2019 and, in 2022, introduced Section 1322, Requirements for Mandatory Minimum Payment Innovations in Health Insurance.[12] This regulation includes both primary care transformation goals and APM adoption goals. In primary care, payors must achieve a target of 75% of primary care providers engaged in care transformation activities by 2026. For APM adoption, payors covering over 10,000 Delaware residents in the fully-insured market are required to expand the use of meaningful APMs by shifting 50% of TME to HCPLAN Categories 3A and 3B of which 25% must be in HCPLAN Category 3B. Notably, there is no compliance requirement for this in 2023.[13]

Initial HCPLAN APM adoption occurred in the early years; however, in more recent years, this has stabilized around 46%. Also in more recent years, growth has occurred within HCPLAN Categories, progressing to higher levels in the HCPLAN Framework. Driven by the primary care and APM adoption requirements, the largest growth has occurred between HCPLAN Categories 3A and 3B. The data indicate that upside gainsharing arrangements have been converted to shared upside gainsharing and downside risk arrangements (Figure 4).

Figure 3. Percent of Total Medical Expense in HCPLAN Categories, 2019-2023*



Excludes HCPLAN Categories 2A & 4B as they represent less the 1% of overall TME

[12] Delaware Department of Insurance. Regulation 1322: Mandatory Disclosure Requirements for Settlement Agreements. Delaware Administrative Code, https://regulations.delaware.gov/AdminCode/title18/1300/1322.pdf. Accessed

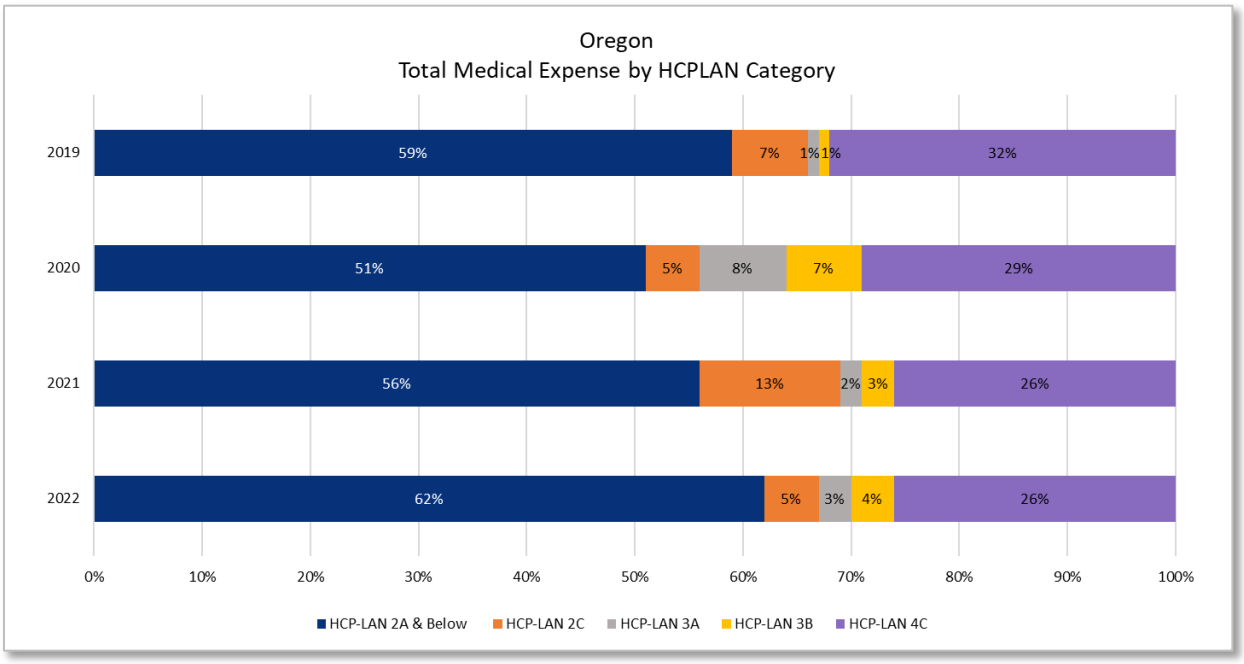
[13] Delaware Department of Insurance. Delaware Annual Review of Progress Towards Value-Based Payment and Delivery System Reform. Delaware Department of Insurance, https://insurance.delaware.gov/wp-content/uploads/sites/15/2023/02/Delaware-Annual-Review-of-Progress-Towards.pdf. Accessed 2024.

Maryland saw initial growth in overall HCPLAN 2C and above adoption, as well as growth within HCPLAN categories despite not having a formal APM adoption requirement.

In 2022, the Oregon Health Authority and the Oregon Health Leadership Council jointly sponsored the Oregon VBP Compact, which applies to commercial payors.[14] The Oregon VBP Compact "is a voluntary commitment by payors and providers across the state to increase the use of VBP to lower the rate of cost growth, improve quality and outcomes, and foster health equity."

The adoption pattern in Oregon is notably different from what is seen in Delaware. Initially, there was significant progress in the commercial market, with an increase in APM adoption in HCPLAN 2C and above and a decrease in fee-for-service (Figure 5). However, this trend reversed between 2020 and 2022, this reversal may be an outcome of the voluntary nature of the Oregon VBP Compact. Also, in Delaware, a requirement to increase primary care investment has contributed to increases in APM adoption as payors chose to use VBP to accomplish the primary care investment goals. It is also important to note that this variability occurs across the COVID-19 pandemic, which may have impacted commercial contract arrangements and the adoption of HCPLAN Framework APMs. The high adoption of HCPLAN Category 4C payments is driven by Kaiser Permanente, which accounts for all payments in this category.[15]

Figure 4. Oregon Percent of Total Medical Expense in HCPLAN Categories, 2019-2022



**The high adoption of HCPLAN 4C payments is driven by Kaiser Permanente, which accounts for the entire percentage in this category.*

Oregon's experience demonstrates the importance of monitoring progress and highlights the need for continued state investment in goal setting and partnerships with payors.

[14] Oregon Health Authority. Value-Based Payment (VBP) Compact Roadmap. Oregon Health Authority, https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/6.-VBP-Compact-Roadmap.pdf. Accessed 2024.
[15] See n. 14, Supra.

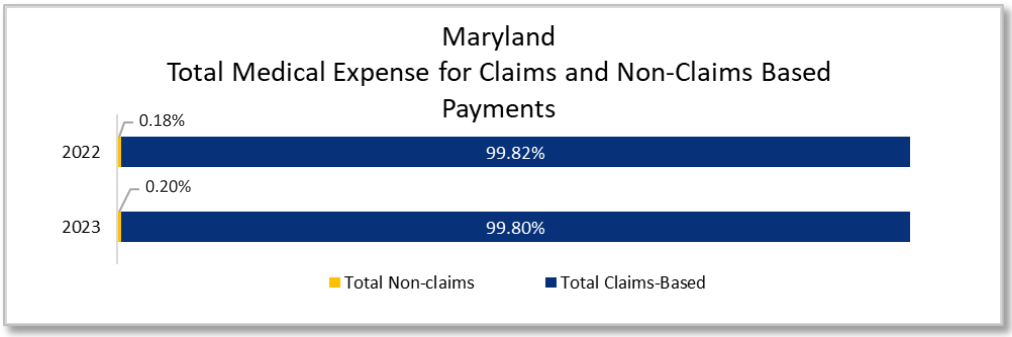
Non-claims Payments

When examining progress across HCPLAN Framework Categories and value-based payment arrangements, it is important to understand how payments are made. In most cases, reporting is based on the total TME that flows through the contract. This means that if a provider organization participates in an HCPLAN value-based arrangement, all FFS and non-claims are reported. Tracking the proportion of total medical expense coming from non-claims payments in those arrangements provides insight into the payments tied to value within the arrangement.

Non-claims payments, particularly for population-based payments, represent the value-based component of the payment. These resources support care delivery transformation and new models of care. As providers continue to adopt more advanced APMs, it is desirable to see a transition to non-claims payments to enable care transformation.

When examining Maryland's current proportion of non-claims payments, the total amount is marginal, ranging from 0.18% to 0.20% in 2022 and 2023, respectively (Figure 6). This indicates that the majority of payments remain FFS. It suggests that while providers are engaging in more APMs, they continue to have a very small portion of their payments tied to value. Therefore, they may feel insufficient pull to transition to more value-based care delivery and instead continue to focus on volume to preserve revenues and remain competitive. The low amounts of non-claims payments would not sufficiently incentivize or provide opportunity for care transformation.

Figure 5. Maryland Non-Claims Payments, 2022-2023

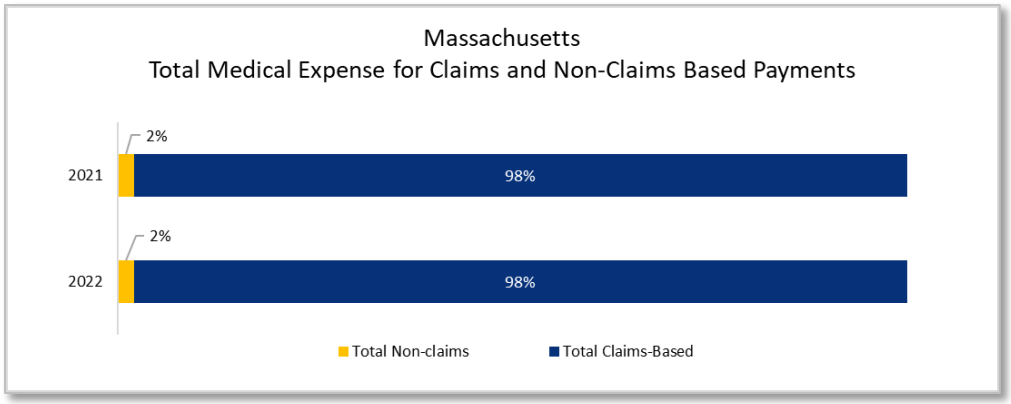


However, compared to national peers, Maryland is less of an outlier. In Delaware's 2022 Annual Review of Progress Towards Value-Based Care, it was noted that data indicated that non-claims payments have hovered around 1% of total cost of care.[16] In 2012, Massachusetts set goals to increase the APM adoption in Chapter 224 of their state regulations.[17] In its most recently reported data, Massachusetts showed a consistent non-claims portion of TME, hovering at 2% (Figure 7).

[16] Delaware Department of Insurance. Delaware Annual Review of Progress Towards Value-Based Care. Delaware Department of Insurance, https://insurance.delaware.gov/wp-content/uploads/sites/15/2023/02/Delaware-Annual-Review-of-Progress-Towards.pdf. Accessed 2024.

[17] Massachusetts Legislature. Chapter 224 of the Acts of 2012: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation. Massachusetts General Court, https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224. Accessed 2024.

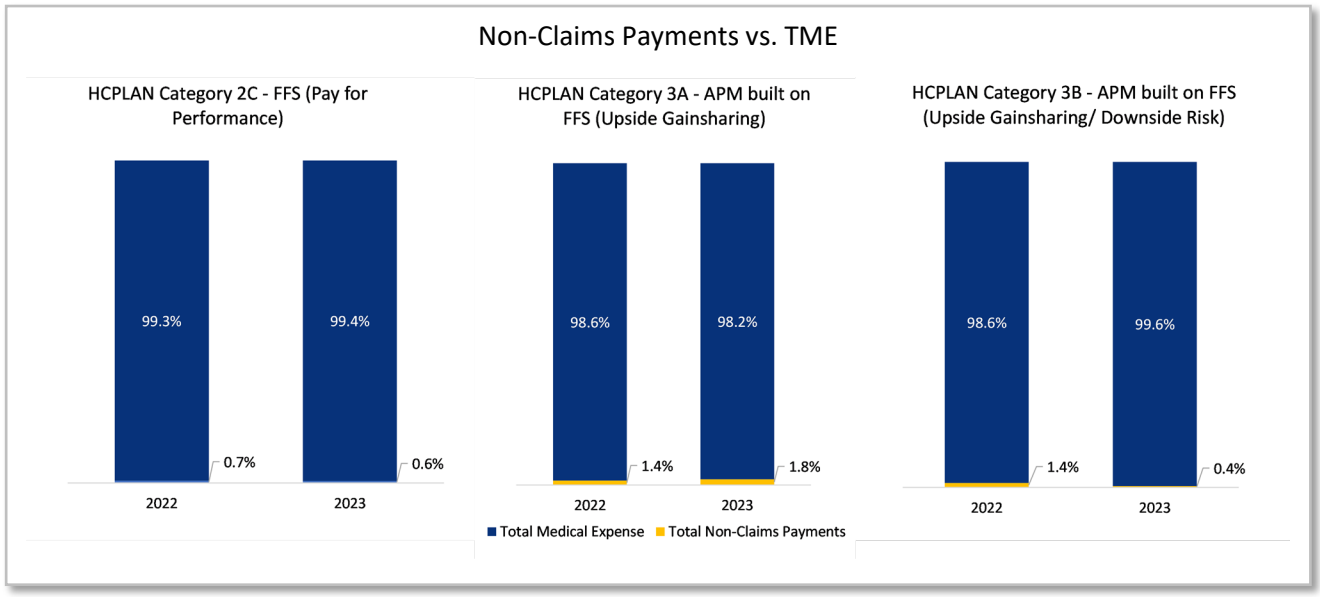
Figure 6. Massachusetts Non-Claims Payments, 2021-2022.*



**Some Massachusetts FFS TME under global budgets here may be paid via non-claims, but is reported as FFS equivalents as required by CHIA.*

MHCC chose to analyze non-claims as a percent of TME at the HCPLAN Category level to understand whether within these value-based arrangements, the proportion of payments tied to value was higher than in aggregate. When examining non-claims payments at the HCPLAN Category level, proportional payment amounts are slightly higher than aggregate reporting (Figure 8), though greater than 98% of payments in each type of arrangement remains FFS. For 2023, there was a marginal increase in HCPLAN Category 3A and marginal decreases in Categories 2C and 3B. It is worth noting that the proportion of non-claims payments was higher for all categories compared to the aggregate for the same time frames since the aggregate includes.

Figure 7. Maryland HCPLAN Category Non-Claims Payments

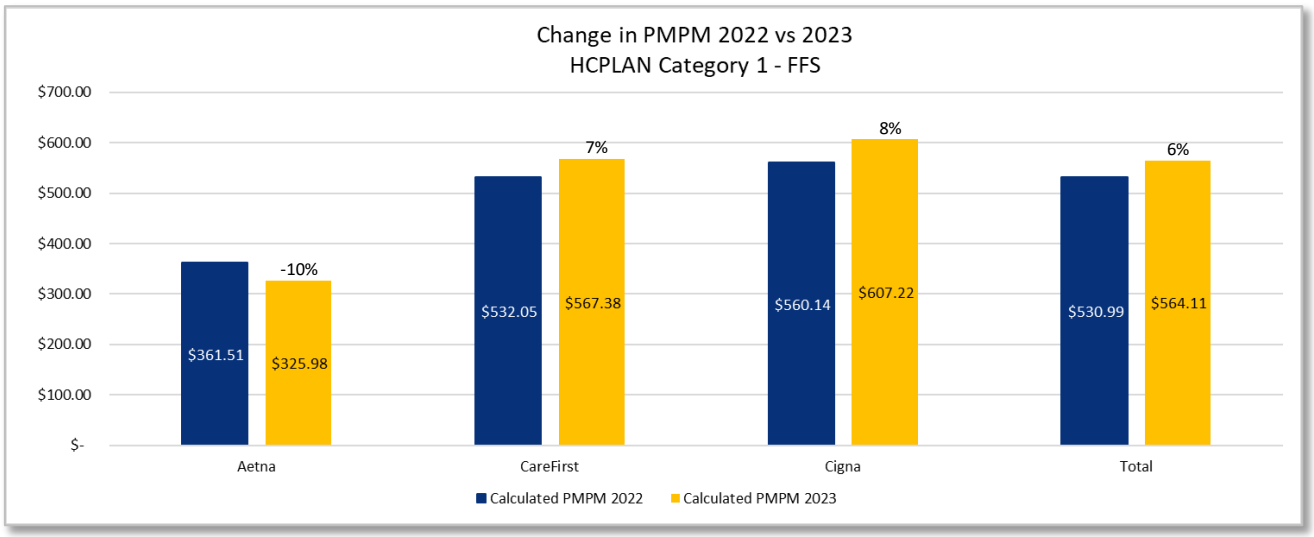


This suggests providers may not have sufficient incentives to engage these arrangements or payments to transform care delivery and focus on value.

HCPLAN Population-Based APM Summary

Comparing PMPM change from 2022 to 2023, Maryland commercial fully-insured trends were generally consistent with national trends. For 2022 national health expenditure data reported that private health insurance spending grew 5.9%, and project over the next ten years overall health expenditure growth to average 5.6%.[18] In Maryland, HCPLAN Categories 1 and 3A increased as a similar rate, 6% and 8% respectively (Figures 9 and 11).

Figure 9. HCPLAN Category 1 – FFS – TME PMPM Comparison, 2022-2023



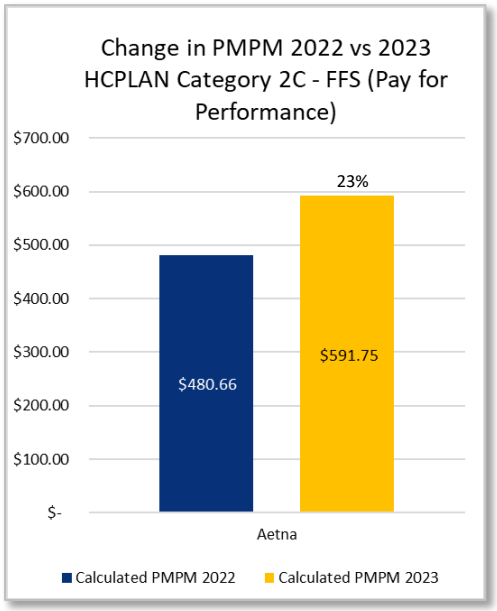
*Aetna's PMPM appears low due to a significant mix of student plan membership.

For Aetna's HCPLAN Category 2C, one reason why the PMPM may be higher than the FFS is that the FFS is more likely to include individuals who never received care. To be attributed to a provider, and in turn an APM, a member had to receive some care. Included in the summary analysis, but excluded from detailed examination is CareFirst's HCPLAN Category 2C APM. CareFirst reported approximately 980 members for this APM.

Aetna was the only payor included in MHCC's 2C analysis. While Aetna's PMPM increased by 23% from 2022 to 2023, total membership decreased from approximately 767 members to 484 members (Figure 10). Aetna's overall PMPM for this APM was consistent with market averages. The payor experienced a decrease in provider participation in this category, resulting in a 37% reduction in attributed member months.

All payors had an HCPLAN Category 3A APM in 2022 and 2023. For these APMs, PMPMs increased year over year, with an average increase of 8%. Aetna experienced the largest increase,

Figure 8. HCPLAN Category 2C – FFS (Pay for Performance) – TME PMPM Comparison, 2022-2023



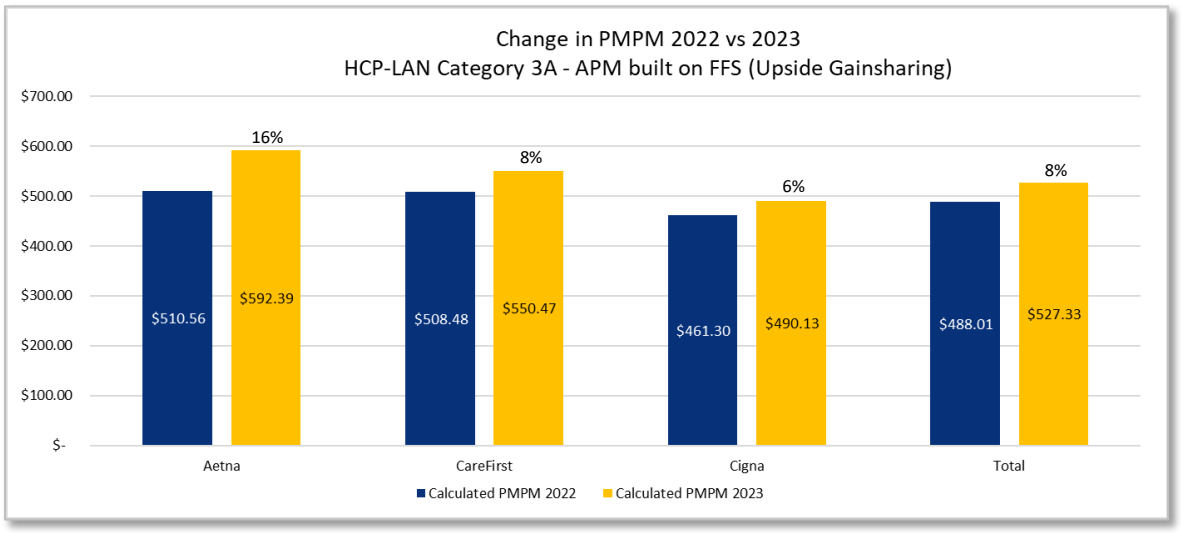
**Excludes CareFirst's HCPLAN 2C APM due to low PMPM.*

[18] Centers for Medicare & Medicaid Services. National Health Expenditure Fact Sheet. U.S. Department of Health and Human Services, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Private%20health%20insurance%20spending%20grew,11%20percent%20of%20total%20NHE. Accessed 2024.

at 16% from 2022 to 2023. In contrast to their HCPLAN 2C model, Aetna saw an increase in provider participation and member months in HCPLAN Category 3A. One new provider organization was added in 2023, and another transitioned from HCPLAN Category 2C to 3A. Member months for Aetna's HCPLAN Category 3A increased by 75% compared to 2022.

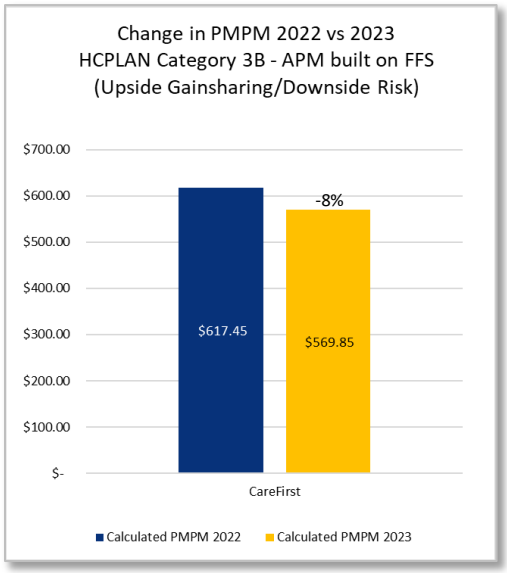
Cigna's PMPM growth was the most modest and the lowest among all payors, increasing by 6% and coming in $61.38 PMPM lower than the next carrier, CareFirst (Figure 11). Aetna had the largest growth in PMPM, an increase of 16%, or $81.83 PMPM. Cigna's membership growth in HCPLAN Category 3A was driven by the addition of a new provider organization. Notably, there was no provider organization overlap between Cigna's population-based APMs and episode-based APMs.

Figure 10. HCPLAN Category 3A – Upside Gainsharing – TME PMPM Comparison, 2022-2023



**Excludes CareFirst's pediatric APM due to low member months (76).*

Figure 11. HCPLAN Category 3B –Upside Gainsharing/Downside Risk – TME PMPM Comparison, 2022-2023



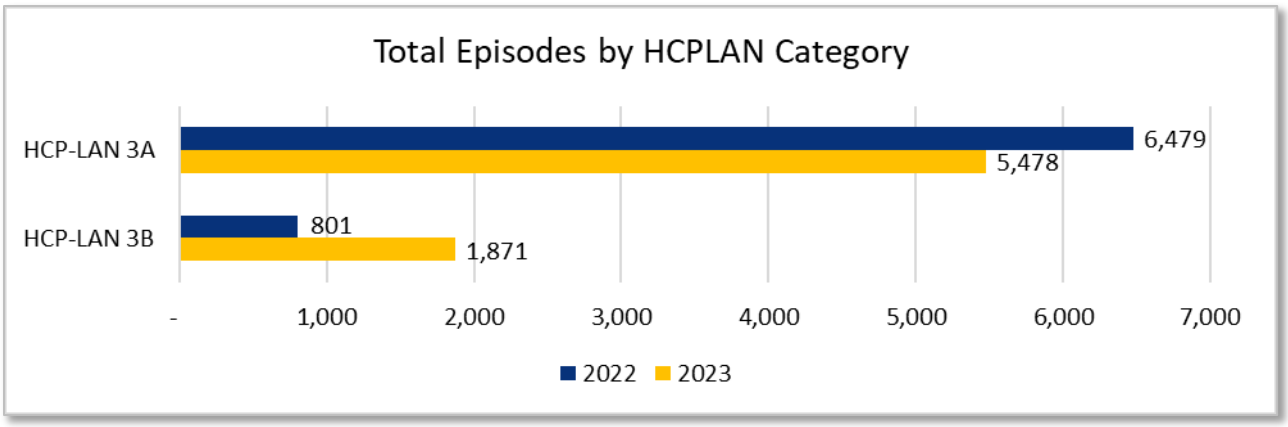
While CareFirst saw a decrease in the overall PMPM of 8% for HCPLAN Category 3B, they increased member months by 203%, or approximately 56,000 members (Figure 12). This was all driven by the addition of five new provider organizations, resulting in approximately 54,000 new members. That is to say that CareFirst both grew their two-sided risk arrangements while reducing overall costs.

In summary, these data show that payors in general have attempted to grow their population-based APMs and have worked with providers to transition them into more advanced HCPLAN APM Categories. In some cases, this effort has led to reduced TME on a PMPM basis where downside risk exists with the provider. In all other cases, TME on a PMPM basis has either remained stable relative to health care inflation, or, in the case of HCPLAN 2C, has significantly increased from 2022 to 2023.

HCPLAN Episode-Based APM Summary

Similar to population-based APM adoption trends, the largest area of growth for episode-based payment arrangements occurred among HCPLAN Category 3B – upside gainsharing and downside risk. Episodes for this category increased by 134% from 2022 to 2023 (Figure 13).

Figure 12. Episode Comparison Year-over-year



Episodes-based APMs for 2023 included:

1. Colonoscopy
2. Esophagogastroduodenoscopy
3. Hip Replacement & Hip Revision
4. Hysterectomy
5. Knee Arthroscopy
6. Knee Replacement & Knee Revision
7. Lumbar Laminectomy
8. Lumbar Spine Fusion
9. Pregnancy
10. Upper Gastrointestinal (GI) Endoscopy

Of these APMs, pregnancies drove most of the growth between 2022 and 2023 under HCPLAN Category 3B – upside gainsharing (Table 5). Pregnancies increased by 580 episodes during this period. It is also worth highlighting the significant increase in upper GI endoscopies. Both increases, pregnancies and upper GI endoscopies, were driven by a single provider organization within their respective HCPLAN Category.

Notably, there were relative increases in hip and knee episodes across HCPLAN Category 3B. All other episodes under both HCPLAN Categories 3A and 3B showed either modest increases or decreases.

Table 6. Episode Comparison Year-over-year, Type of Episode.

HCPLAN Category and Payor	Type of Episode	2022 - Count of Episodes	2023 - Count of Episodes	Change 2022 to 2023
HCPLAN 3A		**6,479**	**5,478**	**-1,001**
CareFirst	Colonoscopy	5,514	4,020	-1494
	Upper GI Endoscopy	660	1,191	531
Cigna	Colonoscopy	58	63	5
	Esophagogastroduodenoscopy	9	11	2
	Hip Replacement & Hip Revision	2	0	-2
	Hysterectomy	22	22	0
	Knee Arthroscopy	6	5	-1
	Pregnancy	208	166	-42
HCPLAN 3B		**801**	**1,871**	**1,070**
CareFirst	Colonoscopy	47	26	-21
	Hip Replacement & Hip Revision	2	87	85
	Knee Arthroscopy	10	272	262
	Knee Replacement & Knee Revision	3	141	138
	Lumbar Laminectomy	1	15	14
	Lumbar Spine Fusion	2	14	12
	Pregnancy	736	1,316	580
Total		**7,280**	**7,349**	**69**

Given the large variability in reported TME and cost per episode, MHCC is working with payors to gather further details on the scope of services included in their episode-based arrangements, as well as identifying how episodes are grouped for payment. Further details will be provided in future reports.

Quality in APM Arrangements

MHCC is working with payors to calculate quality scores using payor-submitted data in the MCDB. The current data collection requires that the Encrypted Enrollee's Identifier, Enrollee Year and Month of Birth, and Enrollee Sex match those that are submitted to the APCD.

Quality measures will include:

1. Acute Hospital Utilization (AHU)
2. Breast Cancer Screening (BCS)
3. Risk of Continued Opioid Use (COU)
4. Eye Exam for Patients With Diabetes (EED)
5. Emergency Department Utilization (EDU)
6. Follow-up After Emergency Department Visit for Mental Illness (FUM)

MHCC has collected the necessary data from each of the participating payors, and in the process of calculating quality performance across APMs. Additionally, MHCC is working to determine the most

appropriate comparison benchmarks for inclusion in future reports. Currently available comparators are not available and requires MHCC adjust available comparison data for reporting purposes. MHCC expects to calculate quality outcomes based on data matching by February 1, 2025.

Feedback on Value-Based Arrangements

Complaints on Value-based Arrangements

Health care practitioners and practices can file complaints regarding violations in law related to APM payor-provider contracting to the Maryland Insurance Administration (MIA). MHCC is required to report these complaints. The MIA has received no complaints.

Provider Feedback on Value-Based Arrangements

MHCC solicited direct feedback from providers during the fall of 2024. Seven provider organizations responded to the survey request.

Providers confirmed participation in various value-based arrangements, including population health, shared savings, capitation, and incentive payment models. Providers shared that their APM program goals include improving patient outcomes, enhancing access, promoting health equity, and reducing costs. Challenges include fee schedule adjustments disincentivizing participation, lack of clarity on quality measures and shared savings calculations, administrative burdens like prior authorizations, and misalignment in data reporting and analytics. Financial incentives and alignment in contracting and performance measures were cited as critical areas for improvement to ensure additional APM adoption.

One respondent noted “Value based care has a potential to be extremely beneficial in improving health outcomes, improving patient access to care, and reducing overall costs. However, the current arrangements are leaning toward increasing administrative burden on primary care practices and reducing their financial sustainability.”

The feedback also highlighted the overall responsiveness of payors to provider performance expectations and requirements.

Review of Requirements in Maryland

This report seeks to fulfill MHCC’s reporting requirements by addressing the targeted outcomes, including: the number and types of value-based arrangements entered into; the quality outcomes achieved through these arrangements; the number of complaints reported regarding value-based arrangements; the cost-effectiveness of these models; and gathers initial feedback from providers on the impact of two-sided incentive arrangements on the fee schedules of health care practitioners included in the target budget who are not eligible providers.

As data is made available, MHCC will address the quality outcomes achieved through VBP arrangements in future reports.

Looking Ahead

There are several learnings that MHCC will incorporate in future reporting cycles, and will consider in response to the outcomes of this report. First, MHCC will continue to work with payors to improve data accuracy and data collection in future cycles. This includes revising the Data Collection Template used by payors to better reflect learnings within Maryland and national trends, as well as improving review of data

and collection in a effort to address quality reporting requirements. This includes but is not limited to review and adoption of Non-Claims Payment (NCP) Data Layout in future Data Collection Templates.[19] Additionally, MHCC will continue to refine and automate reporting techniques to gather further insight into APM adoption, value-based payments, and outcomes for Marylanders.

Nationally, states are moving toward greater standardization and consistent reporting. However, drawing conclusions across states remains elusive as the application of the HCPLAN Framework and payment model specific classification may vary from state to state. MHCC, has made significant strides in setting a standard for APM data collection and tracking these data over time. In the coming year, MHCC intends to continue this progress through the adoption of NCP Data Layout, which adds greater specificity to the classification system and provides improved standardization across plans. The NCP Data Layout is a newly developed data collection tool that is being explored and adopted nationally as a common standard for reporting APM and non-claims payments.

Based on data reported to MHCC, there are limitations in making comparisons across HCPLAN payment models, especially among episode-based payment methodologies. Moving forward, MHCC will collaborate with payors to better understand the nature of these payment models, including the scope of services within the APM and the grouping methodologies used to determine episode-based payments. Simultaneously, MHCC will consider refining its data collection methods to ensure that categories and classification methods are more defined and discrete.

While there is overall progress in APM adoption, with significant advancements from 2022 to 2023, the proportion of non-claims payments remains small when examining overall TME. Collecting more detailed data from providers whose delivery models are more aligned with APM adoption, particularly those related to primary care, would further illuminate how APMs are being adopted. In this light MHCC will collect primary care non-claims data in the future.

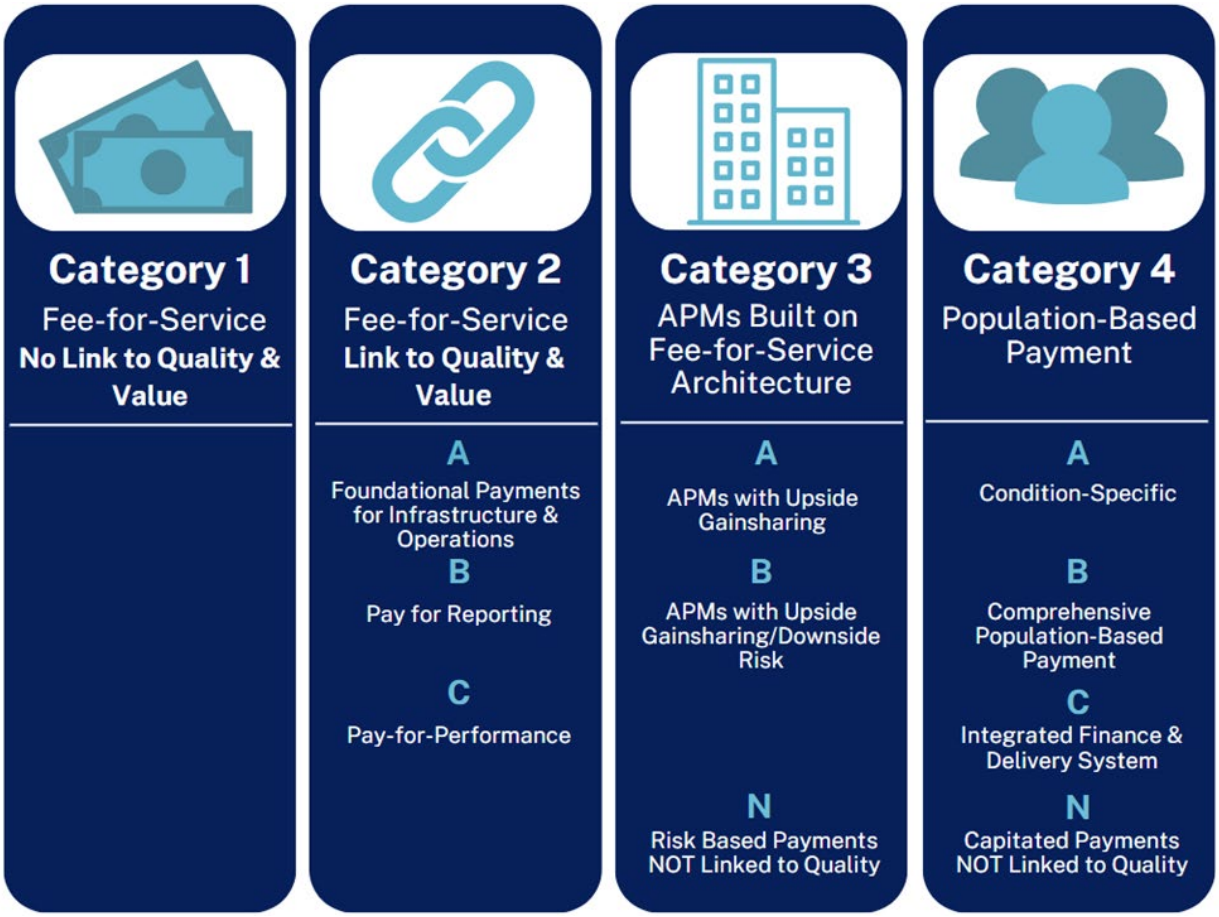
Maryland has made notable progress in adopting APMs, with significant increases in member participation and shifts toward higher-tier value-based arrangements. Maryland is well-positioned to build on current progress resulting in meaningful improvements in value-based care delivery statewide.

[19] National Association of Health Data Organizations. Data Layouts and Standards. National Association of Health Data Organizations, https://www.nahdo.org/datalayouts. Accessed 2024.

Appendix

HCPLAN Category Definitions

Figure 13. HCPLAN APM Framework



HCPLAN Category 1 (Fee for Service) – Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments nor provider reporting of quality data nor provider performance on cost and quality metrics. Additionally, diagnosis-related groups (DRGs) not linked to quality and value are classified as Category 1.

HCPLAN Category 2A (Fee for Service Linked to Quality & Value) – Foundational Payments for Infrastructure & Operations: Payments placed into Category 2A involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A.

HCPLAN Category 2B (Fee for Service Linked to Quality & Value) – Pay-for-Reporting: Payments placed into Category 2B provide positive or negative incentives to report quality data to the health plan and/or to the public. Participation in a pay-for-reporting program gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan's reporting system. Because pay-for-reporting does not link payment to quality performance,

participation in Category 2B payment models should be time limited and will typically evolve into subsequent categories.

HCPLAN Category 2C (Fee for Service Linked to Quality & Value) – Pay-for-Performance: Payments are placed into Category 2C if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well; thus, providing a significant linkage between payment and quality. For example, providers may receive higher or lower updates to their FFS baseline, or they may receive a percent reduction or increase on all claims paid, depending on whether they meet quality goals. In some instances, these programs have an extensive set of performance measures that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in hospital-acquired infections. Payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures. Note that a contract with pay-for-performance that affects the future fee-for-service base payment would be categorized in Category 2C.

HCPLAN Category 3A (APMs Built on Fee-for-Service Architecture) – APMs with Shared Savings: In Category 3A, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. However, providers do not compensate payors for a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of-network, etc., all of the dollars associated with the attributed members can be included.

HCPLAN Category 3B (APMs Built on Fee-for-Service Architecture) – APMs with Shared Savings and Downside Risk: In Category 3B, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Additionally, payors recoup from providers a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of-network, etc., all of the dollars associated with the attributed members can be included.

HCPLAN Category 3N (Risk Based Payment) – Category 3N includes APMs built on a fee-for-service architecture not linked to quality data. Payments in Category 3N lack incentives to providers for quality and appropriateness of care.

HCPLAN Category 4A (Population-Based Payment) – Condition-Specific Population-Based Payment: Category 4A includes bundled payments for the comprehensive treatment of specific condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering, for example, only chemotherapy payments. Additionally, prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians (e.g., primary care or orthopedics). For the purposes of this reporting, payors should designate all episode-based payment arrangements as HCPLAN Category 4A including those for a specific procedure, such as those designed to look similar to The Episode Quality Improvement Program (EQIP).

HCPLAN Category 4B (Population-Based Payment) – Comprehensive Population-Based Payment: Payments in Category 4B are prospective and population-based and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements in which payors and providers are organizationally distinct.

HCPLAN Category 4C (Population-Based Payment) – Integrated Finance & Delivery System: Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of payors that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. Additionally, it is important to note that when integrated lines of business comprise a portion of a company's portfolio, only the integrated payments count toward Category 4C.

HCPLAN Category 4N (Capitated Payment) – Category 4N includes population-based payments not linked to quality. Payments in Category 4N lack incentives to providers for quality and appropriateness of care.

Glossary of terms

All-Payor Claims Database (APCD): A statewide database that collects healthcare claims data from all payors, including private insurers and public programs, to support analysis and policy development.

Alternative Payment Models (APMs): Payment approaches that go beyond traditional fee-for-service reimbursement. APMs do not necessarily need to be value-based and can range from shared savings models to capitated arrangements, where providers take on greater financial and clinical responsibility for patient care.

Care Management Fees: Payments to providers to support care coordination and management of patients, often used in value-based payment models.

Downside Risk: An APM feature where providers share in financial losses if costs exceed predefined benchmarks, incentivizing cost control.

Episode-Based Payments: Payments tied to a specific episode of care, such as a surgical procedure, incentivizing cost control and care quality within a defined scope.

Fee-for-Service (FFS): Traditional payment approach where providers are reimbursed for each service delivered.

Value-Based Payments (VBP): Is a payment approach where reimbursement is tied to the quality of care rather than the volume of services provided. VBPs reward providers for achieving better patient outcomes, improving care, and reducing costs.

Non-Claims Payments: Payments made to providers that are not tied directly to individual claims for services rendered. They may include care management fees, infrastructure investments, population-based payments, or episodic-based payments.

Upside Gainsharing: An APM feature where providers share in cost savings achieved by reducing unnecessary utilization of services, without bearing financial risk for losses.

Total Medical Expense (TME): The total cost of care for a population, including all claims and non-claims payments under a specific payment arrangement.

Population-Based Payments: Fixed payments made to providers for the care of a defined population.

Medical Care Data Base (MCDB): Maryland's specific APCD used to collect claims data for analyzing healthcare costs, utilization, and quality.

Payor: Health insurance companies responsible for financing or reimbursing the cost of healthcare services.

Fully-Insured Product: A health insurance arrangement in which an employer contracts with an insurance company to cover employees' medical claims and pays premiums directly to the insurer. The insurer assumes the financial risk of the claims.

Self-Insured Product: A health insurance arrangement where the employer assumes the financial risk of providing health care benefits to employees, often contracting with third parties for administrative functions.

Two-Sided Risk: A payment arrangement where providers share in both the savings and losses based on their ability to manage costs and quality.

Acknowledgements

This report and its underlying data collection were developed by subject matter experts from Freedman HealthCare, the Maryland Health Care Commission's contractor for value-based care and project management for the Maryland Medical Care Data Base:

- *Gary Swan, MBA, MHPA, Senior Consultant*
- *Vinayak Sinha, MPH, CSM, Senior Consultant*
- *Sarah Lindberg, MS, Senior Data Consultant*
- *Mary Jo Condon, MPPA, Principal Consultant*

Questions about the report should be directed to Shankar Mesta at shankar.mesta@maryland.gov.