Overview of Alternative Payment Model Arrangements in Maryland

COMMERCIAL FULLY-INSURED MARKET

12/1/2025

Purpose and Outcomes

- Provide an overview and update on progress toward APM adoption
- Summarize findings and highlight trends to inform future decision making
- Share learnings and national context

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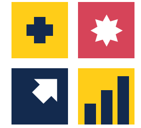
What is Value-based Care?



*"Value-based care ties the amount health care providers earn for their services to the results they deliver for their patients, such as the quality, equity, and cost of care. These programs aim to hold providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time."**

- 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.
- Generally, as providers move to APMs with greater risk, the reliance on non-claims-based payments typically increases.
- The goal is not to push every provider to take on the most risk. The goal is to create the right mix of incentives aligned with provider readiness, capacity, and patient needs.

The Commonwealth Fund. Value-Based Care: What It Is, and Why It's Needed. Feb. 7, 2023.

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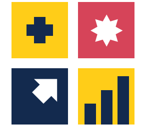
What forms do these models take?



- Evidence suggests providers are more motivated to change how they deliver care when more of their revenue comes from value-based payments, since more is at stake. When more revenue is tied to value-based payment, there's also less administrative burden for providers that often receive payment from a variety of sources
  - Upside and downside risk:
    - Providers can gain or lose revenue if they exceed expectations on quality, cost, or equity targets.
  - Prospective versus retrospective payments:
    - Upfront payments to providers to manage a population or a set of conditions or payments after services are delivered
  - Providers are more likely to be motivated by financial incentives that are offered to them directly and given without delay
  - Incentives should be clearly linked to specific outcomes and large enough to be meaningful

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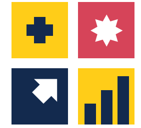
Chapter 298/297 of 2022 Laws of Maryland



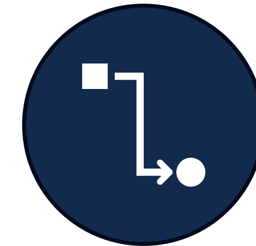
- Enabled payors and providers to engage in capitation and two-sided risk contracting
- Effective October 1, 2022
- MHCC required to gather data and develop annual report on:

Number & type of value-based arrangements

Quality outcomes of value-based arrangements

Number of complaints made regarding value-based arrangements

Cost-effectiveness of value-based arrangements



Impact of two-sided incentive arrangements on fee schedules

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Data Collection The Expanded Non-Claims Payment Framework

- Freedman HealthCare, LLC (FHC) supported The California Department of Health Care Access and Information (HCAI) in developing an Expanded Non-Claims Payment Framework (**HCAI-FHC Expanded Framework**) to capture non-claims health care spending data, the intended purpose of those payments and the corresponding level of risk assumed by the provider.

- The framework integrates and refines elements from two existing models: the Health Care Payment Learning and Action Network (HCP-LAN) and Milbank Memorial Fund-Bailit (Milbank).

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California: The Expanded Framework in Action

Four coordinated efforts at California's Department of Health Care Access and Information (HCAI), will use the Expanded Framework to serve four distinct purposes.

Total Health Care Expenditures

Primary Care/Behavioral Health Spend

Health Care Payments Database

Alternative Payment Model Adoption

- Non-claims payments are an important component of spending across numerous healthcare transformation efforts.
- A consistent approach across measurement efforts will reduce burden and increases comparability.
- Measuring the purpose of the spending is important, as well as the amount.

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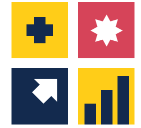
Continuum of Provider Clinical and Financial Risk



A. Population Health and Infrastructure Payments

- A1. Care Management
- A2. Primary Care and Behavioral Health Integration
- A3. Social Care Integration
- A4. Practice Transformation
- A5. HER/HIT Infrastructure and Other Data Analytics

B. Performance Payments

- B1. Pay-for-reporting
- B2. Pay-for-performance

C. Shared Savings Payments and Recoupments

- C1. Procedure-related, episode-based with shared savings
- C2. Procedure-related, episode-based with risk of recoupments
- C3. Condition-related, episode-based with shared savings
- C4. Condition-related, episode-based with risk of recoupments
- C5. Risk for total cost of care with shared savings
- C6. Risk for total cost of care with risk of recoupments

D. Capitation and Full Risk Payments

- D1. Primary Care Capitation
- D2. Professional Capitation
- D3. Facility Capitation
- D4. Behavioral Health Capitation
- D5. Global Capitation
- D6. Payments to integrated, comprehensive payment and delivery systems

Adapted from Office of Health Care Affordability. (2025, April). Total Health Care Expenditures (THCE) Data Submission Guide (Version 2.0)

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Value-based Payment Adoption and National Trends

- Including Maryland, 11 states monitor and collect data on value-based arrangement adoption
  - 8 states publish reports
- Commercial market examples (2023):
  - Based on TME -
    - Nationally, 21.6% of payments were made through downside-risk models (Categories 3B and above), up from 16.5% in 2022
    - Washington reported 83% of managed care payments and 61% of public employee programs HCP LAN Categories 2C and above
  - Based on membership -
    - MassHealth managed care organizations reported 89% APM adoption and commercial markets reported 40.5% in value-based purchasing arrangements

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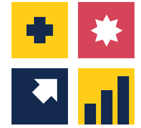
Key Findings



- ***Participation in APMs continued to grow in Maryland's fully insured market***, with 268,467 members attributed to an APM in 2024, a 37 percent increase from 2023
  - Growth was concentrated in pay-for-performance and shared savings arrangements
  - Participation in pay-for-performance arrangements (B2) grew by more than 34,000 members, while participation in shared savings models (C5) grew by more than 45,000 members across payors
- Provider participation also increased, rising from 36 to 39 provider organizations in population-based APMs between 2023 and 2024.
- Though more members are being attributed to APMs and more providers are participating in APM arrangements, ***non-claims spending remains a limited portion total medical expense (TME).***
  - Non-claims payments increased slightly from 0.2 percent to 0.3 percent of TME but remain too limited to meaningfully support care transformation
  - Non-claims payments were largely flat across subcategories
- Providers who responded to an MHCC survey on APMs noted operational challenges, including:
  - Delayed contracting timelines
  - Limited access to actionable data
  - Inconsistent communication on program requirements

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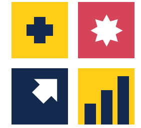
Aggregate TME Across Expanded NCP Categories



- Overall spending shifted into value-based arrangements, especially performance payments (B2) and shared-savings risk (C5)
  - APMs accounted for 29% of total market TME
  - TME for contracts with performance payments (B2) increased by nearly $261M
  - TME for contracts that include shared-savings (C5) grew by nearly $135M
- Fee-for-service TME rose modestly by 1.7% from 2023 to 2024
- Overall TME (FFS + APM) grew 9.5% outpacing national health expenditure growth of 7.5%

Expanded NCP Framework Payment Category	Total Medical Expense - 2023	Total Medical Expense - 2024	Percent TME Change 2022 to 2023
Fee-for-Service	$3,326,402,242	$3,382,706,185	1.7%
Payment Category B - Performance Payments	$194,897,729	$420,057,787	115.5%
Payment Category C - Shared Savings Payments and Recoupments	$800,116,247	$929,971,330	16.2%
All Payments	$4,321,416,218	$4,732,735,302	9.5%

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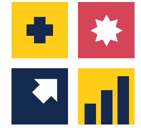
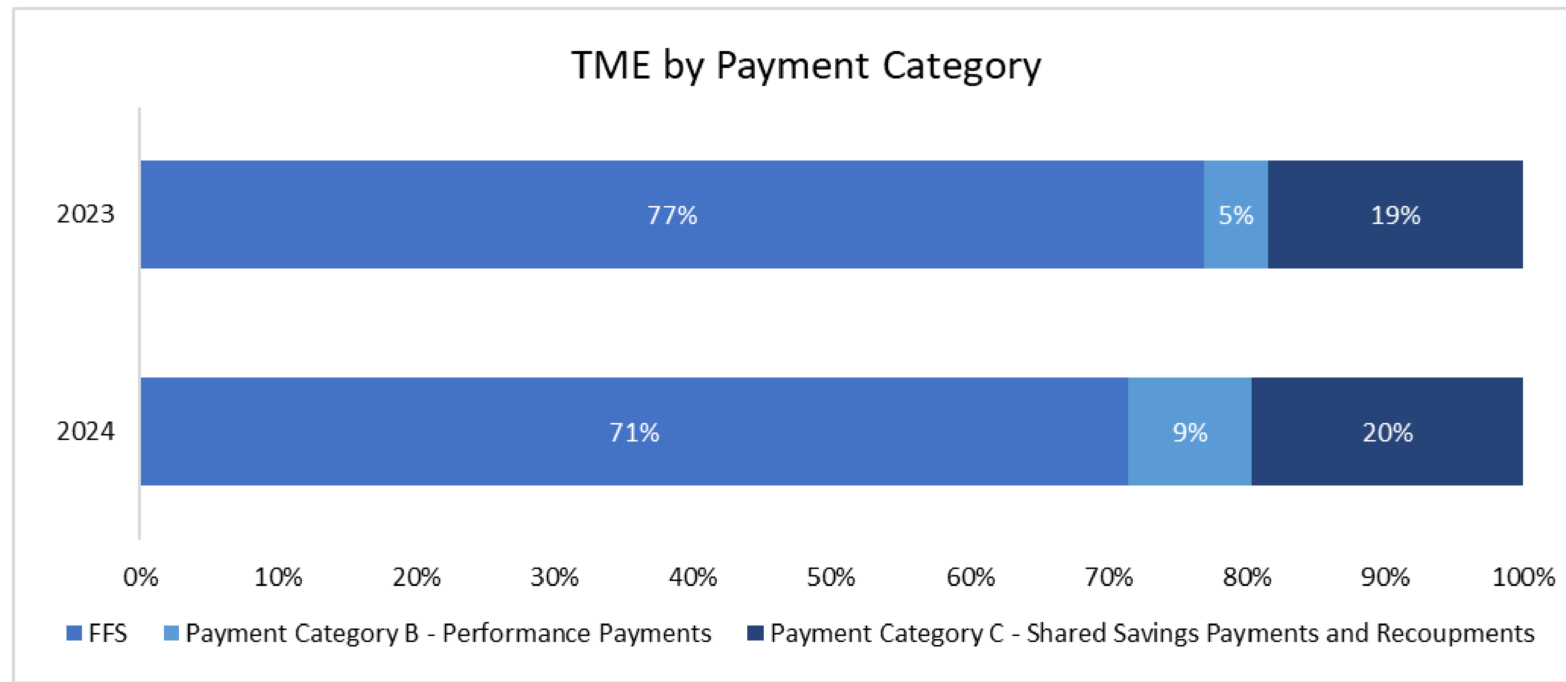
Percent of Total Medical Expense by Expanded NCP Framework Category, 2023-2024



- TME tied to contracts with an APM increased from 2023 to 2024, with growth in both performance payments and shared savings payments and recoupments
- Attributed TME in performance payments rose from 5 percent to 9 percent, while shared savings payments and recoupments increased from 19 percent to 20 percent



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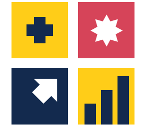
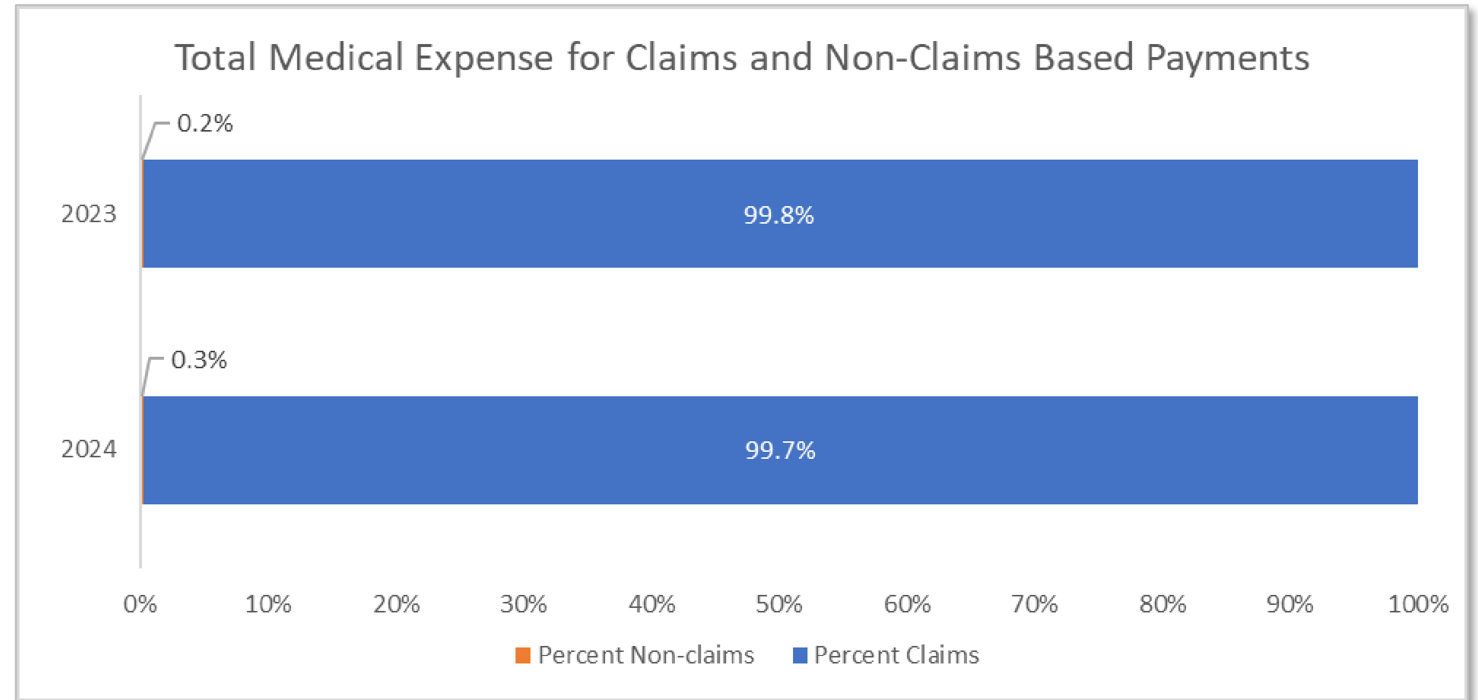
Non-claims Payments



- Despite increases in contracts that include an APM component, members attributed to an APM, and TME tied to an APM, non-claims spending remains a small sliver of TME
    - An increase of about $2.5M (from $9.3M to $11.9M)
- No specific payment subcategory drove the change
    - Non-claims payments were flat across all categories
    - However, per-member payments received in Shared Savings Payments and Recoupments were twice that received in Performance Payments



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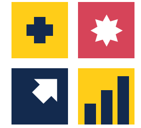
Quality Performance



- MHCC calculates HEDIS measures using MCDB data and payor-submitted information to assess performance for APM and non-APM populations. The analysis includes 11 quality measures across five domains.
- Quality results rely on payor-submitted data, several payors did not submit complete or timely data for this cycle. One payor did not provide membership identifiers, while another did not provide corrected member information in time for this report. An addendum will be issued once updated data is available.

Domain	Measure Name
Prevention and Screening	Breast Cancer Screening
	Colorectal Cancer Screening
Diabetes	Blood Pressure Control for Patients with Diabetes
	Glycemic Status Assessment for Patients with Diabetes
	Eye Exam for Patients with Diabetes
	Statin Therapy for Patients with Diabetes
Behavioral Health	Follow Up After Emergency Department Visit for Mental Illness, 7 day
	Follow Up After Emergency Department Visit for Mental Illness, 30 day
Overuse and Appropriateness	Risk of Continued Opioid Use
Utilization	Acute Hospital Utilization
	Emergency Department Utilization

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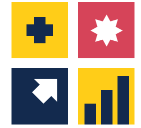
Other Assessments



- The Maryland Insurance Administration received no complaints from health care practitioners this reporting period
- Three providers responded to MHCC’s 2025 survey, ranging from large systems to a small independent primary care practice
    - Two participated in multiple value-based models, while the small practice reported that private-carrier arrangements were financially unsustainable
    - Common focus areas included primary care, preventive care, chronic disease management, care coordination, and workflow changes such as virtual care, care management, remote monitoring, and data-driven reporting.
    - Key challenges cited were administrative burden, delayed contracts, limited actionable data, interoperability issues, shifting program requirements, and the need for greater oversight and auditing of carrier-managed models.
    - Respondents emphasized the need for reliable data, clear communication, and stable program design to support ongoing participation, noting that operational and financial barriers remain especially difficult for smaller practices.

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Looking Ahead

- Maryland continues to expand value-based participation and build a structured reporting system, with ongoing monitoring, stakeholder engagement, and annual reporting to guide future decision-making
- Maryland implemented the Expanded NCP Framework for the first time, strengthening its position as a national leader in transparent, standardized tracking of APM adoption, non-claims payments, and value-based performance
  - Maintaining this framework will enable clearer, market-wide visibility into value-based care trends, support cross-state comparisons, and improve the consistency and comparability of data over time
  - More consistent reporting will help identify long-term patterns in provider participation, non-claims investments, risk-bearing, and total medical expense, informing policy and targeted support for providers, especially in primary care.
- MHCC plans to enforce more timely and complete data submissions, potentially including fines, after several payors failed to provide required information this year
- MHCC will explore acquiring episode-based grouper software to validate episode costs across APM and non-APM populations, improve comparability, and strengthen analytics
- Currently, data collection is limited to the commercial fully insured market. In alignment with Maryland's Total Cost of Care (TCOC) Model and the forthcoming AHEAD MHCC will explore opportunities to incorporate these payment structures into data collection efforts

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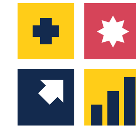
Thank you



Acknowledgements

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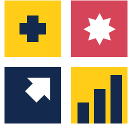
  - Gary Swan, MBA, MHPA, Senior Consultant
  - Vinayak Sinha, MPH, CSM, Senior Consultant
  - Sarah Lindberg, MS, Senior Data Consultant
  - Mary Jo Condon, MPPA, Principal Consultant



Appendix

Expanded Non-Claims Payment Framework Payment Categories and Subcategories

- Converts HCP-LAN categories into a more detailed framework that give insight on the purpose of payment and the level of risk assumed by providers
- Gives flexibility to capture non-claims payment details in a single framework

Payment Category	Description/Valid Values
A	Population health and practice infrastructure payments
B	Performance payments
C	Payments with shared savings and recoupments
D	Capitation and full risk payments
E	Other non-claims payments
X	Fee for service

Payment Subcategory	Description/Valid Values
A1	Care management/care coordination/population health/medication reconciliation
A2	Primary care and behavioral health integration
A3	Social care integration
A4	Practice transformation payments
A5	EHR/HIT infrastructure payments
B1	Retrospective/prospective incentive payments: pay-for-reporting
B2	Retrospective/prospective incentive payments: pay-for-performance
C1	Procedure-related, episode-based payments with shared savings
C2	Procedure-related, episode-based payments with risk of recoupments

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Expanded Non-Claims Payments Framework and HCP-LAN Framework Crosswalk

- Payment Categories and Payment Subcategories have specific definitions that can be used in identifying the type of payment arrangement with providers
- APM Data Collection Template will leverage this new structure over HCP-LAN

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
B2	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C
⋮			
C5	Risk for total cost of care (e.g., ACO) with shared savings (Linked to quality)	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements. Payments in this subcategory are “linked to quality”.	3A
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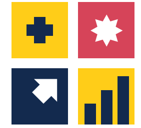
PMPM Across Expanded NCP Categories, 2023-2024



- TME for contracts tied to an APM also increased on a PMPM basis between 2023 and 2024
  - There was a significant increase in the overall PMPM for Payment Category B
    - This was driven by Payment Subcategory B2, which increased by $88.02 PMPM over the period
    - There was also an increase in Payment Category C, although it was much more modest at $3.39 PMPM

Expanded NCP Framework Payment Category	Total Medical Expense PMPM - 2023	Total Medical Expense PMPM - 2024	Difference (2024 less 2023)
Payment Category B - Performance Payments	$538.09	$626.12	$88.02
Payment Category C - Shared Savings Payments and Recoupments	$551.44	$554.83	$3.39

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Membership for Population-based APMs

- APM participation in Maryland reached 268,467 members in 2024, a 37% increase from 2023
  - Payment Category B – Performance Payments grew, with CareFirst's B2 pay-for-performance adding ~34,000 members.
  - Payment Subcategory C5, risk for total cost of care with shared savings, also expanded. CareFirst added 32,498 members and Cigna added 13,386
  - Overall, Categories B and C grew by 72,051 members year-over-year
- CareFirst consisted of 83% of all APM membership in 2024 (222,245 members), followed by Cigna at 16% and Aetna at 2%

NCP Framework Payment Category and Payor	2023	2024	Difference	Percent Change
Payment Category B - Performance Payments	46,889	73,278	26,389	56%
Aetna	766	897	131	17%
CareFirst	37,922	72,381	34,459	91%
Cigna	8,201	-	-	-
Payment Category C - Shared Savings Payments and Recoupments	149,527	195,189	45,662	31%
Aetna	3,857	3,635	(222)	-6%
CareFirst	117,366	149,864	32,498	28%
Cigna	28,304	41,690	13,386	47%
All Members	196,416	268,467	72,051	37%

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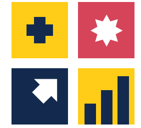
Provider Organization Participation in APMs



- Population-based APM participation grew to 39 provider organizations in 2024
  - Payment Category C increased from 27 to 30 provider organizations, driven by CareFirst and Cigna adding 3 new provider organizations
  - Category B remained at 9 provider organizations
- Membership growth was led by
  - Johns Hopkins managing 24,993 newly attributed members in Payment Category B
- Under Payment Category C
  - Adventist (+12,615 newly attributed members)
  - Helix Resources Management (+23,154 newly attributed members)
  - University of Maryland (+10,000 newly attributed members)

Expanded NCP Framework Payment Category and Payor	Provider Organizations in Population-based APMs		Provider Organizations in Episode-based APMs	
	2023	2024	2023	2024
Payment Category B - Performance Payments	9	9	-	-
Aetna	5	5	-	-
CareFirst	3	4	-	-
Cigna	1	-	-	-
Payment Category C - Shared Savings Payments and Recoupments	27	30	8	-
Aetna	6	6	-	-
CareFirst	11	12	6	-
Cigna	10	12	2	-
All Provider Organizations	36	39	8	-

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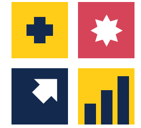
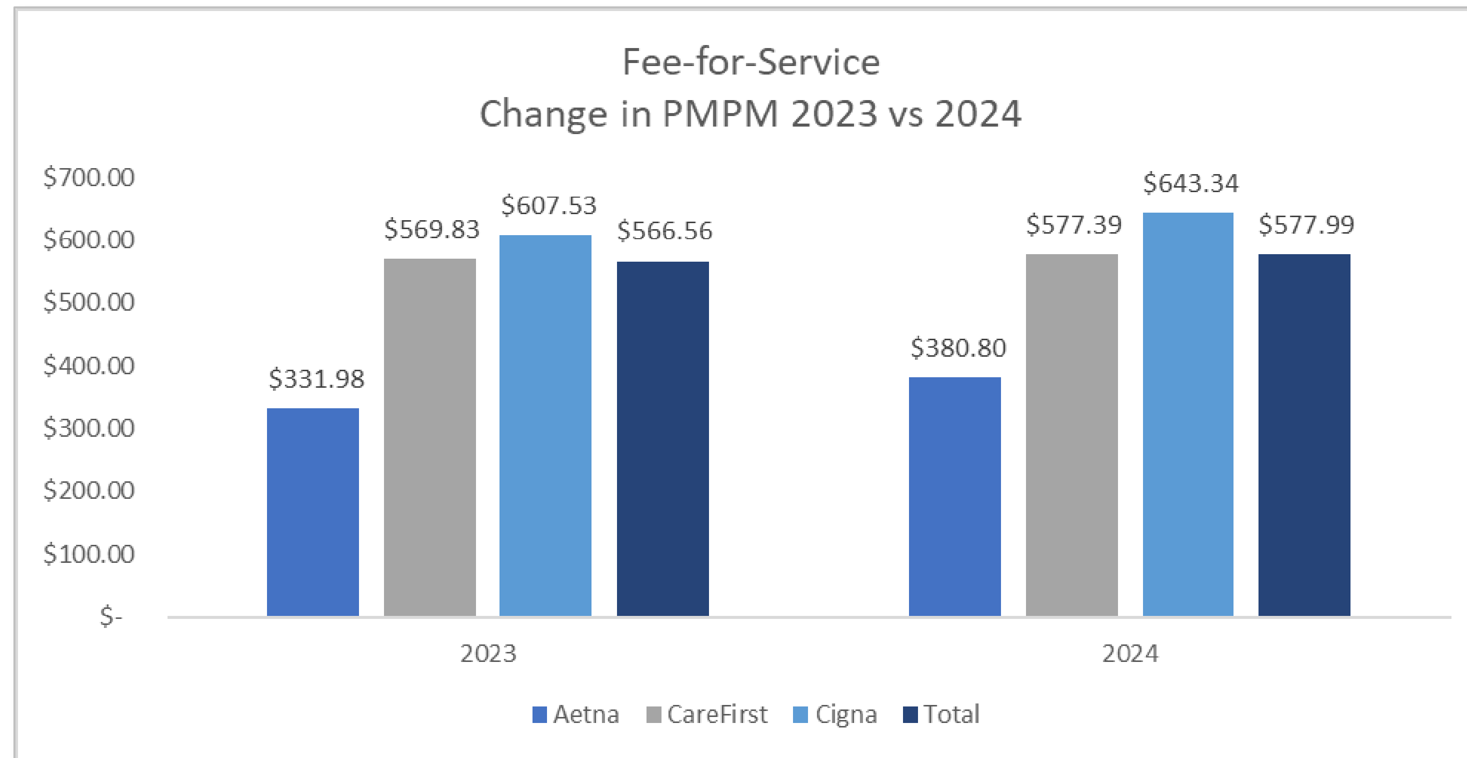
Fee-for-Service PMPMs Across Expanded NCP Categories, 2023-2024



- There was a modest increase in total FFS PMPMs between 2022 and 2023
- Aetna reported the lowest overall FFS PMPM yet showed the largest year-to-year increase
- CareFirst and Cigna had higher FFS PMPMs but experienced smaller annual increases compared to Aetna



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Payment Category B - Performance Payments by Payment Subcategory

- CareFirst expanded its B2 pay-for-performance model in 2024
  - increasing participating providers by 77% and more than doubling attributed membership
  - its PMPM rose by $137 (from $490 to $627)
- Cigna's B1 pay-for-reporting model was noted as a legacy COVID-19 arrangement that it is being phasing out as providers transition to more advanced APMs

Payor and Year	Member Months	Total Medical Expense	Total Non-claims Payments	TME PMPM	Percent Non-claims
B1 - Pay-for-reporting payment					
Cigna					
2023	40,328	$36,758,213	$257,385	$911.48	0.7%
B2 - Pay-for-performance payments					
Aetna					
2023	5,922	$3,320,854	$23,890	$560.77	0.7%
2024	5,861	$2,893,330	$28,114	$493.66	1.0%
CareFirst					
2023	315,951	$154,818,662	$763,721	$490.01	0.5%
2024	665,032	$417,164,457	$1,824,385	$627.28	0.4%
Total					
2023	321,873	$158,139,516	$787,611	$491.31	0.5%
2024	670,893	$420,057,787	$1,852,499	$626.12	0.4%

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Payment Category C - Shared Savings Payments and Recoupments

- Payment Subcategory C5 (shared savings) and C6 (recoupment).
- Aetna, CareFirst, and Cigna all operated a risk for total cost of care with shared savings APM
- Aetna was the only payor with payment model with the risk of recoupments
- Across both models, non-claims payments remained a small share of total medical expense
- PMPM trends varied by payor:
- Aetna and Cigna experienced PMPM increases within shared-savings arrangements, while CareFirst reported a PMPM decline

Payor and Year	Member Months	Total Medical Expense	Total Non-claims Payments	TME PMPM	Percent Non-claims
C5 - Risk for total cost of care (e.g., ACO) with shared savings					
Aetna					
2023	15,063	$8,637,060	$161,679	$573.40	1.9%
2024	16,694	$10,824,720	$56,158	$648.42	0.5%
CareFirst					
2023	1,232,705	$678,473,453	$7,152,879	$550.39	1.1%
2024	1,378,807	$737,054,732	$7,491,823	$534.56	1.0%
Cigna					
2023	186,996	$102,824,412	$863,440	$549.87	0.8%
2024	271,922	$176,548,338	$1,451,704	$649.26	0.8%
Total					
2023	1,434,764	789,934,925	8,177,998	$550.57	1.0%
2024	1,667,423	924,427,790	8,999,685	$554.41	1.0%
C6 - Risk for total cost of care (e.g., ACO) with risk of recoupments					
Aetna					
2023	16,186	$10,181,322	$110,724	$629.02	1.1%
2024	8,702	$5,543,540	$22,222	$637.04	0.4%

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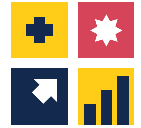
Non-claims Payments – Payment Category B - Performance Payments



Payor and Year	Non-claims PMPM
B1 - Pay-for-reporting payment	
Cigna	
2023	$6.38
B2 - Pay-for-performance payments	
Aetna	
2023	$4.03
2024	$4.80
CareFirst	
2023	$2.42
2024	$2.74
Total	
2023	$2.45
2024	$2.76

- PMPM values remained relatively small and stable across participating payors
- For Payment Subcategory B2, pay-for-performance, the PMPM increased slightly from $2.45 in 2023 to $2.76 in 2024
- Overall, Payment Category B shows consistent PMPM performance across years, suggesting that providers have developed familiarity with pay-for-reporting and pay-for-performance structures

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Non-claims Payments – Payment Category C - Shared Savings Payments and Recoupments

Year	Non-claims PMPM
C5 -Risk for total cost of care (e.g., ACO) with shared savings	
Aetna	
2023	$10.73
2024	$3.36
CareFirst	
2023	$5.80
2024	$5.43
Cigna	
2023	$4.62
2024	$5.34
Total	
2023	$5.70
2024	$5.40
C6 - Risk for total cost of care (e.g., ACO) with risk of recoupments	
Aetna	
2023	$6.84
2024	$2.55

- PMPM values exhibited greater variation across payors
- For Payment Subcategory C5, the PMPM was $5.70 in 2023 and $5.40 in 2024.
  - Aetna was experienced a notable decline from $10.73 to $3.36
    - This reduction may to be driven by shifts in provider participation and attributed membership,
  - Aetna was the sole payor submitting data for Payment Subcategory C6
    - For this model one provider left, while the remaining organizations experienced either modest membership growth or flat enrollment
- Providers participating in Payment Category C models received approximately twice the incentive of those participating in Payment Category B models
- Continued investment and collaboration will support provider readiness as organizations assume increasing levels of financial accountability

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Episode-based Payments
Payment Category C - Shared Savings Payments and Recoupments

Payor and Episodes	Number of Episodes	Total Medical Expense	Cost per Episode
C1 - Procedure-related, episode-based payments with shared savings			
CareFirst			
Colonoscopy	4,020	$5,616,072	$1,397.03
Upper GI Endoscopy	1,191	$1,623,765	$1,363.36
Cigna			
Colonoscopy	67	$94,073	$1,404.08
Hysterectomy	24	$556,891	$23,203.80
Upper GI Endoscopy	11	$15,944	$1,449.45
Total			
Colonoscopy	4,087	$5,710,145	$1,397.15
Hysterectomy	24	$556,891	$23,203.80
Upper GI Endoscopy	1,202	$1,639,709	$1,364.15
C2 - Procedure-related, episode-based payments with risk of recoupments			
CareFirst			
Colonoscopy	26	$41,935	1,612.90
Hip Replacement and Hip Revision	87	$1,697,879	$19,515.85
Knee Arthroscopy	272	$1,575,311	$5,791.59
Knee Replacement and Knee Revision	141	$2,963,121	$21,015.04
Lumbar Laminectomy	15	$130,421	$8,694.70
Lumbar Spine Fusion	14	$650,767	$46,483.33
Pregnancy	1,316	$29,052,980	$22,076.73

- MHCC cannot fully validate episode-based APM costs because it lacks a claims grouper to generate comparable episode-level data; instead, results were compared with Wear the Cost benchmarks from 2020–2021.
- Upper GI endoscopy episode costs for CareFirst and Cigna averaged $1,364, well below the Maryland Wear the Cost estimate of $2,257
- Colonoscopy episode costs under shared-savings arrangements averaged $1,397, also below the Maryland average
- Pregnancy episode costs averaged $22,077, notably higher than the $14,676 Maryland benchmark for vaginal delivery

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