MARYLAND
Health Care
Commission

Marcia Boyle, MS, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

January 14, 2026

The Honorable Pamela G. Beidle
Chair, Senate Finance Committee
James Senate Office Building
11 Bladen Street
Annapolis, MD 21401

The Honorable Heather Bagnall
Chair, Health and Government Operations Committee
Taylor House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: SB0834/Ch. 298, HB 1148/Ch. 297(2), 2022 - Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization - Mandate Evaluation Report (MSAR #14245)

Dear Chair Beidle and Chair Bagnall,

In accordance with SB0834/Ch. 298, HB 1148/Ch. 297(2), 2022 - Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization the Maryland Health Care Commission (MHCC) is submitting this report that provides our third annual assessment of alternative payment model (APM) adoption in Maryland's fully insured commercial market, covering calendar years 2023 and 2024. This year marks Maryland's first use of the Expanded Non-claims Payment (NCP) Framework, offering a more consistent and structured approach to classifying APMs and the non-claims payments flowing through them. The results show continued growth in APM participation, steady expansion of population-based models, and modest increases in non-claims spending.

Summary of the key findings and recommendations:

• 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.

• Provider participation also increased, rising from 36 to 39 provider organizations in population-based APMs between 2023 and 2024.

• No formal complaints related to APM contracting were filed with the Maryland Insurance Administration during the reporting period.

• Though more members are being attributed to APMs and more providers are participating in APM arrangements, non-claims spending remains a limited portion of 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.

Recommendations in the report include continued refinement of data collection of non-claims payments, ongoing collaboration to improve timely submission of data, further consideration for payment categorization under AHEAD, and transitioning more of the health care dollar to support advanced value-based care arrangements and care transformation.

We appreciate your consideration. If you have any questions, please do not hesitate to contact me at douglas.jacobs@maryland.gov or Ms. Tracey DeShields, Director of Policy Development and External Affairs at tracey.deshields2@maryland.gov.

Sincerely,

Douglas Jacobs, MD, MPH
Executive Director

cc:

The Honorable Wes Moore, Governor
The Honorable Bill Ferguson, President of the Senate
The Honorable Joseline Pena-Melnyk, Speaker of the House
House Health Committee
Senate Finance Committee
The Honorable Meena Seshamani, Secretary, Maryland Department of Health (MDH)
Michael Huber, Deputy Chief of Staff, Governor's Office (on behalf of Governor Moore)
Hannah Dier, Deputy Legislative Office, Governor's Legislative Office
Jason Heo, Governor's Office
Vijay Ramasamy, Senior Policy Advisor, Governor's Office
Sarah Albert, Department of Legislative Services (5 hard copies)

Nathan McCurdy, Committee Counsel, Senate Finance
Meghan Lynch, Director, Governmental Affairs, MDH
Tracey DeShields, Director of Policy Development and External Affairs, MHCC

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 2025

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Executive Summary

This report provides the Maryland Health Care Commission's (MHCC) third annual assessment of alternative payment model (APM) adoption in Maryland's fully insured commercial market, covering calendar years 2023 and 2024. This year marks Maryland's first use of the Expanded Non-claims Payment (NCP) Framework, offering a more consistent and structured approach to classifying APMs and the non-claims payments flowing through them.[1] The results show continued growth in APM participation, steady expansion of population-based models, and modest increases in non-claims spending.

Key Findings

The Number and Types of Value-based Arrangements:

- 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. Population-based payment models pay for a set of services for an individual's care during a given period or for a specific condition. These differ from episode-based models. Most of this expansion occurred in shared savings models, where two payors added new participating organizations.
- Episode-based APMs were limited to 2023 and focused primarily on colonoscopy, upper GI endoscopy, and pregnancy episodes. No episode-based arrangements were reported for 2024.

Complaints and Health Care Practitioners' Feedback:

- No formal complaints related to APM contracting were filed with the Maryland Insurance Administration during the reporting period.
- Regarding APM programs, providers who responded to an MHCC survey on APMs noted operational challenges, including delayed contracting timelines, limited access to actionable data, and inconsistent communication on program requirements.
- Smaller practices reported difficulty participating in commercial APMs due to reimbursement levels and resource constraints, limiting their ability to engage in value-based models.
- Respondents emphasized the need for more reliable data, clearer expectations, and stronger support from payors to successfully participate in APMs.

Cost-effectiveness:

[1] Sinha, V., & Bourgault, J. (2024, April). A Standardized Approach to Collecting Non-Claims Payment Data. National Association of Health Data Organizations (NAHDO).

- Though more members are being attributed to APMs and more providers are participating in APM arrangements, non-claims spending remains a limited portion of 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.
- Further, non-claims payments were largely flat across subcategories, indicating limited new investments to help providers advance into more mature risk-bearing arrangements.
- Since APM participation remains limited and many arrangements are in the nascent stages, cost-effectiveness is difficult to assess.
- However, some APMs are showing lower year-over-year increases compared to fee-for-service, particularly shared savings arrangements.

Quality Outcomes:

- 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. UnitedHealthcare did not provide membership identifiers, and CareFirst did not provide corrected member information in time. An addendum will be issued once updated CareFirst data is available.

Recommendations:

- Continue refining implementation of the Expanded NCP Framework to strengthen consistency, comparability, and clarity in value-based reporting across payors.
- Ongoing collaboration with payors will be essential to improving timely, accurate data submissions and resolving data quality or reconciliation challenges.
- Maryland payors should transition more of the health care dollar to non-claims payments to support provider readiness for advanced value-based arrangements and care transformation.
- As data collection continues to mature in future years, MHCC will leverage trend information to inform policy discussions on APM expansion, provider support needs, and market readiness.
- MHCC will further assess collection of value-based payments for vertically owned providers and how to categorize payments made under the new AHEAD model in subsequent years.
- Maintaining a consistent reporting structure will allow Maryland to monitor long-term changes in cost, quality, and provider risk-taking as value-based care continues to evolve.

Introduction

The Maryland Health Care Commission (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 Alternative Payment Models (APMs) and their impact on Maryland. MHCC has now submitted two reports to the Senate Finance Committee and House Health and Government Operations Committee. The first report was submitted in December 2023, covering a single year of data (CY 2022), and the second report was submitted in December 2024, covering calendar years 2022 and 2023. This will be the third year MHCC has collected and submitted a report on Maryland's progress toward value-based purchasing. In this report, MHCC presents results from data collected for calendar years 2023 to 2024.

Requirements in Maryland

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

MHCC is tasked with developing a collaborative data collection method with stakeholders to meet COMAR 10.25.06.14 requirements.[2] This involves creating a non-fee-for-service expenses report and updating the Commission's annual Medical Care Data Base (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.

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.[3] As part of the requirements, MHCC previously reported 2022 and 2023 results in December 2024. This report captures results for 2023 and 2024 data.

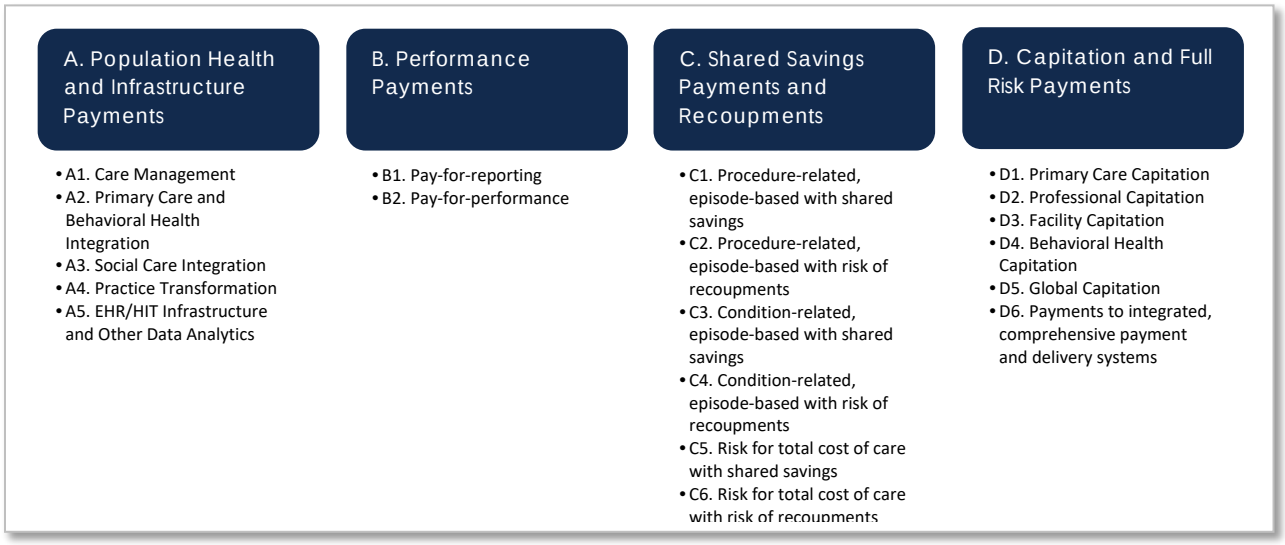
[2] Maryland Department of Health. COMAR Online: Maryland Regulations and Administrative Code. Maryland Department of Health, https://dsd.maryland.gov/regulations/Pages/10.25.06.14.aspx. Accessed 2024.
[3] See n. 10, Supra

Adoption of the Non-claims Payment Data Layout (Expanded NCP Framework)

In its 2024 report, MHCC noted its intent to review and consider adoption of the Expanded Non-claims Payment (NCP) Framework for future data collection efforts (see Figure 1). The Expanded NCP Framework offers more detailed classification of APMs and standardizes non-claims payment reporting across payors. As MHCC continues to refine its approach to measuring APM adoption, the Expanded NCP Framework presents an opportunity to further create consistency, comparability, and transparency in statewide reporting.

The Expanded NCP Framework's standardized approach supports comparability of APM adoption and non-claims spending trends across markets over time. It helps to reduce ambiguity in how payments are classified and allows for more consistent comparisons across payors. The framework also improves administrative efficiency by providing a single, predictable reporting structure that reduces reporting burden for payors operating in multiple states. It is a clearer categorization of APMs than alternative approaches and can help states better understand the purpose of APMs, non-claims payments and the level of provider risk.

Figure 1. NCP Framework and Provider Risk



Developed by the California Department of Health Care Access and Information with support from Freedman HealthCare, the Expanded NCP Framework standardizes the capture of non-claims payments across states and payors. It builds on the Health Care Payment Learning & Action Network (HCP-LAN) APM categories and the Milbank Memorial Fund/Bailit Health methodology by creating a single shared structure for categorizing non-claims spending.[4] Following its development in 2024, the Expanded NCP Framework is quickly becoming a national standard.

The National Association of Health Data Organizations (NAHDO) has incorporated the NCP data layout into the APCD Common Data Layout (APCD-CDL), making it a national reference standard as states

[4] Pegany, V., Brandt, M., Tran, N., Valle, M., & Krawczyk, C. (2024, March 18). A New Standard for Categorizing and Collecting Non-Claims Payment Data. Milbank Memorial Fund. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

consider APM and non-claims data collection. In 2025, California adopted the Expanded NCP Framework, which serves as the foundation for the NAHDO NCP data layout.[5] In 2025, Colorado's Center for Improving Value in Health Care (CIVHC) integrated the Expanded Framework into its APCD non-claims data collections, including a new member-level capitation file.[6] Additional states such as Massachusetts, Oregon, Utah, Vermont, and Minnesota are participating in NAHDO-led workgroups focused on non-claims standardization and are exploring alignment with the NCP data layout as part of their cost-growth benchmark initiatives and APCD modernization efforts. As more states align to the layout, the Expanded NCP Framework is rapidly becoming the national approach for non-claims data collection and APM tracking.

MHCC has been a national leader in capturing non-claims payments and APM adoption information in a consistent, structured format. Through its required annual reporting, Maryland has established one of the few statewide, mandatory submissions of non-claims payment data linked to APM reporting. Adoption of the Expanded NCP Framework continues this leadership by aligning with the most current national standard for non-claims and APM reporting, allowing for national comparisons over time.

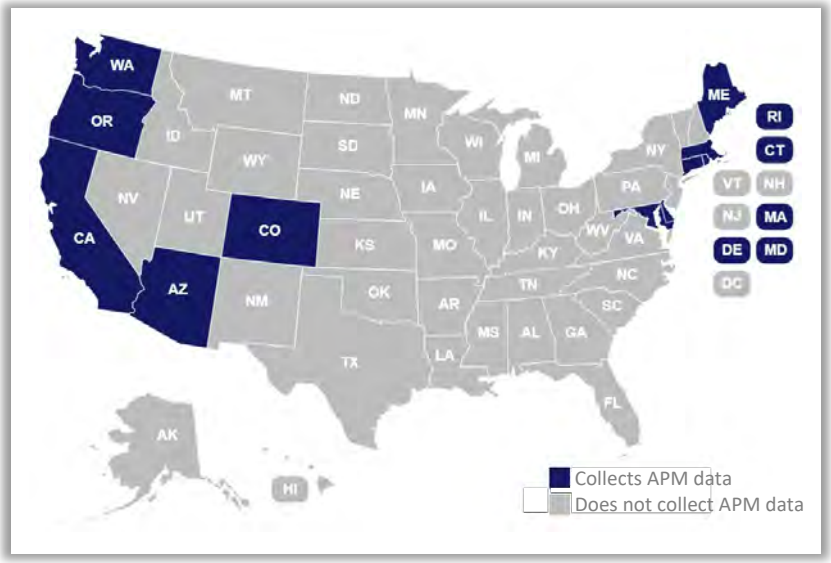
As seen in Figure 1, the Expanded NCP Framework organizes APMs into four primary payment categories. It is worth noting that the Expanded NCP Framework crosswalks with the HCP-LAN framework (see Appendix). Payment Category A includes population health and infrastructure payments, including investments in care transformation, data infrastructure, practice redesign, and other capacity-building activities. Payment Category B includes pay for performance and performance-based payments tied to quality, access, utilization, or other performance metrics. Payment Category C includes shared savings payments and recoupments, capturing both upside shared savings and downside risk features associated with population-based or episode-based models. Payment Category D captures capitation and full-risk payments, including global, partial, primary care, and professional capitation arrangements. Across these Payment Categories, the framework incorporates subcategories that allow for more granular reporting, such as differentiating procedure-based episodes of care and condition-based episodes of care.

[5] California Department of Health Care Access and Information. (2025, October). NCP Data Collection Fact Sheet v4-1. https://hcai.ca.gov/wp-content/uploads/2025/10/NCP-Data-Collection-Fact-Sheet-v4-1.pdf
[6] Center for Improving Value in Health Care. (2025). Alternative Payment Model Submission Guide (April 2025). https://civhc.org/wp-content/uploads/2025/07/Alternative-Payment-Model-Submission-Guide-FINAL.pdf

National Trends in Value-based Care

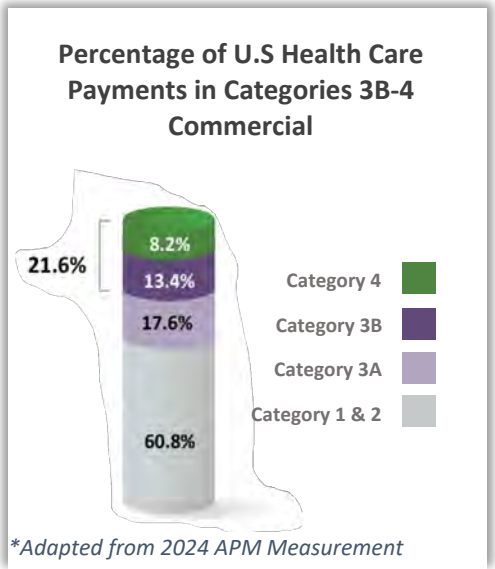
In the 2024 APM report, the ongoing shift toward value-based care (VBC) and MHCC's commitment to tracking progress was underscored. Historically, meaningful comparisons across states and payors have been difficult due to the wide variability in how non-claims payments and APMs are classified and reported. MHCC's prior work, including the mandatory statewide non-claims payment submission linked to APM reporting, positioned Maryland among the few states capable of offering structured, statewide data on APM adoption.

Figure 2. States Collecting APM Data



In that report, it was noted that eleven states, Arizona, California, Colorado, Connecticut, Delaware, Maine, Maryland, Massachusetts, Oregon, Rhode Island, and Washington, monitor and collect data on value-based arrangement adoption (see Figure 2). Of these eleven states, eight have published reports on APM adoption for payors in their state.

Figure 3. HCP-LAN Preformance - National Commercial Payors



*Adapted from 2024 APM Measurement

Nationally, HCP-LAN's 2024 Measurement & Results Report shows increasing adoption of advanced payment models.[7] Commercial data, representing 71.5% of the national market in CY 2023, show continued movement toward advanced APMs. In CY 2023, 21.6% of payments were made through downside-risk models (Categories 3B and above), up from 16.5% in CY 2022 (see Figure 3). The HCP-LAN goal for the commercial market in 2024 was 25% adoption in HCP-LAN categories 3B and 4, APMs with shared savings and downside risk and comprehensive population-based payment models.

It is important to note that as of May 2025, HCP-LAN announced that they will discontinue APM measurement efforts.[8] In light of this, strengthening data consistency and encouraging use of the Expanded NCP Framework will be necessary to increase transparency and fill the void left by federal measurement initiatives.

[7] Health Care Payment Learning & Action Network. 2024 APM Measurement Infographic. August 2025. Available at: https://hcp-lan.org/2024-infographic/

[8] Health Care Payment Learning & Action Network. "HCP-LAN Reaffirms Commitment to Value-Based Care." HCP-LAN, 19 May 2025.

Data Collection Methodology

Payors were required to return the APM Data Collection Template by September 30, 2025, capturing the previous two years of data, and were instructed to assign members or episodes and total medical expense (TME) according to the Expanded NCP Framework. Because members may be part of more than one APM, payors were directed to assign all TME to the payment methodology that is farthest along the continuum of clinical and financial risk, consistent with other states.[9] For example, if a member's TME could be counted under either Payment Subcategory B2, pay-for-performance payments, or Payment Subcategory C5, risk for total cost of care with shared savings, such as an ACO, the TME would be assigned to Subcategory C5. After MHCC received the completed templates, staff completed a data quality review and worked with payors to resolve questions and resubmit data when needed.

Although payors were allowed to voluntarily report on additional market segments, such as Medicare Advantage or self-insured plans, the required reporting focused on Maryland residents enrolled in fully insured products. Because only fully insured information was submitted, the findings in this report reflect the fully insured market only. Kaiser did not offer APM programs in 2023 and 2024 outside of its existing health and medical groups and was granted a waiver for this reporting year. Data submitters for this cycle included Aetna, CareFirst, Cigna, and UnitedHealthcare.

To calculate quality measures such as HEDIS, MHCC chose to use the MCDB rather than rely on direct submissions from payors. This approach allows MHCC to report claims-based measures more consistently across payors and over time, while also reducing administrative burden for both MHCC and participating payors.

Data Limitations:

While UnitedHealthcare submitted APM data for Payment Categories A, population health and infrastructure payments, and D, capitation and full risk payments including primary care capitation, its data was excluded from the tables and figures in this report due to low PMPM amounts for reported APMs. UnitedHealthcare also was unable to provide member identifiers needed for quality measure calculations, so this payor will be excluded from those measures as well. In addition, several episodes of care reported by Cigna were removed due to outlier cost-per-episode values. The CareFirst membership data included in this report is based on initial submissions and may be subject to change pending subsequent resubmissions.

Aggregate Results

Summary of Submitted Data

Participation in APMs in Maryland totaled 268,467 attributed members in 2024, an increase of 37% over the previous year (see Table 1). There was significant growth in both performance payment models and shared savings and recoupment models, e.g. shared savings and shared risk. Membership increased in Payment Category B, driven largely by CareFirst's growth in Payment Subcategory B2, pay-for-

[9] Office of Health Care Affordability. (2025, April). Total Health Care Expenditures (THCE) Data Submission Guide (Version 2.0).

performance, which added about 34,000 members. There was also substantial growth in Payment Subcategory C5, which reflects risk for total cost of care with shared savings. In this category, CareFirst added 32,498 members, and Cigna added 13,386 members. Altogether, across Payment Categories B and C, membership grew by 72,051 members from 2023 to 2024.

In 2024, CareFirst accounted for the majority of APM membership, with 222,245 members out of 268,467 total members, or 83% of overall membership in APMs. Cigna accounted for 16% of overall membership, and Aetna accounted for 2% of overall membership.

Table 1. Membership for Population-based APMs

Expanded 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%

For population-based APMs, the number of participating provider organizations increased between 2023 and 2024 (see Table 2). In Payment Category B, performance-based payments, there were 9 provider organizations in both years. In Payment Category C, shared savings and recoupments, participation grew from 27 provider organizations in 2023 to 30 provider organizations in 2024. This increase was driven by CareFirst and Cigna, which each added 3 provider organizations in total. For Payment Category B, the growth was driven primarily by the addition of a new provider, Johns Hopkins, which contributed 24,993 newly attributed members in 2024. For Payment Category C, the increase resulted from several provider organizations. Adventist added 12,615 newly attributed members, Helix Resources Management added 23,154 newly attributed members, and the University of Maryland contributed an additional 10,000 newly attributed members during the same period. In total, there were 39 provider organizations participating in population-based APMs in 2024.

For episode-based payments, activity was more limited. In 2023, episode-based APMs were reported only by CareFirst and Cigna. Notably, no provider organizations reported episode-based APMs in 2024.

Table 2. Provider Organization Participation in APMs

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	-

Between 2023 and 2024, TME for fee for service members, or those not participating in an APM, modestly increased by 1.7 percent (see Table 3). The more notable changes were related to a larger share of TME being attributed to value-based arrangements. The most significant growth occurred in TME tied to performance payments, driven by increases in Payment Subcategory B2, pay for performance payments, for both Aetna and CareFirst. These payments increased by just under $261 million dollars. There was also meaningful growth in Payment Subcategory C5, risk for total cost of care with shared savings, which increased by just under $135 million dollars between 2023 and 2024.

Total medical spending for these members comprised 29% of TME for the market (see Table 3). National health expenditures increased by 7.5 percent in 2023, according to Centers for Medicare & Medicaid Services (CMS).[10] Between 2023 and 2024, combined fee-for-service and APM TME increased by 9.5 percent (see Table 3). This suggests that Maryland outpaced national spending trends over the same period, with overall medical expenditures growing at a faster pace than the country overall.

Table 3. TME Across Expanded NCP Framework Payment Categories

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%

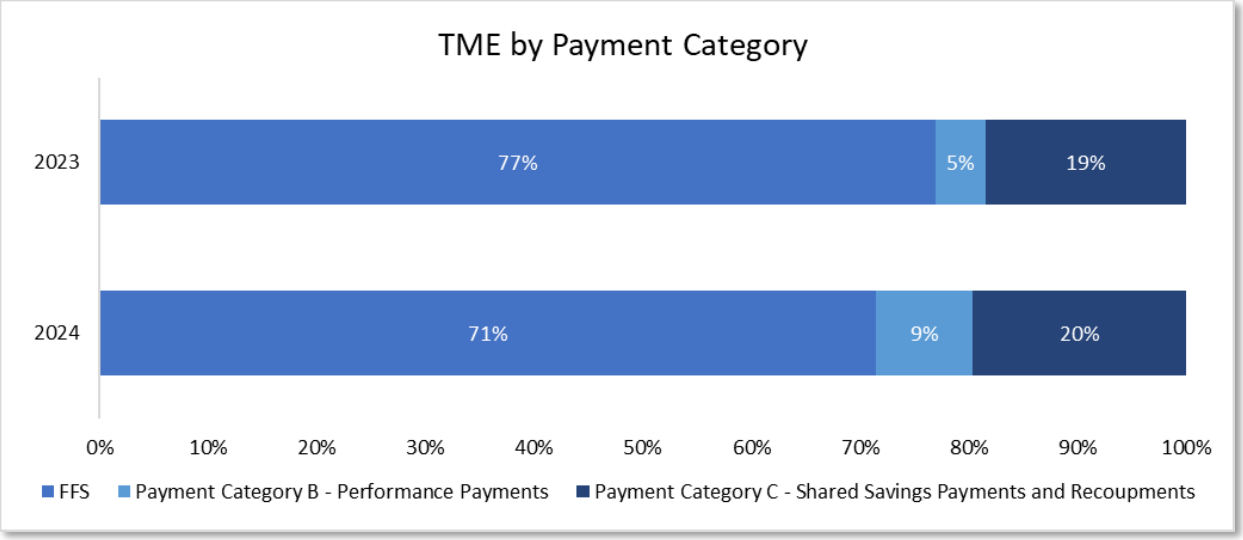
**Note: Episode-based TME is excluded, this table represents TME for the attributed population.*

TME increased from 2023 to 2024, with growth in both performance payments and shared savings payments and recoupments (see Figure 4). Attributed TME in performance payments rose from 5

[10] Centers for Medicare & Medicaid Services. (2025, June 24). NHE Fact Sheet.

percent to 9 percent, while shared savings payments and recoupments increased from 19 percent to 20 percent.

Figure 3. APM Participation According to TME



Between 2023 and 2024, there was a significant increase in the overall PMPM for Payment Category B (see Table 5). 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.

Table 5. PMPM Across HCP-LAN Category

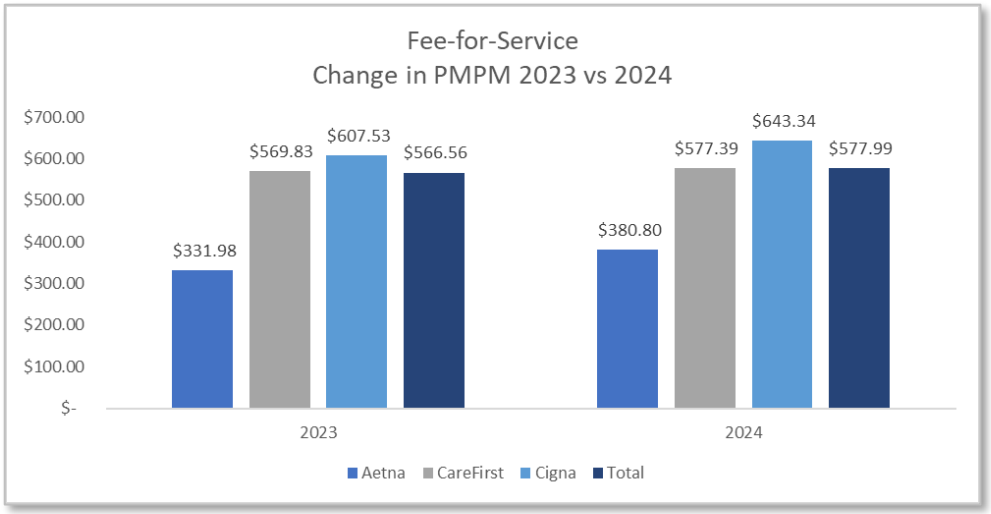
Expanded NCP Framework Payment Category	Total Medical Expense PMPM - 2023	Total Medical Expense PMPM - 2024	Difference (2024 less 2023)
Payment Category B - Performance Payments	$538.09	$626.12	$88.02
Payment Category C - Shared Savings Payments and Recoupments	$551.44	$554.83	$3.39

Overall, this movement shows clear progress in the transition from fee-for-service to value-based care. The data reflect steady growth in both the number of provider organizations participating in these arrangements and the membership attributed to them. This trend also signals continued progression toward more advanced models over time, as payors and providers gain experience with population-based APMs. Together, these changes indicate that value-based care is becoming a more established part of the commercial market in Maryland.

Population-Based APM Summary

In this section, we examine population based APMs and how they have changed over time. Looking at PMPMs across all population based APMs, there was a relatively modest increase in total PMPMs between 2023 and 2024 (see Figure 5). Aetna reported the lowest overall PMPM yet showed the largest year-to-year increase. In contrast, CareFirst and Cigna had higher PMPM levels but experienced smaller annual increases compared to Aetna.

Figure 5. Fee-for-Service PMPM Comparison, 2023-2024



For pay-for-performance arrangements, Payment Subcategory B2, CareFirst expanded participation between 2023 and 2024 (see Table 6). The number of participating providers, based on tax identification numbers, increased by 10, representing a 77 percent increase.[11] This growth aligns with the substantial increase in membership attributed to this payment model for CareFirst, which more than doubled over the same period.

When examining PMPMs, Aetna saw a decrease, while CareFirst experienced a significant increase. For CareFirst, PMPMs rose by $137.27, increasing from $490.01 to $627.28 between 2023 and 2024. MHCC also collects an age/gender adjustment factor for populations attributed to different types of APM arrangements, which accounts for census characteristics. A higher age/gender factor indicates an older population and may imply a higher cost of care. Results are expected to be greater than 0.5 and less than 2. However, results can exceed 2.0 for ages 65 and older. CareFirst reported a modest increase in the age/gender factor; however, the age/gender adjustment remained near one, indicating that changes in the demographic makeup of the covered population did not meaningfully influence overall costs.

Cigna indicated that its Payment Subcategory B1, pay-for-reporting methodology, is a legacy arrangement stemming from the COVID-19 pandemic, during which Cigna offered PMPM-based

[11] Each tax identification number under a provider organization may include multiple providers with members assigned under an APM. Provider organizations may include more than one tax identification number.

payments to support providers. Cigna noted that it is continuing to work with providers to transition them into more advanced APMs.

Table 6. Performance Payments Summary

Payment Category B - Performance Payments by Payment Subcategory					
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%

For shared savings payments and recoupments, two payment models were reported, Payment Subcategory C5, risk for total cost of care with shared savings, and Payment Subcategory C6, risk for total cost of care with recoupment (See Table 7). Aetna, CareFirst, and Cigna each participated in Payment Subcategory C5, while Aetna was the only payor reporting activity in Payment Subcategory C6. As noted earlier, the percent of non-claims payments in these arrangements remained minimal compared with total medical expense.

Across these models, PMPMs increased for Aetna and Cigna, while CareFirst experienced a decrease. Aetna also saw a significant decline in membership in its Payment Subcategory C6 model, with membership falling by half between 2023 and 2024.

When examining the age/gender factor, there was no strong pattern across payors. All payors reported only modest increases in the age/gender factor for Payment Subcategory C5, increases ranging from 0.02 to 0.07. These changes are small and do not suggest meaningful shifts in the demographic makeup of the covered populations.

Table 7. Shared Savings and Recoupments Summary

Payment Category C - Shared Savings Payments and Recoupments					
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%

Summary of Findings

Overall, the data show that providers are continuing to increase their participation in alternative payment models and are moving gradually toward value-based care. This is reflected in the growing number of provider organizations participating in these arrangements and the corresponding increases in membership reported by payors across several payment methodologies. A key factor influencing continued progress is the amount of non-claims payments as a proportion of TME. These funds allow providers to invest in infrastructure and care transformation activities that support the shift away from fee-for-service. Without meaningful growth in non-claims payments, provider organizations may face limits on how far they can advance along the value-based continuum.[12]

Whether increased participation is translating into lower costs is still uncertain. PMPM results across payment models are mixed, with some showing lower PMPMs than fee-for-service and others trending higher. Payment Subcategory C5, risk for total cost of care with shared savings, stands out in this regard. When examining PMPMs for C5, the levels and the year-over-year increases were lower than those observed in fee-for-service, both before and after adjusting for the age/gender factor. This may suggest that providers participating in C5 models are beginning to experience some benefit from value-based efforts, though more data are needed before drawing firm conclusions. The impact of demographic

[12] Health Care Payment & Learning Action Network. (2025, August). APM Framework White Paper. https://hcp-lan.org/wp-content/uploads/2025/08/APM-Framework-White-Paper.pdf

differences is also important to acknowledge. For example, in Cigna's C5 model, adjusting for the age/gender factor reduced the year-over-year PMPM change from $99.39 to $60.06, showing that population makeup can meaningfully influence results.

The findings point to steady progress in provider engagement with value-based care and a foundation for continued advancement. However, for providers to move into more advanced arrangements and sustain performance improvements, increased investment in non-claims payments and ongoing support for care transformation will likely be necessary. More data over time will help clarify whether these efforts lead to meaningful, lasting changes in cost and quality.

National Comparison

A review of comparable states shows that Maryland is unique in its consistent, year-over-year reporting of APM progress. The comparative information referenced in the 2024 APM report relied on data from states such as Delaware and Oregon. To date, no new statewide APM adoption data have been published since that time. Among other states that report APM adoption, Washington conducts an annual value-based purchasing survey across payors as part of its statewide goal to achieve 90% APM adoption in managed care and public employee markets.[13]

For state-financed health care in 2023, Washington reported that 83% of managed care payments were in HCP-LAN Categories 2C and above, and 82% in 2023. Public employee programs reported 61% in Categories 2C and above in 2022, and increased to 63% in 2023. Massachusetts provides another example of state-driven APM adoption efforts. The state has maintained longstanding APM adoption targets for its managed care plans.[14] Using a membership-based view of APM participation, MassHealth managed care organizations reported 89% APM adoption in 2023, while commercial markets reached 40.5% in value-based purchasing arrangements.[15]

These state examples highlight the impact of statewide targets and purchasing power, particularly within Medicaid and state-funded populations. They also underscore a consistent trend: commercial markets often lag behind state-sponsored programs.

Non-claims Payments

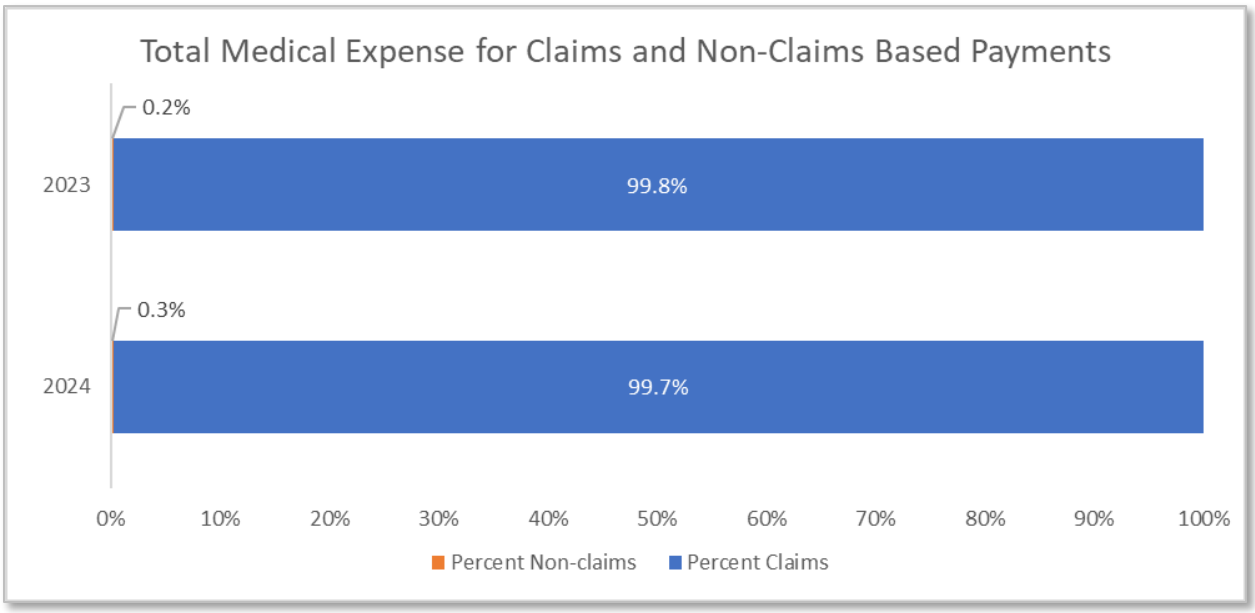
When reviewing progress across the Expanded NCP Framework and value-based arrangements, it is helpful to understand how payments are counted. The reporting above reflects the total TME that flows through each contract, meaning all fee-for-service and non-claims dollars are included when a provider participates in a value-based arrangement. Looking at the share of TME coming from non-claims payments helps show how much of the arrangement is tied directly to value rather than service volume.

Non-claims payments, especially population-based payments within the Expanded NCP Framework, represent the portion of funding that supports value-based care. These dollars help providers redesign

[13] Washington State Health Care Authority. 2024 Paying for Value Survey Results. December 23, 2024. Available at: https://www.hca.wa.gov/assets/program/paying-for-value-survey-results-2024.pdf
[14] 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, 2012.
[15] Center for Health Information and Analysis. (2025, March). Annual Report on the Performance of the Massachusetts Health Care System. Commonwealth of Massachusetts. https://www.chiamass.gov/assets/2025-annual-report/2025-Annual-Report.pdf

care, invest in new capabilities, and adopt new models of delivering services. As provider organizations move into more advanced arrangements, an increasing share of payments coming through non-claims pathways is expected and reflects deeper support for care transformation.

Figure 6. Maryland Non-claims Payments, 2023-2024



When looking at non-claims payments in Maryland, there was only a very modest increase from 0.2 percent to 0.3 percent of all spending, in fee-for-service (see Figure 6). In dollar terms, non-claims payments rose by $2,540,688 between 2023 and 2024, increasing from $9,333,717 to $11,874,405. While this represents progress, the growth is minimal in the context of all health care spending in Maryland. The change was not driven by any particular payment subcategory (see Figure 7); rather, non-claims payments were essentially flat across all reported subcategories. The slight increase is more likely the result of changes in overall medical expense rather than meaningful growth in non-claims investments.

Figure 7. Expanded NCP Framework Payment Subcategory Non-Claims Payments

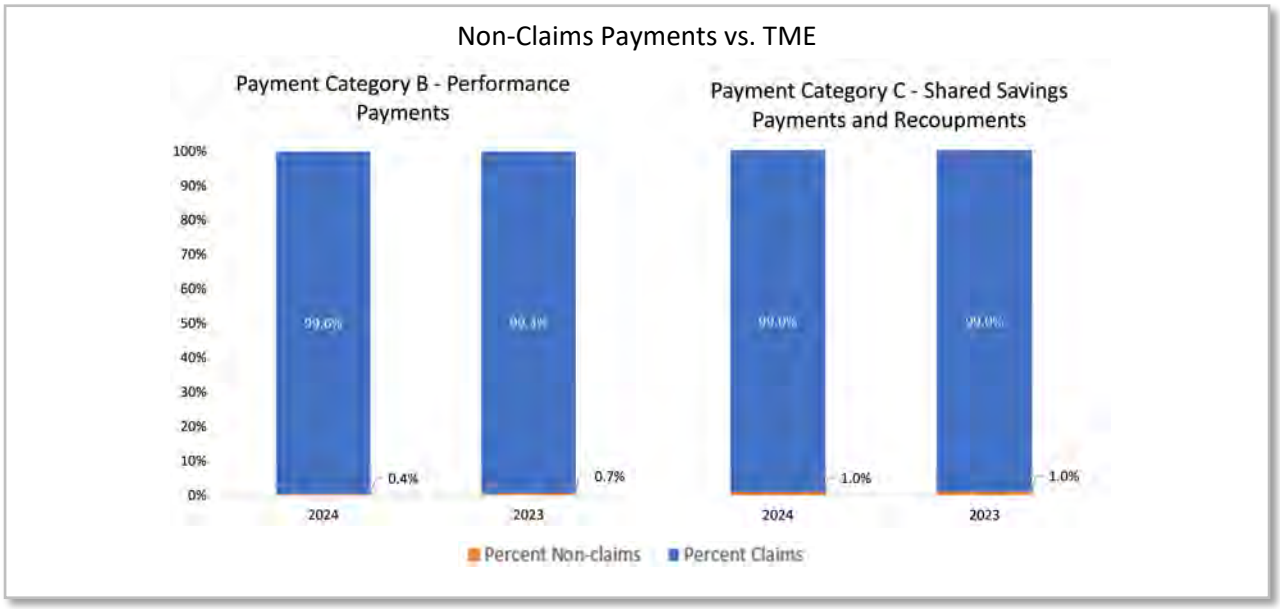


Table 8. Payment Category B - Non-claims PMPM Payments

Payment Category B - Performance Payments by Payment Subcategory	
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

years of participation with performance-based incentives. 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.

Payment Category C includes shared savings and two-sided risk arrangements. Table 9 shows the shared savings payments – or the dollars retained by the provider organization due to its participation in the model – on a PMPM basis.

These PMPM values exhibited greater variation across payors. For Payment Subcategory C5, risk for total cost of care with shared savings, the overall PMPM was $5.70 in 2023 and $5.40 in 2024. The primary exception was Aetna, which experienced a notable decline from $10.73 to $3.36 over the same period. This reduction may be driven by shifts in provider participation and attributed membership, as one provider organization exited the arrangement and two new provider organizations joined, and the remaining

It is also important to note that the current amount of non-claims funding is too limited to drive care transformation. To support practice change and the adoption of more advanced value-based models, a more substantial increase in non-claims payments will be necessary.

Table 8 shows non-claims payments on a PMPM basis for Payment Category B, performance payments. These payments reflect the PMPM amounts paid to the provider organization as a bonus payment in exchange for reporting on a defined set of quality metrics or meeting performance targets for a defined set of quality measures. For Payment Category B, PMPM values remained relatively small and stable across participating payors. In Payment Subcategory B1, pay-for-reporting, the PMPM in 2023 was $6.38. For Payment Subcategory B2, pay-for-performance, the overall PMPM increased slightly from $2.45 in 2023 to $2.76 in 2024, potentially a result of multiple

Table 9. Payment Category B - Non-claims PMPM 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

provider organizations experienced a minimal membership increase or declining membership. These participation and population changes may have contributed to year-to-year PMPM changes. Aetna was the sole payor submitting data for Payment Subcategory C6, risk for total cost of care with the risk of recoupment. Its PMPM decreased from $6.84 in 2023 to $2.55 in 2024, again potentially due to one provider leaving the two-sided risk arrangement, while the remaining provider organizations experienced either a modest increase in attributed membership or no changes.

Both CareFirst and Cigna experienced modest year-to-changes in Payment Category C5, risk for total cost of care with shared savings. Providers participating in Payment Category C models received approximately twice the incentive of those participating in Payment Category B models. The modest increases reported by CareFirst and Cigna in shared savings arrangements suggest continued progress as providers take on more advanced alternative payment methodologies. Continued investment and collaboration will support provider readiness for APM adoption as organizations assume increasing levels of financial accountability.

Episode-Based APM Summary

For episode-based payments, payors provided data only for 2023. The reported payment models fell under shared savings payment arrangements, with episodes classified either as shared savings or shared savings with risk of recoupment (see Table 10). Most episodes were for colonoscopies and upper GI endoscopies, which are relatively minor procedures. Pregnancy episodes also represented a meaningful share of the volume. The upper GI and colonoscopy episodes were reported under episode-based shared savings arrangements, while pregnancy episodes were reported under episode-based shared savings with risk of recoupment.

Table 10. Episodes – Shared Savings and Recoupments

Payment Category C - Shared Savings Payments and Recoupments - Episodes (Data for 2023 only)			
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

Payor and Episodes	Number of Episodes	Total Medical Expense	Cost per Episode
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

Episodes-based APMs for 2023 included:

1. Colonoscopy
2. Hip Replacement and Hip Revision
3. Hysterectomy
4. Knee Arthroscopy
5. Knee Replacement and Knee Revision
6. Lumbar Laminectomy
7. Lumbar Spine Fusion
8. Pregnancy
9. Upper GI Endoscopy

When assessing episode-based APMs, MHCC is limited in its ability to validate costs per episode because no claims grouper is available for generating comparable data. To provide insights on the performance of these APMs and verify episode costs, grouper software is needed to calculate comparable episode-level costs for non-APM participant populations.

In lieu of alternative comparable information, MHCC compared these Payor reported results with average cost estimates from the Wear the Cost tool, based on MCDB private insurance data from 2020 and 2021.[16] For upper GI endoscopies, the average cost in Maryland was $2,257, while the cost-per-episode reported by CareFirst and Cigna averaged $1,364.15, which is lower than both the Maryland benchmark and average cost of $1,833 reported for colonoscopies in Delaware. Similarly, the cost-per-episode for colonoscopies under shared savings arrangements averaged $1,397.15, again below the Maryland average. For pregnancy episodes, however, the payor reported cost-per-episode averaged $22,076.73, which is higher than the Maryland average vaginal delivery cost of $14,676 reported by Wear the Cost. It is unclear whether differences in services included in the Wear the Cost estimates versus the payer reported episode-based bundles account for these variations.

Across all episode-based payment models, no member responsibility was reported, indicating that patients did not incur out-of-pocket costs for these episodes under the arrangements submitted.

[16] Maryland Health Care Commission. Wear the Cost. Private insurance provider, 2020/2021. https://www.wearthecost.org/

Quality in APM Arrangements

The quality results presented in this report are based on data submitted by the payors. MHCC is working with payors to calculate quality scores using payor-submitted data in the MCDB. Several payors did not submit data in time for inclusion in this report. UnitedHealthcare was unable to provide the necessary membership identifiers for this reporting cycle, and indicated that member information would be available in future reporting cycles. CareFirst did not provide corrected member information in time to complete measure results. Due to this, an addendum will be issued once updated data from CareFirst becomes available.

The analysis uses data from the MCDB and payor provided data to calculate HEDIS measures across APMs. Each payor identifies members participating in an APM, which allows MHCC to determine measure performance for both APM and non-APM populations. A total of 11 quality measures across 5 domains are included in the analysis. The table below lists each measure grouped by its domain (see Table 11). The selected measures focus on key domains of population health, with an emphasis on indicators that can be reliably derived from claims-based data. Quality measures will continue to be aligned with the AHEAD framework to ensure consistency and comparability over time.

Table 11. Performance Measures

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

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.[17]

Provider Feedback on Value-Based Arrangements

MHCC issued a provider feedback survey request to gather feedback on participation in value-based arrangements during the fall of 2025 and received 3 responses from provider organizations that varied widely in size and capacity. Two respondents reported active participation in multiple value-based models, including shared savings arrangements, practice infrastructure payments, and incentive programs. The third respondent, a small independent primary care practice, noted that participation in private-carrier models was financially unsustainable under current reimbursement levels. All respondents emphasized a strong focus on primary care, with performance measures largely centered on preventive care, chronic disease management, and improving coordination across the care continuum. Most had implemented workflow changes, such as expanded virtual care, care management programs, data-driven reporting, and remote monitoring, to support participation in these arrangements.

Across responses, several challenges and concerns surfaced. One respondent described significant administrative burdens, including delayed contract execution, limited access to actionable data, interoperability issues, and shifting program requirements that created uncertainty for practices. Another respondent highlighted the need for independent oversight and regular auditing of carrier-managed value-based models to ensure transparency and accuracy in data and metrics. A consistent theme across submissions was the importance of reliable data, clear communication, and stable program structures to support sustained participation. These responses indicate growing engagement in value-based care among some providers, while also underscoring the operational and financial barriers that continue to limit broader participation, particularly among smaller practices.

Looking Ahead

This reporting year marks Maryland's first use of the Expanded NCP Framework for collecting information on APM adoption and non-claims payments, and is an important step in continuing as a leader for consistent and transparent tracking of progress toward value-based care. As the state continues to measure APM adoption in future years, maintaining the Expanded NCP Framework will allow Maryland to develop a more complete picture of how value-based care is evolving across the commercial market. Maryland has been a national leader in data capture by collecting alternative payment model participation, non-claims payments, and quality performance using a consistent and comparable structure. This approach allows for comparisons across these different dimensions. As other

[17] Maryland Insurance Administration. (n.d.). File a Complaint. Retrieved December 2, 2025, from https://insurance.maryland.gov/Consumer/pages/fileacomplaint.aspx

states follow Maryland in adopting the Expanded NCP framework, and begin to report data in a similar fashion, continued investment in refining data collection will support national comparisons over time.

To ensure the integrity of future reporting, MHCC will place greater emphasis on timely and complete data submissions from all payors. Several payors were unable to provide the required data this cycle, underscoring the need for clearer expectations and stronger accountability. Looking forward, MHCC will examine available tools in support of accurate and timely submission of data, including the potential issuance of fines should payors fail to meet reporting requirements.

In addition, consistent reporting will also help to identify longer-term patterns in payment model participation, use of non-claims payments, provider risk-bearing, and changes in total medical expense. These data will inform policy discussions about how best to support providers as they move into more advanced value-based arrangements and where targeted investments may help accelerate care transformation, particularly for primary care.

MHCC will also explore acquiring or implementing episode-based grouper software to enable validation of episode costs across both APM and non-APM populations. Access to a standardized grouper would enhance the comparability of cost data, strengthen analytic capabilities, and improve confidence in future episode-based APM evaluations.

There is also recently published literature on potential gaming of regulatory requirements between vertically integrated payors and owned providers.[18] If payer-provider organizations are calling intercompany transfers “value-based purchasing” as a way to skirt medical-loss ratio requirements, rather than improving the overall cost and quality of care, it could potentially limit the benefits of more advanced value-based models for Marylanders.[19] MHCC will explore if there is additional data that can be collected to improve transparency.

Currently, data collection is limited to the commercial fully insured market. However, many providers participate in multiple lines of business and may receive non-claims payments through programs such as Maryland’s Total Cost of Care (TCOC) Model and the forthcoming AHEAD Model. Payments for these models may not be included in the present data collection effort, yet they support movement along the value-based continuum. In future phases, MHCC will explore opportunities to incorporate these payment structures into data collection efforts. This expanded approach will help capture a more complete picture of non-claims payments and value-based activity across the health care system in Maryland.

Maryland has made steady progress in expanding participation in value-based arrangements and establishing a more structured approach to reporting. Continued commitment to refining the data collection process, supporting payors in consistent submissions, and maintaining a clear, stable framework will help ensure that the state is well positioned to use these data to guide future decision-making. MHCC will continue to monitor trends, engage stakeholders, and report annually on Maryland’s progress as value-based care becomes an increasingly central part of the state’s health care system.

[18] Arnold, D. R., & Fulton, B. (2025). UnitedHealthcare pays Optum providers more than non-Optum providers. Health Affairs. Advance online publication. https://doi.org/10.1377/hlthaff.2025.00155
[19] Angeles, J., & Bailit, M. (2025, September 29). How insurers that own providers can game the Medical Loss Ratio rules. Health Affairs Forefront. https://doi.org/10.1377/forefront.20250926.660140

Appendix

Expanded Non-claims Payments Framework

Freedman HealthCare (FHC) collaborated with the California Department of Health Care Access and Information (HCAI) to develop the Expanded Non-claims Payment (NCP) Framework. This framework is designed to capture non-claims healthcare spending, the purpose of these payments, and the level of risk assumed by providers.

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

Key features include:

- Cross-references the HCP-LAN Framework to assess provider risk levels and reduce data collection burden.
- Categorizes and subcategorizes healthcare spending in clear and current terms aligned with actual payor-provider contracts and payments.
- Assists policymakers and stakeholders in evaluating the value of non-claims payments and their alignment with healthcare priorities.

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

Payors should use these definitions when classifying their provider contract and payment arrangement.

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
A	**Population Health and Infrastructure Payments**	**Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.**	
A1	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A
A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
A4	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A
A5	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A
B	**Performance Payments**	**Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.**	
B1	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B
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
C	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category may be considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality." Payments in this category may also not be "linked to quality".**	
C1	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. 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.	3A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
C2	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. 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.	3B
C3	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. 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.	3A
C4	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. 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.	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	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.	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	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. If the defined spending target is not met,	3B

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
		the payer may recoup a portion of the initial fee-for-service payment. 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 50% 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 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings."	
D	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category may be considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality." Payments in this category may also not be "linked to quality".**	
D1	Primary care capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A
D2	Professional capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
D3	Facility capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
D4	Behavioral health capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
D5	Global capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
D6	Payments to integrated, comprehensive payment and delivery systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C
E	**Other Non-claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).**	

Glossary of terms

Age/Gender Factor: A demographic-based adjustment factor that shows the ratio of the census-adjusted population to the unadjusted population for a given contract arrangement. The adjustment uses payor-specific census factors for gender by age group and by payor population.

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.

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.

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

Member Months: A measure of enrollment over time, where one member enrolled for one month equals one member month, used to standardize cost and utilization measures.

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.

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

Per-Member Per-Month (PMPM): A normalized measure calculated by dividing total medical expense by total member months.

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

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.

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

Total Member Responsibility Amount: The total of all member responsibility amount, which is a sum of member copay, coinsurance, and deductibles.

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

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

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.

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