MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

January 16, 2024

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

The Honorable Joseline A. Peña- Melnyk
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 Peña- Melnyk,

SB0834/Ch. 298, HB 1148/Ch. 297(2), 2022 - Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization requires the Maryland Health Care Commission (MHCC) to aggregate the (1) the number and type of value–based arrangements entered into in accordance with the authority established under the law; (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 and report it to the Senate Finance Committee and the House Health and Government Operations Committee, on or before December 31, 2023, and annually thereafter until December 31, 2032.

Across the United States, per capita healthcare costs have risen nearly 5% a year, each year since 1991.[1] One strategy to improve healthcare value is to tie payments to the cost, quality and outcomes of the care received. Alternative Payment Models (APMs) utilize non-fee-for-service (non-FFS) or non-claims payments to pay for health care services and often tie the amount paid to the value of care provided. The movement toward these value-based

[1] KFF. *Average Annual Percent Growth in Health Care Expenditures per Capita by State of Residence. (2023).* https://www.kff.org/other/state-indicator/avg-annual-growth-per-capita

arrangements is occurring nationally. Nine states, including Maryland, now collect information on APMs.

The MHCC contracted with Freedman Healthcare, a data analytical consulting firm, to assist in conducting the study for this report. Since the law passed in October 2022, few of these arrangements existed during that year. Please note, this initial report includes the limited data that was available from 2022. This report provides a baseline to begin monitoring alternative payer models (APM) adoption and their impact in Maryland.

Key Findings and Summary Statistics:

- Payors reported 47 APM arrangements linked to quality were available in the Maryland commercial, fully insured market in 2022.

- Approximately 117,747 Maryland residents were covered under these arrangements.

- There were 12 arrangements that included shared savings and downside risk, or the two-sided incentive arrangements, enabled by Chapter 297. These arrangements put the provider at risk for losses if costs exceed a defined target or benchmark.

- Nineteen of the APM arrangements were episode of care arrangements for procedures ranging from colonoscopies to knee replacements. Under these arrangements, several services related to a procedure are grouped. If the total cost of those services is less than expected, the provider shares in the savings. If the total cost is more than expected, the provider may be responsible for a portion of the additional cost.

- Eight of the 19-episode arrangements reported by Maryland payors included downside risk.

- The Maryland Insurance Administration received no complaints from health care practitioners or practices about the APM arrangements in 2022.

Moving forward the MHCC will collect data on APMs annually until at least 2032 in accordance with *SB0834/Ch. 298, HB 1148/Ch. 297, 2022.* This comprehensive, longitudinal data collection will provide a better understanding of the financial impact and cost effectiveness of arrangements, the impact of two-sided arrangements on the value and quality of care.

We appreciate your consideration. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at ben.steffen@maryland.gov or 410-764-3566 or Ms. Tracey DeShields, Director of Policy Development and External Affairs, at tracey.deshields2@maryland.gov or 410-764-3588.

Sincerely,

Ben Steffen,
Executive Director

cc:

The Honorable Wes Moore, Governor
The Honorable Bill Ferguson, President of the Senate
The Honorable Adrienne A. Jones, Speaker of the House
House Health and Government Operations Committee
Senate Finance Committee
The Honorable Laura Herrera Scott, Secretary, Maryland Department of Health
Marie Grant, Assistant Secretary, Health Policy, Maryland Department of Health
Jonny Dorsey, Deputy Chief of Staff, Governor's Office
June Chung, Deputy Legislative Office, Governor's Legislative Office
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Sophie Bergmann, Governor's Office
Sarah Albert, Department of Legislative Services (5 hard copies)
Lisa Simpson, Committee Counsel, House Health and Government Operations,
Patrick Carlson, Committee Counsel, Senate Finance
Kenneth Yeates-Trotman, Director, Center for Analysis and Information Systems
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 2023

Prepared by the Maryland Health Care Commission

Table of Contents

Acknowledgements

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

- Vinayak Sinha, MPH, CSM, *Senior Consultant*
- Marissa Smith, MPH, CSM, *Project Manager*
- Mary Jo Condon, MPPA, *Principal Consultant*

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

Executive Summary

Across the United States, per capita healthcare costs have risen nearly 5% a year, each year since 1991.[1] One strategy to improve healthcare value is to tie payments to the cost, quality and outcomes of the care received. Alternative Payment Models (APMs) utilize non-fee-for-service (non-FFS) or non-claims payments to pay for health care services and often tie the amount paid to the value of care provided. The movement toward these value-based arrangements is occurring nationally. Nine states, including Maryland, now collect information on APMs. This report by the Maryland Health Care Commission provides a baseline to begin monitoring APM adoption and its impact in Maryland.

Background on national and Maryland APM data collection

Maryland and the Centers for Medicare & Medicaid Services (CMS) developed the Maryland Total Cost of Care (TCOC) Model and the Maryland Primary Care Program (MDPCP) to help control healthcare costs and improve value in Maryland. These APMs include non-FFS payments such as care management fees, performance-based incentive payments, and comprehensive primary care payments (CPCP). These payments incent providers to address issues efficiently and effectively to avoid the need for more costly care in the future.

In 2022, the Maryland legislature recognized the national movement toward APMs and the need for the commercial market to better align with the MD TCOC and MDPCP model. Chapter 297 of 2022 Laws of Maryland and the Code of Maryland Regulations (COMAR)10.25.06.14: Non-Fee-for-Service Expenses Report requires the Maryland Health Care Commission (MHCC), an independent regulatory agency, to collect data and report on APM arrangements.

Please note, this initial report includes the limited data that was available from 2022. Since the law passed in October 2022, few of these arrangements existed during that year. However, this report provides an important baseline for future reporting.

MHCC required payors to categorize APM arrangements according to the Health Care Payment Learning & Action Network (HCP-LAN) framework outlined in Figure 1: HCP-LAN APM Framework (see Appendix 1 for detailed category definitions). CMS and large national payors developed the HCP-LAN framework to group APMs by payment type and the degree of risk assumed by the provider.

Payors reported non-FFS payments by provider organization for each HCP-LAN Category. Payors reported fee-for-service (FFS) payments in aggregate. Payors also reported the total spending for members attributed to an APM arrangement in the category furthest along the HCP-LAN continuum.

[1] KFF. *Average Annual Percent Growth in Health Care Expenditures per Capita by State of Residence. (2023).* https://www.kff.org/other/state-indicator/avg-annual-growth-per-capita

Six payors submit claims data to the Maryland Medical Care Data Base (MCDB). Three of those six payors – Aetna, CareFirst, and Cigna – submitted information for this APM data submission. Two others – Kaiser and United HealthCare – offered APM programs that do not require data submission and received waivers. Humana only offers Medicare Advantage plans, which were not collected as part of this data collection. CareFirst provided an incomplete submission, which only included data on HCP-LAN Category 3 payments.

Key Findings and Summary Statistics

- Payors reported 47 APM arrangements linked to quality were available in the Maryland commercial, fully-insured market in 2022.
- Approximately 117,747 Maryland residents were covered under these arrangements.
- There were 12 arrangements that included shared savings and downside risk, or the two-sided incentive arrangements, enabled by Chapter 297. These arrangements put the provider at risk for losses if costs exceed a defined target or benchmark.
- Nineteen of the APM arrangements were episode of care arrangements for procedures ranging from colonoscopies to knee replacements. Under these arrangements, several services related to a procedure are grouped. If the total cost of those services is less than expected, the provider shares in the savings. If the total cost is more than expected, the provider may be responsible for a portion of the additional cost.
- Eight of the 19 episode arrangements reported by Maryland payors included downside risk.
- The Maryland Insurance Administration received no complaints from health care practitioners or practices about the APM arrangements in 2022.

Looking ahead

MHCC will collect data on APMs annually until at least 2032 according to Chapter 297 of 2022 Laws of Maryland. This comprehensive, longitudinal data collection will provide a better understanding of the financial impact and cost effectiveness of arrangements, the impact of two-sided arrangements on the value and quality of care. Only one carrier had two-sided arrangements in 2022.

Introduction

The Maryland Health Care Commission (MHCC) is an independent regulatory agency that provides the state with information on the availability, cost, and quality of healthcare services in Maryland. In 2022, a new law tasked MHCC with collecting information and reporting on the adoption of alternative payment models (APMs) and their impact in Maryland. This inaugural report provides a baseline to begin this monitoring and identify opportunities to inform future policy development.

Background and Purpose

National movement towards APMs and value-based arrangements

Across the United States, per capita healthcare costs have risen nearly 5% a year, annually since 1991.[2] The United States spends nearly double the average of peer countries on healthcare per person. Despite the high cost, the United States consistently performs worse than its peers on important measures of health including life expectancy, infant mortality, and diabetes.[3] One strategy to improve healthcare value is to tie payments to the cost, quality and outcomes of the care received.

In the United States, healthcare payments are predominantly made on a fee-for-service (FFS) basis.[4] FFS payments may incent provider organizations to administer additional services to drive revenue without adding value. APMs typically utilize non-FFS or non-claims payments to pay for healthcare services. These models often tie the amount of the payment to the value of the care provided. These "value-based payments" aim to incent higher-quality, more cost-efficient care.[3] In 2021, approximately 60% of healthcare spending nationally, covered by commercial, Medicare and Medicaid payors, flowed through a contract with some type of an APM in place.[4] Still, in most of these contracts, total payments tend to be only minimally impacted by the value of care received.

In 2016, the Centers for Medicare and Medicaid Services (CMS) and large payors established the Health Care Payment Learning & Action Network (HCP-LAN). They created the HCP-LAN to support the nation in advancing APM adoption. The HCP-LAN framework categorizes APMs according to the level of risk a provider assumes and provides a common nomenclature standard for comparing APMs nationally.[5] The HCP-LAN APM Framework is included in Figure 1.

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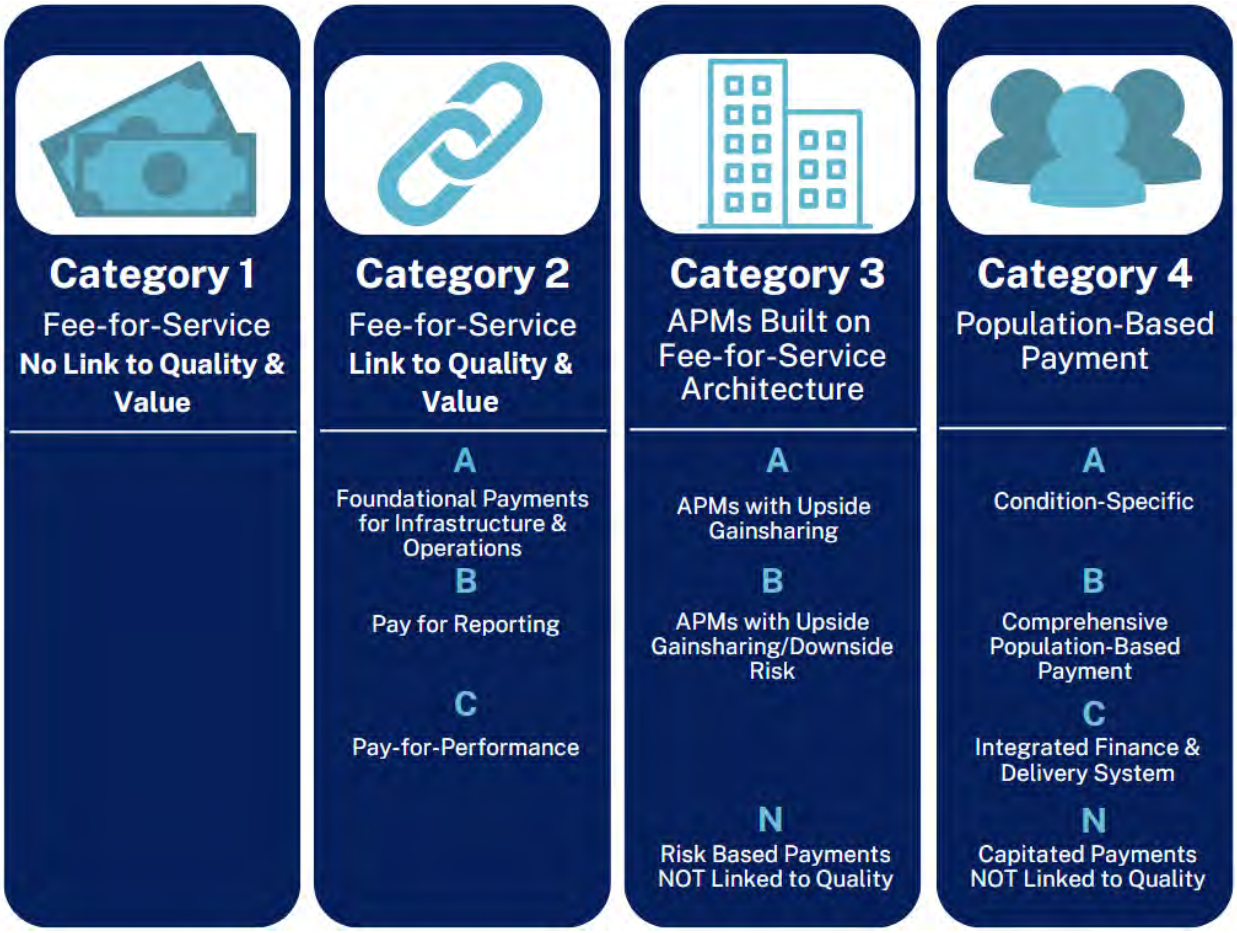
[2] KFF. *Average Annual Percent Growth in Health Care Expenditures per Capita by State of Residence. (2023).* https://www.kff.org/other/state-indicator/avg-annual-growth-per-capita

[3] Peter G Peterson Foundation. *Why the American Healthcare System Underperforms.* (2023). https://www.pgpf.org/blog/2023/07/why-the-american-healthcare-system-underperforms

[4] HCP-LAN. *APM Measurement Progress of Alternative Payment Models: 2023 Methodology and Results Report.* (2023). https://hcp-lan.org/workproducts/apm-methodology-2023.pdf.

[5] HCP-LAN. *Alternative Payment Model APM Framework.* (2017). https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

Figure 1. HCP-LAN APM Framework



Currently, nine states monitor and collect data on value-based arrangement adoption, including California, Colorado, Connecticut, Delaware, Maine, Maryland, Massachusetts, Oregon, and Rhode Island, see Figure 2. Of these nine states, five have published reports about APM adoption among payors in their state. HCP-LAN establishes APM adoption goals for the nation. In 2020,

Figure 2. APM Data Collection Across the United States

Oregon[6] and Delaware established APM adoption goals for payors within their states. Currently, California is working to establish similar goals. APM adoption goals or benchmarks for the nation are listed in Table 1.

Table 1. HCP-LAN National Commercial Market APM Adoption Goals, 2024 – 2030

HCP-LAN Year	Adoption Goal*
2024	25%
2025	30%
2030	50%

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

Background on healthcare market and changes in Maryland

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

Requirements in Maryland

In 2022, the Maryland legislature recognized the national movement toward value-based payments and the need for the commercial market to strengthen alignment with Medicare programs like the MD TCOC and MDPCP models. It passed Chapter 297 of 2022 Laws of Maryland, which enables commercial healthcare payors to develop payment models with two-sided provider risk and capitation arrangements. Unlike most states, these arrangements were previously banned in Maryland. The law also requires MHCC to collect data and report on APM arrangements, including the following:

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.

[6] Paying for Value in Health Care: A Roadmap for implementing the Oregon value-based payment compact. (2022). https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/6.-VBP-Compact-Roadmap.pdf

MHCC data collection to support the Chapter 297 of 2022 Laws of Maryland, is also based on the Code of Maryland Regulations (COMAR)10.25.06.14: Non-Fee-for-Service Expenses Report. All carriers are required to report their value-based arrangement data to MHCC in accordance with COMAR 10.25.06.14 and the APM Data Submission Guide found here.

Please note, this initial report includes the limited data that was available from 2022. Since the law passed in October 2022, few of these arrangements existed during that year. However, this report provides an important baseline for future reporting.

Results

Summary of APM Arrangements

Approximately 117,747 Maryland commercially-insured residents received care through one of 47 APM arrangements offered in the state in 2022. Information on the APM arrangements offered and membership is included in Table 2.

All of these arrangements required providers achieve quality goals to receive the full payment. APMs without a link to quality are not included in this report. Nineteen of the 47 arrangements paid for an episode of care for a medical procedure. For eight of the 19 arrangements, providers were at risk for recoupment if costs exceeded the expected amount. Episode of care arrangements included the following procedures:

- Colonoscopy
- Hysterectomy
- Pregnancy
- Upper gastrointestinal endoscopy
- Esophagogastroduodenoscopy (EGD)
- Hip replacement and revision
- Knee replacement and revision
- Lumbar arthroscopy
- Lumbar laminectomy
- Lumbar spine fusion

None of the APM arrangements in the market in 2022 were pediatric arrangements, which MHCC defined as having more than 75% of members under the age of 18. There were 12 arrangements that included shared savings and downside risk, also known as two-sided incentive arrangements, all administered by CareFirst. These arrangements were enabled by Chapter 297. CareFirst did not report whether it had capitation arrangements also enabled by this legislation. Other payors reported no capitation arrangements with a link to quality.

Table 2: Numbers of Types and Members in APM Arrangements, 2022[7]

Payors	Aetna		CareFirst*		Cigna		Kaiser		UnitedHealthcare		Total	
HCP-LAN Payment Category	Contracts	Members /Episodes	Contracts	Members/Episodes	Contracts	Members /Episodes	Contracts	Members /Episodes	Contracts	Members/ Episodes	Contracts	Members /Episodes
2C – FFS (Pay for Performance)	6	771	Did not Report	Did Not Report	0	0	0	0	0	0	6	771
3A – APM built on FFS (Shared Savings Only)	4	1,457	3	1,5826	11	18,865	0	0	0	0	18	36,148
3B – APM built on FFS (Shared Savings/ Downside Risk)	0	0	4	49,143	0	0	0	0	0	0	4	55,764
3A – APM built on FFS - Episodes of Care (Shared Savings Only)	0	0	3	18,777	8	256	0	0	0	0	11	19,033
3B – APM built on FFS - Episode of Care (Shared Savings/ Downside Risk)	0	0	8	1,777	0	0	0	0	0	0	8	1,777

*The CareFirst data for episode of care arrangements includes self-insured members.

[7] Note: Membership is based on member months data provided divided by 12. For episode of care arrangements payors submitted the number of unique episodes.

Quality outcomes of the value–based arrangements

MHCC will calculate quality scores using payor-submitted data in the all-payer claims database (APCD). The current data collection requires that the Encrypted Enrollee's Identifier, Enrollee Year and Month of Birth, and Enrollee Sex match those that are submitted to the APCD. Quality measures will include:

1. Acute Hospital Utilization (AHU),
2. Emergency Department Utilization (EDU),
3. Follow-up After Emergency Department Visit for Mental Illness (FUM),
4. Breast Cancer Screening (BCS),
5. Comprehensive Diabetes Care (CDC), and
6. Risk of Continued Opioid Use (COU).

The MHCC was not able to calculate quality outcomes with the limited data provided for 2022.

Complaints on value-based arrangements received by Maryland Insurance Administration (MIA)

Health care practitioners and practices can file complaints regarding violations in law related to APM payor-provider contracting. The MIA has received no complaints.

Cost–effectiveness of the value–based arrangements

The MHCC was not able to assess the cost-effectiveness of the programs in the first year of reporting required under Chapter 297 of 2022 Laws of Maryland. While some programs generated savings relative to a target funding level, several other programs resulted in costs above the target, which would constitute losses to the practice and possibly the carrier.

Impact of two–sided incentive arrangements on the fee schedules

The impact of two-sided incentive arrangements on traditional fee for service cannot be analyzed with the one year of data collected. Two-sided incentive arrangements began in October 2022 in Maryland. Some incentive programs may slow growth in traditional fee-for-service payments to reflect the additional non-fee-for-service payments. All practices will not move to two-sided arrangements; smaller practices will be more hesitant if other arrangements are more attractive. MHCC has not found evidence that fees for non-participating practices are reduced to compensate for the incentive payments made to participating practices with the limited data.

Data Collection Methodology

HCP-LAN framework for data collection

MHCC required payors to categorize APM arrangements according to the HCP-LAN framework outlined in Figure 1: HCP-LAN APM Framework (see Appendix 1 for detailed category definitions). This aligns data collection in Maryland with several other national and state efforts.

Payors reported non-FFS payments by provider organization for each HCP-LAN Category. Aetna, CareFirst, and Cigna submitted information for this APM data submission. Kaiser and United HealthCare offered APM programs in 2022 that do not require data submission and received waivers. Humana only offers Medicare Advantage plans, which were not collected as part of this data collection. CareFirst provided an incomplete submission, which only included data on HCP-LAN Category 3 payments.

Looking Ahead

This report will inform Maryland as it considers how to support movement towards value-based care in the state. MHCC will collect data on APM adoption annually until at least 2032 per Chapter 297 of 2022 Laws of Maryland. When multiple years of data are available, MHCC will have the longitudinal performance information necessary to evaluate the quality and cost-effectiveness of APM arrangements. This longitudinal comparative data also will support a better understanding of the impact of two-sided risk arrangements, those that put providers at risk for losses when care costs more than expected. It will also provide insight into the impact of two-sided arrangements on fee schedules for non-participating providers.

In this report, MHCC does not report on financial information or average cost per episode due to limited data. As additional episodes of care arrangements exist, MHCC hopes to report on average cost per episode of care on those arrangements. MHCC looks forward to working with payors to ensure that all requested data is included in future reports.

Appendix

Data Collection Methodology

HCP-LAN framework for data collection

MHCC required payors to categorize APM arrangements according to the HCP-LAN framework outlined in Figure 1: HCP-LAN APM Framework (see Appendix 1 for detailed category definitions). This aligns data collection in Maryland with several other national and state efforts.

Payors reported non-FFS payments by provider organization for each HCP-LAN Category. Payors reported fee-for-service (FFS) payments in aggregate. Payors also reported the total spending for members attributed to an APM arrangement in the category furthest along the HCP-LAN continuum. See Table 5 for more information. Data on APM arrangements classified as HCP-LAN categories 3N and 4N were not collected because those arrangements do not have a link to quality.

Table 5. APM Arrangement Data Collection

HCP-LAN Category	Collected by Billing Provider Organization
Category 2: FFS – Linked to quality or value (Categories 2A, 2B, & 2C)	✓
Category 3: APMs built on FFS architecture (Categories 3A, & 3B)	✓
Category 4: Population-based payments (Categories 4A, 4B, & 4C)	✓

Data collection process and submitters

With the passing of the statute and COMAR 10.25.06.14, MHCC discussed the need for APM data collection with payors and inquired about the types of programs currently offered, their vision for future programs and how the payors organize APM data internally. Informed by these discussions and data collection nationally and in other states, MHCC decided the HCP-LAN Framework was the most appropriate way to categorize the payors' APM programs. Materials for data collection were developed, including the APM Data Submission Manual and the APM template, and shared with payors for two rounds of feedback and revisions. Final data collection materials including the 2023 MCDB Data Submission Manual and the 2023 MCDB APM Data Template were published in December 2022. MHCC also developed and distributed MHCC APM Frequently Asked Questions (FAQs) to answer payors common questions in a single, accessible location. As payors completed the template, MHCC held technical calls with each payor to support accurate submissions and avoid rework.

To reduce payor burden for data submission, MHCC aligned the data collection with MCDB data elements and highlighted the need for reporting key data elements. Payors were directed to report APM arrangements in the category furthest along the

continuum of clinical and financial risk for the provider organization and to include total medical expense for these arrangements in that category. Based on payor feedback, MHCC requested calendar year (CY) 2022 data by the end of September 2023 to allow for nine months of run out. The nine months of run out allowed payors to have sufficient time to reconcile retrospective payments and/or recoupments.

HCP-LAN Category Definitions

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

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

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

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

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

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

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

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

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

HCP-Lan Category 4C (Population-Based Payment) – Integrated Finance & Delivery System: Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated

arrangements consist of payors that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. Additionally, it is important to note that when integrated lines of business comprise a portion of a company's portfolio, only the integrated payments count toward Category 4C.

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