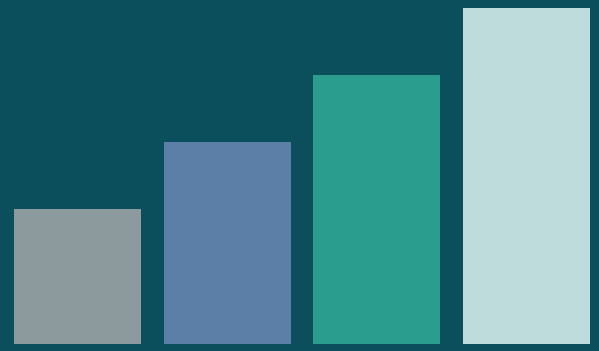
Value-Based Care in the US

Lessons from Maryland and Johns Hopkins for UK HealthTech

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Value-based care is a spectrum of who holds the risk

Most US hospitals are still paid per admission, with quality bonuses or penalties on top. Maryland's hospitals sit at the far right.

	Most US hospitals *paid per admission, plus quality programs*			Maryland hospitals
Financial risk on the provider *lower → higher*	**Fee-for-service**	**Pay-for-performance**	**Shared savings**	**Fixed budgets**
How it pays	A fee for each visit, test or admission	Bonuses or penalties based on quality scores	A share of savings against a spending target	A fixed budget or premium for a whole population
At Hopkins	Physician services; our hospitals in DC and Florida	Maryland hospital quality programs; health plan quality ratings	Johns Hopkins Clinical Alliance, our clinically integrated network	**Hospital global budgets; Johns Hopkins Health Plans**
Closest NHS parallel	Activity-based payment for elective care	QOF in general practice	Little direct equivalent	ICB allocations and fixed contracts

Hopkins operates across the whole spectrum: fee-for-service outside Maryland, fixed budgets inside it, and a health plan that keeps the savings from avoidable care.

Our integrated payer: Johns Hopkins Health Plans

Part of Johns Hopkins Medicine, so the same organization both pays for care and delivers it.

Priority Partners
Medicaid

Maryland's largest Medicaid plan, with 300,000+ members. Co-owned with the state's community health centers.

Advantage MD
Medicare Advantage

Private Medicare plans for people 65 and over, in Maryland and Northern Virginia.

US Family Health Plan
Military families (TRICARE Prime)

Care for military families and retirees. Rated 4.5 out of 5 by NCQA in 2026.

Employer Health Programs
Employer coverage

Health benefits for Johns Hopkins employees and their families.

Plus the Johns Hopkins ACG System: our population health risk analytics, used in about two dozen countries, including by NHS integrated care boards.

400,000+
members

$3B+
in annual premiums

Why plan + provider matters

- **One view of the patient:** claims and clinical records together
- **Shared incentives:** savings from avoided care stay with Hopkins
- **One care team:** not plan and provider calling the same patient

Maryland is the exception, not the US norm

Maryland is the only state where every hospital runs on a fixed budget for all payers: fewer than 1% of US hospitals.

	NHS (England)	Most of the US	Maryland
Who sets hospital prices	National tariff and local contracts	Negotiated with each insurer; Medicare and Medicaid set their own	**The state sets one price for every payer**
How hospitals are funded	Mostly fixed contracts, some activity-based payment	Paid per admission or per service	**A fixed annual budget for each hospital**
An avoided admission	Frees capacity	Usually lost revenue	**Protects the hospital's margin**
Hospital quality incentives	National targets and regulation	Medicare penalties, on Medicare payments only	**State programs across all payers**
Primary care	Nearly everyone registered with a GP	Many people have no regular primary care doctor	**Same as the US, plus a state program funding care management**



What this means for you: in Maryland, preventing an admission saves the hospital money, much as it frees capacity in the NHS. In the other 49 states the business case is different, so don't generalize from Maryland.

AHEAD: Medicare is taking Maryland's model to other states

After more than a decade of Maryland's hospital global budgets, Medicare's AHEAD model offers a version of them to more states.

Provider risk →	Fee-for-service	Pay-for-performance	Shared savings	Fixed budgets
Maryland *the pilot*	*1977 all-payer rates → 2014 global budgets → 2019 total cost of care*			**Global budgets since 2014; AHEAD since 2026**
AHEAD states *from 2028*		**Connecticut · Hawaii · Rhode Island · New York (5 counties)**		
		Vermont was also selected but withdrew in August 2026		
Rest of the US *most hospitals*	**Paid per admission, plus Medicare quality programs**			

What Medicare is taking from Maryland

- Hospital global budgets across payers
- Statewide limits on total cost growth
- More investment in primary care

Why it matters to you

These states are where a Maryland-style business case could travel next, though dates can slip and states can leave.

Even if all join, most US hospitals will still be paid per admission.

What this means for you: find the measure and the budget

Three questions every US buyer will ask

Whose budget does it save? Outside Maryland, an avoided admission usually costs the hospital revenue, so the buyer is often a health plan or a provider network in a shared-savings contract.

Which measure does it move? Name the readmission, complication or quality measure, and show the effect in their own data.

When will they see it? Quality programs pay out a year or more after performance. Show early results within one contract year.

Where this delegation could fit

Readmissions and avoidable admissions
Aide Health, Heim, Mana Medical

Infections and hospital complications
Haigh

Length of stay and operating room flow
Open Medical, VitVio

Quality gaps in chronic disease (HEDIS, Stars)
Bedfont and TidalSense (asthma, COPD), Megi Health (maternal health), Psyomics (behavioral health)

Specialist access and plan costs
Community Dermatology (Map My Mole)

Illustrative, based on each company's delegation profile.

Questions?

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Pay-for-performance: the programs we work on

Maryland runs its own versions of Medicare's hospital programs and applies them to every payer.

Program	What it measures	Maryland: at stake	Rest of US
Hospitals *Maryland's apply to every payer; elsewhere, Medicare's apply to Medicare patients only*			
Quality-based reimbursement QBR	Experience, mortality, infections, sepsis	**±2% of inpatient revenue**	Medicare: 2% withheld
Hospital-acquired conditions MHAC	Preventable complications and safety events	**±2% of inpatient revenue**	Medicare: −1%, worst 25%
Readmissions RRIP	30-day unplanned readmissions	**±2% of inpatient revenue**	Medicare: up to −3%
Avoidable utilization PAU	Admissions good primary care could prevent	**Penalty only**	No national equivalent
Length of stay new	Emergency and inpatient length of stay	**±0.5% from 2027, rising to ±1%**	No national equivalent
Health plans *set by Medicare and Maryland Medicaid*			
Medicare Star Ratings	Clinical quality, experience, pharmacy	**4+ stars earn a 5% bonus**	Same nationally
Medicaid value-based purchasing	HEDIS preventive and chronic care measures	**About ±1% of plan payments**	Varies by state

Hospital figures are the maximum reward or penalty per program; combined exposure is capped at 3.54% of inpatient revenue (rate year 2028).