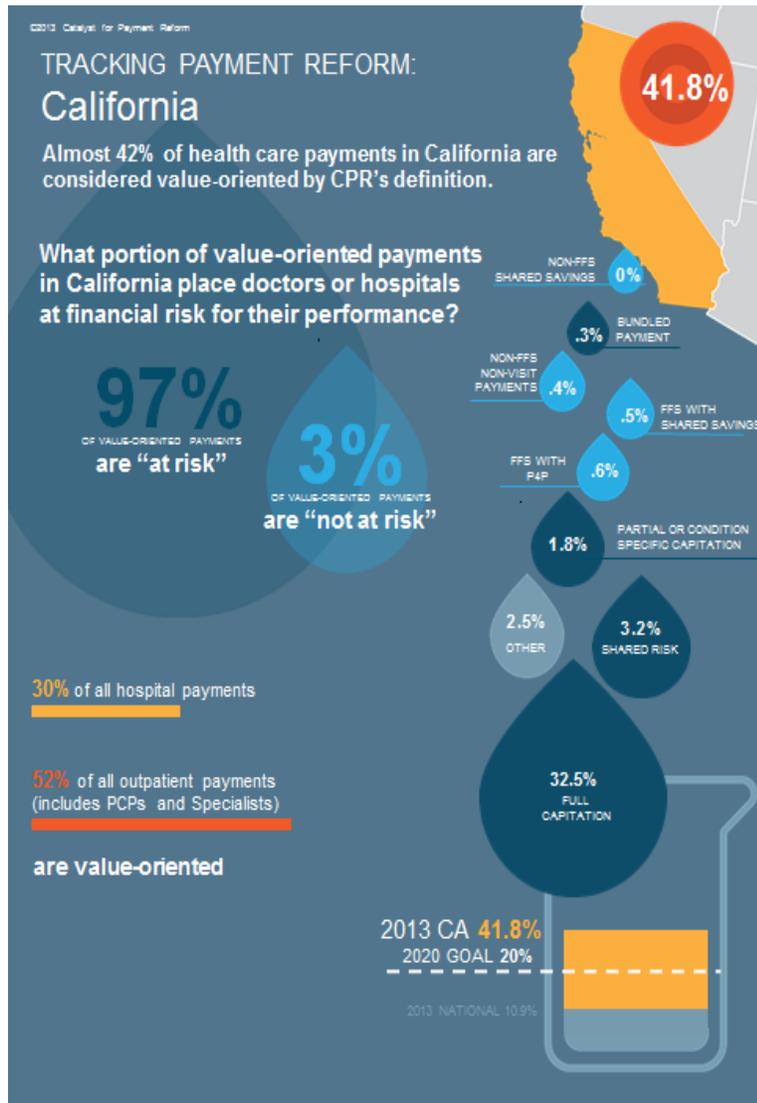




# CATALYST FOR PAYMENT REFORM

# California Scorecard on Payment Reform: Methodology



Section 1: [2013 California Scorecard on Payment Reform General Methodology](#)

Section 2: [2013 California Scorecard on Payment Reform Metric Methodology](#)

Section 3: [2013 California Scorecard on Payment Reform Definitions](#)

## 2013 California Scorecard on Payment Reform General Methodology

### Scorecard Metrics:

CPR's multi-stakeholder National Advisory Committee, including employers, health plans, providers and payment reform experts, provided guidance on the scope and definition of payment reform and the metrics (the metrics, including numerators and denominators, can be found [here](#)).

The California Scorecard on Payment Reform defines payment reform as *“a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.”*

The metrics developed by the advisory committee fell into six domains:

- 1) Public and Commercial Dollars Paid – Health plans reported total dollars paid to providers through public programs (e.g. Medicare and Medicaid) and total dollars paid to providers for in-network commercial members. The total dollars paid to providers for in-network commercial members provides the denominator for Domain 2.
- 2) Characteristics of the Payment Reform Environment – These metrics measure status quo forms of payment, including traditional fee-for-service and other payment methods that do not include quality, as well as payment reform methods, such as shared savings, shared risk, capitation, bundled payment, etc. – all including quality.
- 3) Plan Member Reach – This metric gauges the volume of patients treated by providers with payment reform contracts. To minimize the administrative burden on the plans of doing exhaustive claims reports, counting attributed members enables us to see how many patients are impacted by payment reform.
- 4) Provider Participation – These metrics show the proportion of payments made to hospitals and physicians in the outpatient setting that is value-oriented.
- 5) Building Blocks of Payment Reform – These metrics on consumer engagement and transparency tools gauge important payment reform-related activity, though they do not measure the use of new payment methods themselves.
- 6) Quality Indicator - The all-cause readmissions measure is in the Scorecard as an indicator of both quality and efficiency that the Scorecard can track over time as a potential correlate to the changes in payment methods.

### Data Collection Survey:

The 2013 California Scorecard on Payment Reform was derived from data collected through the National Business Coalition on Health's eValue8 health plan survey process. eValue8 is an annual, national request for information (RFI) to health plans. It is a voluntary survey and is not designed to ensure a representative sample of health plans. CPR and NBCH worked collaboratively to add the payment reform questions needed to populate the Scorecard to the 2013 eValue8 RFI. Where possible, we used existing eValue8 questions and definitions. We also eliminated unnecessary payment reform questions

and developed or added standard definitions where needed. The value-oriented payment information collected represents the *total* dollars paid through payment reform programs, not just the portion of the payment when quality and efficiency measures are met.

#### **Data Source:**

All data in the California Scorecard on Payment Reform come from health plans. In 2013, seven California health plans responded to the eValue8 RFI. These seven plans represent approximately 20 million covered lives in the California commercial group market, which is approximately 92 percent of California's commercial enrollment. Participation in the eValue8 RFI is voluntary and as such, not all health plans participated and not all health plans responded to all of the RFI questions. See Scorecard Metrics section for additional information.

eValue8's instructions informed participating health plans that their responses to certain questions would be used to populate the California Scorecard. The instructions explained that the Scorecard would report plan responses in aggregate and not identify plans by name. Health plans with multi-dimensional payment reform programs, such as a care-coordination fee (defined as non-visit function) combined with pay-for-performance, were instructed to report the total amount paid in a program based on the "dominant" or primary method of payment.

The California health plans responding to the payment reform questions of eValue8 represent a significant portion of the California market and, given the unique attributes of the California market (e.g. presence of staff model HMOs and large, organized delivery systems), they may be more capable of implementing new forms of payment than their peers in other states. The results also include data from HMOs, which could impact the findings.

#### **Limitations:**

- 1) Health plan data systems: Health plans reported challenges with reporting payment dollars in the Scorecard's specific categories due to limitations with their data systems.
- 2) Health plan participation: Health plan participation in eValue8 is voluntary and as such, not all health plans responded to all of the RFI questions. For specific information about the number of plans included in each Scorecard metric, please see the Scorecard Metrics section of this document. The Scorecard findings may also be biased by self-selection -- the health plans actively pursuing payment reform may be more likely to respond to the payment reform questions, which could bias the results in a favorable manner.

## 2013 California Scorecard on Payment Reform Metric Methodology

Metric	Numerator	Denominator	Method for Calculating and Reporting the Metric
<p><b>Dollars under the status quo:</b> Percent of total dollars paid through traditional FFS payment methods in CY 2012 or most recent 12 months.</p>	Total dollars paid to providers tied to contracts that contain only traditional FFS payments in CY 2012 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.	<p>Single metric displayed as a percentage (sum of numerators of lines 3-6 divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
	Total dollars paid to providers through bundled payment programs without quality in CY 2012 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.	
	Total dollars paid to providers through partial or condition-specific capitation without quality in CY 2012 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.	
	Total dollars paid to providers through fully capitated programs without quality in CY 2012 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.	

<p><b>Dollars in shared-risk with quality programs:</b> Percent of total dollars paid through shared-risk with quality programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers in CY 2012 or most recent 12 months through shared-risk programs with quality.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Dollars in FFS-based shared-savings with quality programs:</b> Percent of total dollars paid through FFS-based shared-savings with quality programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers in CY 2012 or most recent 12 months through FFS-based shared-savings with quality programs.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Dollars in non-FFS-based shared-savings with quality programs:</b> Percent of total dollars paid through non-FFS-based shared-savings with quality programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers in CY 2012 or most recent 12 months through non-FFS-based shared-savings with quality programs.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>

<p><b>Dollars in P4P programs:</b> Percent of total dollars paid through FFS plus P4P programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers in CY 2012 or most recent 12 months through FFS plus P4P programs.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>
<p><b>Dollars in fully capitated arrangements with quality (global payment):</b> Percent of total dollars paid through fully capitated payments with quality components in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers through full capitation with quality components in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>
<p><b>Partial or condition-specific capitation with quality:</b> Percent of total dollars paid through partial or condition-specific capitation with quality components in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers through partial or condition-specific capitation with quality components in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>

<p><b>Dollars in bundled payment programs with quality:</b> Percent of total dollars paid through bundled payment programs with quality in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to providers through bundled payment programs with quality in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Atypical payments to providers:</b> Percent of total dollars paid through FFS-based payment modifications for non-visit functions in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid for FFS-based non-visit functions not typically paid for in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Atypical payments to providers:</b> Percent of total dollars paid through non-FFS-based payment modifications for non-visit functions in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid for non-FFS based non-visit functions in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>

<p><b>Other types of performance-based contracts:</b> Percent of total dollars paid through other types of performance-based incentive programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid for other types of performance-based incentive programs in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>
<p><b>Payment Reform: Rebalancing Payments to Primary Care:</b> Share of total dollars paid to primary care physicians versus specialists.</p>	<p>Total dollars paid to primary care physicians in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to primary care and specialists in CY 2012 or most recent 12 months</p>	<p>Roll-up metric showing distribution of payments to primary care physicians versus specialists.  5 plans contributed data to calculate this metric.</p>
	<p>Total dollars paid to specialists in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to primary care and specialists in CY 2012 or most recent 12 months</p>	
<p><b>Payment Reform - Non-FFS Payment with Quality:</b> Percent of non-FFS payments that include a quality component.</p>	<p>Total non-FFS dollars paid that include a quality component (sum of numerators in lines 9, 11,12,13).</p>	<p>Total non-FFS dollars paid (sum of numerators in lines 4,5,6,9,11,12,13,15). Note: line 15 is in the denominator because it is non-FFS dollars paid, but it is not in the numerator because it could not be determined if it included quality or did not include quality.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator)  7plans contributed data to calculate this metric.</p>

<p><b>Payment Reform - Non-FFS Payment without Quality:</b> Percent of non-FFS payments that do not include a quality component.</p>	<p>Total non-FFS dollars paid that do not include a quality component (sum of numerators in lines 4, 5, 6).</p>	<p>Total non-FFS dollars paid (sum of numerators in lines 4,5,6,9,11,12,13,15). Note: line 15 is in the denominator because it is non-FFS dollars paid, but it is not in the numerator because it could not be determined if it included quality or did not include quality.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>
<p><b>Payment Reform Penetration - Dollars:</b> Percent of total dollars paid through "payment reform programs" in CY 2012 or most recent 12 months (lines 7-16).</p>	<p>Total dollars paid to providers through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total in-network dollars paid to providers for commercial members in CY 2012 or most recent 12 months.</p>	<p>Roll-up metric based upon the distribution of payment reform models.  7 plans contributed data to calculate this metric.</p>
<p><b>Payment Reform Penetration - Plan Members:</b> Percent of commercial, in-network plan members attributed to a provider participating in a payment reform contract in CY 2012 or most recent 12 months.</p>	<p>Total number of commercial, in-network health plan members attributed to a provider with a payment reform program contract in CY 2012 or most recent 12 months.</p>	<p>Number of commercial, in-network health plan members enrolled in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>
<p><b>Payment Reform Penetration – Outpatient Services:</b> Percent of total dollars paid for outpatient services (primary care physicians and specialists) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid for outpatient services (primary care and specialists) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid for outpatient services (primary care and specialists) in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).  7 plans contributed data to calculate this metric.</p>

<p><b>Payment Reform Penetration - Hospital (In-Patient):</b> Percent of total dollars paid to hospitals (in-patient) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to hospitals (in-patient) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to hospitals (in-patient) in CY 2012 or most recent 12 months.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Steps to Payment Reform - Breadth of Member Support Tools:</b> Percent of health plans that offered key value-oriented information within their member support tools in CY 2012 or most recent 12 months.</p>	<p>Total number of health plans that offered each of the following elements in CY 2012 or most recent 12 months: cost calculator, cost calculator with hospital chooser tool, cost calculator with physician chooser tool, cost calculator with treatment option decision tool, cost calculator considers member benefits (e.g. copay, coinsurance, deductible etc.), health plan enrollment using the tool. One numerator for each.</p>	<p>Total number of health plans that provided member support tools in CY 2012 or most recent 12 months.</p>	<p>Multiple metrics displayed as percentages (each numerator divided by the denominator).</p> <p>7 plans contributed data to calculate this metric.</p>
<p><b>Readmission Rate:</b> Percent of total hospital admissions that are readmissions for any diagnosis within 30 days of discharge for members 18 years of age and older. NCQA Plan All Cause Readmissions (PCR) measure.</p>	<p>Number of observed acute readmissions for any diagnosis within 30 days, for members 18 years of age and older.</p>	<p>Total number of acute inpatient stays during the measurement year.</p>	<p>Single metric displayed as a percentage (numerator divided by denominator).</p> <p>7 plans contributed data to calculate this metric.</p>

## 2013 California Scorecard on Payment Reform Definitions

Terms	Definition
<b>Attribution</b>	Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purposes of calculating health care costs/savings or quality of care scores for that population. "Attributed" patients can include those who choose to enroll in, or do not opt-out-of, an ACO or PCMH. For the purposes of the Scorecard, Attribution is for Commercial (self-funded and fully-insured) lives only. It does not include Medicare Advantage or Medicaid beneficiaries.
<b>Bonus payments based on measures of quality and/or efficiency</b>	Payments made that reward providers for performance in quality and/or efficiency relative to predetermined benchmarks, such as meeting pre-established performance targets, demonstrating improved performance, or performing better than peers. This does NOT include payments made under shared savings arrangements that give providers an increased share of the savings based on performance.
<b>Bundled payment</b>	Also known as "Episode-based payment" means a single payment to providers or healthcare facilities (or jointly to both) for <u>all</u> services to treat a given condition, or, to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.
<b>Condition-specific capitation</b>	A fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.
<b>Dollars paid</b>	Claims and incentives that were paid to providers (including individual physicians, IPAs, medical groups, and/or inpatient and outpatient facilities) for services delivered to health plan participants in the past year, during the 12 month reporting period, regardless of the time period when the claim or incentive payment was/is due. (i.e., regardless of when the claim was received or when the service was rendered or period of when performance was measured). For example, incentive payments that were paid in calendar year 2012 for performance in calendar year 2011 should be reported. Claims for 2012 services that are in adjudication and not yet paid during the reporting period, should not be included in this response.
<b>Episode-based payment</b>	Also known as "Bundled" Payment, is reimbursement to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.
<b>FFS-based payment</b>	Payment model where providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

<b>Full capitation with quality (sometimes also referred to as global payment)</b>	A fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance and patient risk. Includes quality of care components with pay-for-performance. Full capitation plus P4P is considered full capitation with quality.
<b>Full capitation without quality</b>	A fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year. Payments may or may not be adjusted for patient risk and there are no payment adjustments based on measured performance.
<b>Hospital-physician gainsharing</b>	Arrangement in which hospitals and physicians share the cost savings achieved through collaborative efforts resulting in improved quality and/or efficiency.
<b>Member support tools</b>	Tools (e.g. web-based) that provide transparency including but not limited to quality metrics, quality information about physicians or hospitals, benefit design information, out-of-pocket costs associated with expected treatment or services, average price of service, and account balance information (e.g. deductibles).
<b>Non-FFS-based payment</b>	Payment model where providers receive payment not based on the FFS payment system or not tied to a FFS fee schedule.
<b>Non-visit function</b>	Includes but is not limited to payment for outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists.
<b>Partial capitation</b>	A fixed dollar payment to providers for specific services (e.g. payments for carve outs for high-cost items such as specific drugs or medical devices, like prosthetics) that patients may receive in a given time period, such as a month or year. Non-specified services remain reimbursed under fee-for-service.
<b>Past year (in definition for dollars paid)</b>	Means calendar year 2012 or the most current 12 month period for which Plan can report payment information. This is the reporting period for which the Plan should report all of its data. See also definition of "Reporting Period."
<b>Pay-for-performance</b>	Provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment models.
<b>Payment reform</b>	Refers to a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.
<b>Plan members</b>	Health plan's enrollees or plan participant.
<b>Primary Care Physicians</b>	A primary care physician is a generalist physician who provides care to patients at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. For the purposes of this data collection, PCPs are not specialists. See definition of "specialists."
<b>Program Sponsor</b>	Entity that is the primary owner or administrator of the payment reform program.

<b>Providers</b>	Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities, including ancillary providers.
<b>Quality/Quality Components</b>	A payment reform program that incentivizes, requires, or rewards some component of the provision of safe, timely, patient centered, efficient, and/or equitable health care.
<b>Reporting Period</b>	Reporting period refers to the time period for which the Plan should report all of its data. Unless otherwise specified, reporting period refers to calendar year (CY) 2012. If sufficient information is not available to complete this RFI based on the calendar year, the Plan may elect to report for the time period October 1, 2011 to September 30, 2012. If this election is made, ALL answers to this question should reflect the adjusted reporting period unless otherwise noted e.g., in the payment reform questions. If reporting period is not CY 2012, and October 1, 2011 to September 30, 2012 was used, Plan should interpret "prior calendar year" in the text and tables to be October 1, 2010 to September 30, 2011.
<b>Shared savings</b>	Provides an incentive for providers or provider entities to reduce <u>unnecessary</u> health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared-savings programs can be based on a FFS payment system. Shared Savings can be applied to some or all of the services that are expected to be used by a patient population and may vary based on provider performance.
<b>Shared-risk</b>	Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets; examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of this data collection, shared-risk programs that include shared-savings should only be included in the shared-risk category (e.g. includes both upside and downside risk). Shared-risk programs can be based on a FFS payment system.
<b>Specialists</b>	Specialist physicians have a recognized expertise in a specific area of medicine. They have undergone formal residency and/or fellowship training programs and have passed the specialty board examination in that field. Examples include oncologists, ENTs, cardiologists, OB-GYNs etc. For the purposes of this data collection, specialists are not PCPs. See definition of "primary care physicians."