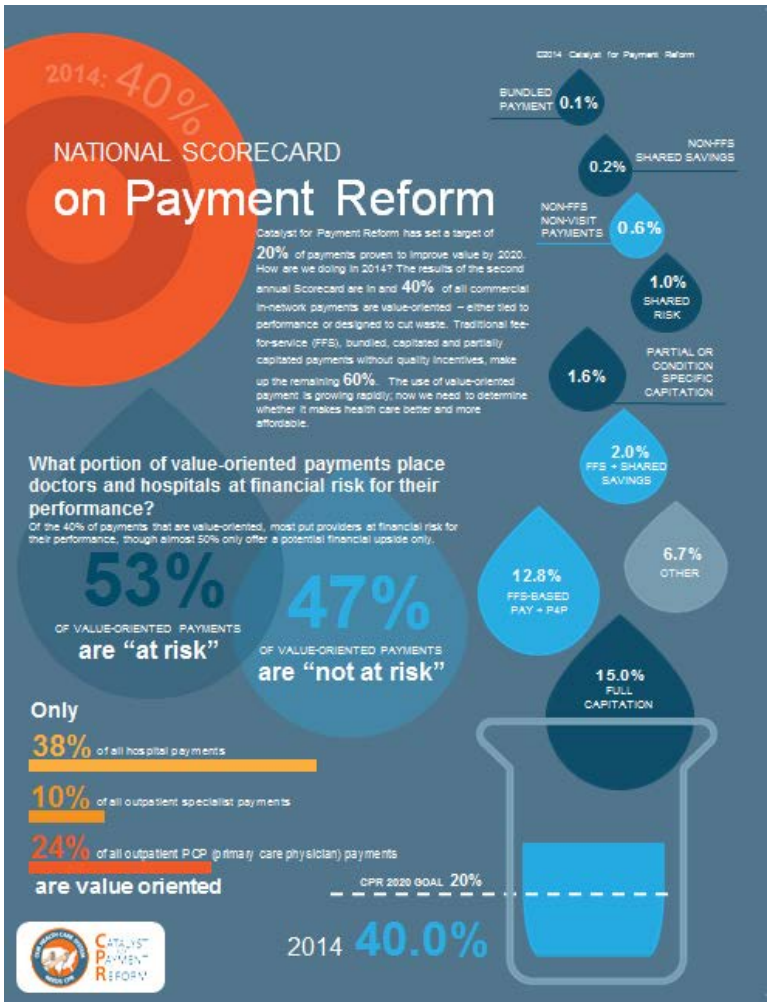
2014 National Scorecard on Payment Reform: Methodology



Section 1: 2014 National Scorecard on Payment Reform General Methodology

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General Methodology

Scorecard Metrics:

In 2013-2014, 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 (see page 5).

The National 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. that include 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 members attributed to a particular provider 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 – This metric on transparency tools gauges important payment reform-related activity, though it does not measure the use of new payment methods themselves.
6) Quality Indicator – The all-cause readmissions measure is 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 2014 National 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 2014 eValue8 RFI. Where possible, we used existing eValue8 questions and definitions, 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 incentive portion of the payment when quality and efficiency measures are met.

Data Source:

All data in the National Scorecard on Payment Reform come from health plans. In 2014, 39 health plans responded to the eValue8 RFI. These 39 plans represent approximately 101 million covered lives in the commercial group market, which is approximately 65 percent of total commercially-insured lives in the U.S. (a total of 156 million Americans under age 65 have employer-based coverage and 19 million have individual coverage).[1] Based on their commercial market share, four out of the top five health plans and seven out of the top 15 health plans are represented in the Scorecard.[2] 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 questions. Additionally, from 2013 to 2014 there was some turnover in the health plans that participated so the health plan sample is not identical from year to year. However, the Scorecard is the most comprehensive and current snapshot of health plan payment reform activity occurring in the commercial market. See Scorecard Metrics Methodology for additional information.

eValue8's instructions informed participating health plans that their responses to certain questions would be used to populate the National 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 health plans responding to eValue8 and the questions on payment reform appear to be, on average, larger than the average health plan in the U.S. As a result, the Scorecard results may not be representative of the health plan industry as a whole as respondents may be more capable of implementing new forms of payment than their smaller peers. The results also include data from HMOs, which could impact the findings.

Limitations:

1) Health plan participation: While eValue8 is the only national health plan RFI and captures 65% of the commercial covered lives in the U.S., it does not have participation by 100% of health plans in the U.S. Furthermore, health plan participation in eValue8 is voluntary. As a result, the Scorecard findings may be biased by self-selection in which health plans that are actively pursuing payment reform are more likely to respond to the payment reform questions, driving the results upwards. In addition, from 2013 to 2014 there was some turnover in the health plans that participated, resulting in somewhat different pools of respondents. For specific information

[1] Employee Benefits Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey" September 2013, p.4. Available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf

[2] Citi Research, April 8, 2014. Based on commercial market share.

about the number of plans included in the numerator and denominator for each Scorecard metric, please see the Metric Methodology that follows.

2) Geography: While several of the nation's largest health plans, which span significant geographies, provided data for their entire commercial business, health plan participation in eValue8 is also influenced by whether NBCH's member business coalitions ask plans to submit data about their markets. Therefore, responses can concentrate on certain geographic areas and not others. This year, seven NBCH business coalitions[3] requested health plan participation.
3) Health plan data systems: Some health plans reported challenges with reporting payment dollars in the Scorecard's specific categories due to limitations with their data systems.

[3] Colorado Business Group on Health, HealthCare 21, Memphis Business Group on Health, Mid-Atlantic Business Group on Health, Northeast Business Group on Health, Pacific Business Group on Health, and the Washington Health Alliance.

Metric Methodology

Metric	Numerator	Denominator	Method for Calculating and Reporting the Metric
Dollars under the status quo: Percent of total dollars paid through traditional FFS payment and other methods devoid of quality metrics in CY 2013 or most recent 12 months.	Total dollars paid to providers tied to contracts that contain only traditional FFS payments in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage 27 plans contributed data to calculate this metric.
	Total dollars paid to providers through bundled payment programs without quality in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	
	Total dollars paid to providers through partial or condition-specific capitation without quality in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	
	Total dollars paid to providers through fully capitated programs without quality in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	

Dollars in shared-risk with quality programs: Percent of total dollars paid through shared-risk with quality programs in CY 2013 or most recent 12 months.	Total dollars paid to providers in CY 2013 or most recent 12 months through shared-risk programs with quality.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in FFS-based shared-savings with quality programs: Percent of total dollars paid through FFS-based shared-savings with quality programs in CY 2013 or most recent 12 months.	Total dollars paid to providers in CY 2013 or most recent 12 months through FFS-based shared-savings with quality programs.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in non-FFS-based shared-savings with quality programs: Percent of total dollars paid through non-FFS-based shared-savings with quality programs in CY 2013 or most recent 12 months.	Total dollars paid to providers in CY 2013 or most recent 12 months through non-FFS-based shared-savings with quality programs.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.

Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P programs in CY 2013 or most recent 12 months.	Total dollars paid to providers in CY 2013 or most recent 12 months through FFS plus P4P programs.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in fully capitated arrangements with quality (global payment): Percent of total dollars paid through fully capitated payments with quality components in CY 2013 or most recent 12 months.	Total dollars paid to providers through full capitation with quality components in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in partial or condition-specific capitation with quality: Percent of total dollars paid through partial or condition-specific capitation with quality components in CY 2013 or most recent 12 months.	Total dollars paid to providers through partial or condition-specific capitation with quality components in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.

Dollars in bundled payment programs with quality: Percent of total dollars paid through bundled payment programs with quality in CY 2013 or most recent 12 months.	Total dollars paid to providers through bundled payment programs with quality in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in atypical payments to providers: Percent of total dollars paid through FFS-based payment methods for non-visit functions in CY 2013 or most recent 12 months.	Total dollars paid for FFS-based non-visit functions in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Dollars in atypical payments to providers: Percent of total dollars paid through non-FFS-based payment methods for non-visit functions in CY 2013 or most recent 12 months.	Total dollars paid for non-FFS based non-visit functions in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.

Dollars in other types of performance-based contracts: Percent of total dollars paid through other types of performance-based incentive programs in CY 2013 or most recent 12 months.	Total dollars paid for other types of performance-based incentive programs in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Payment reform - Rebalancing payments to primary care: Share of total dollars paid to primary care physicians versus specialists.	Total dollars paid to primary care physicians in CY 2013 or most recent 12 months.	Total dollars paid to primary care physicians and specialists in CY 2013 or most recent 12 months.	Roll-up metric showing distribution of payments to primary care physicians versus specialists. 25 plans contributed data to calculate this metric.
	Total dollars paid to specialists in CY 2013 or most recent 12 months.	Total dollars paid to primary care physicians and specialists in CY 2013 or most recent 12 months.	
Payment reform – Non-FFS payment with quality: Percent of non-FFS payments that include a quality component.	Total non-FFS dollars paid that include a quality component.	Total non-FFS dollars paid.	Roll-up metric displayed as a percentage (numerator divided by denominator) 27 plans contributed data to calculate this metric.

Payment reform - Non-FFS payment without quality: Percent of non-FFS payments that do not include a quality component.	Total non-FFS dollars paid that do not include a quality component.	Total non-FFS dollars paid.	Roll-up metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Payment reform penetration - Dollars: Percent of total dollars paid through "payment reform programs" in CY 2013 or most recent 12 months.	Total dollars paid to providers through payment reform programs in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for commercial members in CY 2013 or most recent 12 months.	Roll-up metric based upon the distribution of payment reform models. 27 plans contributed data to calculate this metric.
Payment reform penetration - Plan members: Percent of commercial, in-network plan members attributed to a provider participating in a payment reform contract in CY 2013 or most recent 12 months.	Total number of commercial, in-network health plan members attributed to a provider with a payment reform program contract in CY 2013 or most recent 12 months.	Number of commercial, in-network health plan members enrolled in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Payment reform penetration - Primary care physicians: Percent of total dollars paid to primary care physicians through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to primary care physicians through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to primary care physicians in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 25 plans contributed data to calculate this metric.

Payment reform penetration - Specialists: Percent of total dollars paid to specialists through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to specialists through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to specialists in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 25 plans contributed data to calculate this metric.
Payment reform penetration - Hospital (in-patient): Percent of total dollars paid to hospitals (in-patient) through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to hospitals (in-patient) through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to hospitals (in-patient) in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 27 plans contributed data to calculate this metric.
Steps to payment reform - Breadth of member support tools: Percent of health plans that offered key value-oriented information within their member support tools in CY 2013 or most recent 12 months.	Total number of health plans that offered each of the following elements in CY 2013 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.). One numerator for each.	Total number of health plans that provided member support tools in CY 2013 or most recent 12 months.	Multiple metrics displayed as percentages (each numerator divided by the denominator). 39 plans contributed data to calculate this metric.
Readmission rate: 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.	Number of observed acute readmissions for any diagnosis within 30 days, for members 18 years of age and older.	Total number of acute inpatient stays during the measurement year.	Single metric displayed as a percentage (numerator divided by denominator). 39 plans contributed data to calculate this metric.

2014 National Scorecard Payment Reform Definitions

Terms	Definition
Attribution	Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purpose 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, PCMH, or other delivery models in which patients are attributed to a provider with any payment reform contract. 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.
Bonus payments based on measures of quality and/or efficiency	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. Bonus payments can include programs that pay providers lump sum payments for achieving performance targets (quality and/or efficiency metrics). Bonus payments can also include payments tied to a provider's annual percentage increase in FFS payments based on their achievement of performance metrics. Bonus payments do NOT include payments made under shared savings arrangements that give providers an increased share of the savings based on performance.
Bundled payment	Also known as "episode-based payment," bundled payment means a single payment to providers or healthcare facilities (or jointly to both) for all 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.
Condition-specific capitation	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.
Dollars paid	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 when performance was measured). For example, incentive payments that were paid in calendar year 2013 for performance in calendar year 2013 should be reported. Claims for 2013 services that are in adjudication and not yet paid during the reporting period should not be included in this response.
Episode-based payment	See definition for "bundled payment."
FFS-based payment	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. For the purposes of the CPR Scorecard, DRGs, case rates, and per diem hospital payments are considered FFS-based payment.
Full capitation with quality	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 (quality, safety, and efficiency) and patient risk. Includes quality of care components with pay-for-performance. Full capitation on top of which a quality bonus is paid (e.g. P4P) is considered full capitation with quality.
Full capitation without quality	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, such as quality, safety, and efficiency.
Hospital-physician gainsharing	Arrangement in which hospitals and physicians share the cost savings achieved through collaborative efforts resulting in improved quality and/or efficiency.
Member support tools	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).

Non-FFS-based payment	Payment model where providers receive payment not based on the FFS payment system or not tied to a FFS fee schedule (e.g. bundled payment, full capitation).
Non-visit function	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.
Partial capitation	A fixed dollar payment to providers for specific services (e.g. payments 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.
Past year (in definition for dollars paid)	Means calendar year 2013 or the most current 12 month period for which the health 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."
Pay-for-performance	Provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and potentially also for reducing costs. Incentives are typically paid on top of fee-for-service payment models. The financial incentive payment that is given for achieving certain performance levels is sometimes also referred to as a bonus payment. See "bonus payment" definition.
Payment reform	Refers to a range of health care payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.
Plan members	Health plan's enrollees or plan participants.
Primary care physicians	A primary care physician is a generalist physician who provides care to patients at the point of first contact and takes continuing responsibility for managing 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."
Primary care services	Refers to the services a patient receives at first contact with the health care system, usually involving coordination of care and continuity across providers and settings over time. Primary care services include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care services area performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. There are providers of health care other than physicians who render some primary care services; such as nurse practitioners, physician assistants and some other health care providers. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services and involves effective communication with patients and encourages the role of the patient as a partner in health care.
Program sponsor	Entity that is the primary owner or administrator of the payment reform program.
Providers	Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities, including ancillary providers.
Quality/quality components	The component of a payment reform program that incentivizes, requires, or rewards the provision of safe, timely, patient centered, effective, efficient, and/or equitable health care.
Reporting period	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) 2013. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of calendar year 2013, the plan may elect to report for the time period on the most recent 12 months with sufficient information and note the time period in the "Other Information section at the end of Provider Module" in eValue8 2014. If this election is made, ALL answers on payment dollar questions for CY 2013 should reflect the adjusted reporting period.

Shared-risk	Refers to arrangements in which providers accept some financial liability for not meeting specified financial targets. It may also include arrangements in which providers accept some financial liability for not meeting specified quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; and, withholds that are retained and adjustments to fee schedules. For the purposes of this data collection, shared-risk programs that include shared-savings as well as downside risk should only be included in the shared-risk category. Shared-risk programs are based on a FFS payment system and for the purposes of the CPR Scorecard, shared risk does not include bundled payment, full capitation, or partial or condition-specific capitation.
Shared savings	Provides an upside-only financial incentive for providers or provider entities to reduce unnecessary 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. It may also include arrangements in which providers may share in savings only after meeting specified quality targets. "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 will vary based on provider performance.
Specialists	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."