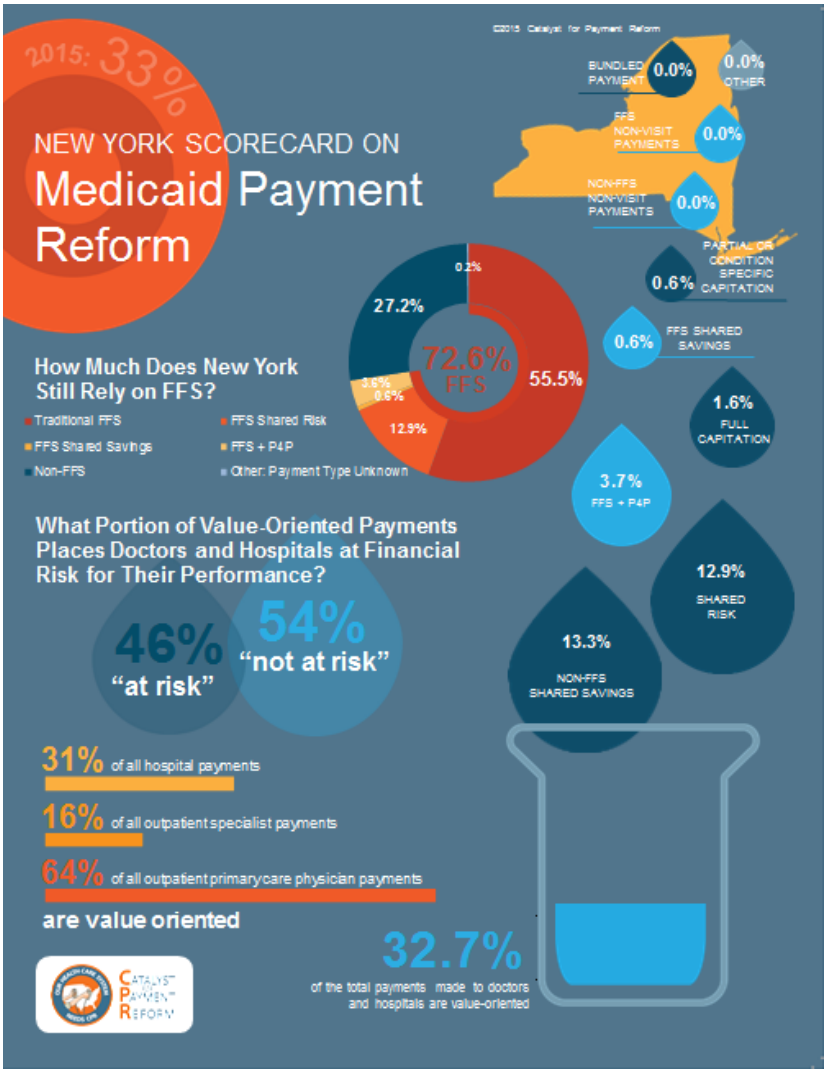
2015 New York Scorecard on Medicaid Payment Reform: Methodology



Background

Payment reform is a powerful strategy to improve the value of health care; thus we need to assure that fundamental changes to payment take hold in both the public and private sectors and expand over time.

Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S. CPR provides thought leadership to and coordination among large health care purchasers, including the large private employers and state Medicaid, employee and retiree agencies in its membership. In 2010, CPR set the goal that by 2020 at least 20 percent of payments to doctors and hospitals would be made through payment methods proven to improve the quality and affordability of health care.

In September 2014, CPR issued its second National Scorecard on Payment Reform and California Scorecard on Payment Reform. Through support from The Commonwealth Fund and the California Healthcare Foundation, these Scorecards were the first of their kind in tracking the nation's progress in implementing reforms to health care payment.

The New York State Health Foundation commissioned CPR to prepare a New York Scorecard on Payment Reform, the backbone of which is a survey of New York commercial and Medicaid health plans, with the aim to quantify the different payment reforms occurring in New York. The results of the survey of health plans set a baseline to help track the implementation of payment reform in New York and inform discussions among stakeholders about where New York needs to make further progress.

This document describes the methodology of the underlying research project, entitled "Tracking New York's Progress on Payment Reform."

General Methodology

General Description of the Domains and Metrics in CPR Scorecards on Payment Reform:

During 2012 and 2013, CPR assembled a multi-stakeholder National Advisory Committee, including employers, health plans, providers and payment reform experts, to provide guidance to CPR on how to track the implementation of payment reform, including the scope and definition of payment reform as well as domains of measurement and specific metrics (see page 6).

For the purposes of its Scorecards, CPR 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 original metrics developed by CPR for its National and California Scorecards on Payment Reform (based on commercial health plan data), with input from the National Advisory Committee, fell into six domains:

1) Public Dollars Paid – Health plans reported total dollars paid to providers through Medicaid. The total dollars paid to providers for Medicaid beneficiaries provides the denominator for Domain 2.
2) Characteristics of the Payment Reform Environment – These metrics measure traditional 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, such as whether transparency tools are available to consumers.
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.

New York Methodology

Modifications to Domains and Metrics for the New York Scorecard on Medicaid Payment Reform:

The New York State Health Foundation (NYSHealth Foundation) commissioned CPR to create both a Scorecard on Commercial Payment Reform and a Scorecard on Medicaid Payment Reform.

The "Building Blocks of Payment Reform" (Domain 5) is not currently applicable to the Medicaid sector. As such, CPR did not include this domain and the corresponding metrics related to transparency tools in the survey of New York Medicaid plans.

The NYSHealth Foundation aims to influence broad statewide health care payment reform initiatives and seeks to advance alternative payment methods that move beyond fee-for-service (FFS) arrangements. To create consistency with CPR's National and California Scorecards, CPR calculated the metrics for the New York Scorecards in the same manner. However, CPR added a metric that sums all of the payment methods that are based on FFS to illustrate the continuing role FFS plays in New York State.

Data Collection Survey:

CPR collaborated with the New York State Department of Financial Services (DFS) to collect data from both Commercial and Medicaid health plans. DFS issued a request for information pursuant to Section 308 of the New York Insurance Law to ensure participation by Medicaid health plans. Plans covering only long-term care services, behavioral health, or services for the dually eligible (Medicaid and Medicare) population were not subject to the mandate. In its request letter to health plans, DFS indicated it would use the CPR metrics as a baseline from which to track each insurer's move from volume- to value-oriented payment over the next five years as planned in New York's Delivery System Reform Incentive Payments (DSRIP) program. The data and results are intended to inform stakeholders about where New York still needs to make progress.

CPR created the 2015 New York Scorecard on Medicaid Payment Reform from data it collected through the National Business Coalition on Health's eValue8 health plan survey platform. The data on value-oriented payment represent the *total* dollars paid through payment reform programs, not just the incentive portion of the payment when health care providers meet quality and efficiency standards.

Data Source and Instructions:

All data in the New York Scorecard on Medicaid Payment Reform come from health plans reporting calendar year 2013 data or the most recent 12 months for which they have data available. Fifteen (15) Medicaid health plans completed the survey. These 15 plans cover approximately 3,989,244 Medicaid beneficiaries in the New York market, which represents virtually all of the Medicaid-insured lives in New York in 2013 that were within the scope of the survey. Although all eligible Medicaid plans reported data, not all plans responded to the metric related to readmissions. Additionally, CPR excluded its standard Scorecard metrics on transparency tools from the Medicaid survey (Domain 5) given that price transparency is not as relevant in the Medicaid sector. However, the 2015 Scorecard is the most

comprehensive and current snapshot of health plan payment reform activity occurring in the Medicaid market in New York. See Scorecard Metrics Methodology for additional information.

The CPR survey instructions informed health plans that it would use their responses to populate a New York Scorecard on Payment Reform for the Medicaid market. The instructions explained that the Scorecard would report plan responses in aggregate. In the case of multi-method payment reform programs, such as a care-coordination fee (defined as non-visit function) combined with pay-for-performance, CPR instructed health plans to report the total amount paid based on the "dominant," or primary, method of payment.

Limitations:

1) Variation in interpretation of metrics: Although CPR clearly defined the categories for payment methods, how each plan interpreted what payment dollars to report in each category may vary. There is a chance that the values plans reported may not represent the exact dollars attributed to each payment reform program due to misclassification of specific programs.
2) Health plan data systems: Some health plans cited challenges with reporting payment dollars in the Scorecard's specific categories due to limitations with their data systems.
3) Health plan participation: CPR included Medicaid health plans operating during 2013 in the data collection process. For the purposes of this analysis, we excluded plans exclusively offering long-term care coverage, dual coverage (both Medicaid and Medicare), or behavioral health coverage. Additionally, although all eligible Medicaid health plans reported data, not all health plans responded to all of the questions. For the number of plans included in the calculation of each Scorecard metric, please see the Metric Methodology that follows.

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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage. 15 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 Medicaid 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 Medicaid 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 Medicaid 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 plans contributed data to calculate this metric.

Dollars in P4P programs: Percent of total dollars paid through FFS plus Pay-for-Performance (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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 fully capitated payments with quality components in CY 2013 or most recent 12 months.	Total in-network dollars paid to providers for Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 plans contributed data to calculate this metric.
Dollars in FFS-based non-visit function 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 plans contributed data to calculate this metric.
Dollars in non-FFS non-visit function 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 plans contributed data to calculate this metric.
Dollars in FFS programs: Percent of total dollars paid through all FFS-based programs (value-or not-value-oriented).	Total dollars paid through all FFS-based programs in CY 2013 or most recent 12 months. Summation of previous FFS-based metrics, including status-quo, traditional FFS.	Total in-network dollars paid to providers for Medicaid members in CY 2013 or most recent 12 months.	Multiple metrics displayed as percentages of total in-network dollars paid to providers based on FFS. 15 plans contributed to 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. 15 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) 15 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). 15 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 Medicaid members in CY 2013 or most recent 12 months.	Roll-up metric combining all payment reform models. 15 plans contributed data to calculate this metric.
Payment reform penetration - Plan members: Percent of Medicaid members attributed to a provider participating in a payment reform contract in CY 2013 or most recent 12 months.	Total number of Medicaid members attributed to a provider with a payment reform program contract in CY 2013 or most recent 12 months.	Number of Medicaid members enrolled in CY 2013 or most recent 12 months.	Single metric displayed as a percentage (numerator divided by denominator). 15 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). 15 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). 15 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). 15 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. National Commission for Quality Assurance (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). 7 plans contributed data to calculate this metric.

Definitions for the 2015 New York Scorecards on Payment Reform

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 accountable care organization (ACO), patient centered medical home (PCMH), or other delivery models in which patients are attributed to a provider with a payment reform contract. For the purposes of CPR's Scorecards, attribution is for Commercial (self-funded and fully-insured) lives and Medicaid beneficiaries only. It does NOT include Medicare Advantage 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 Medicaid health home payments or payments made to PCMH's that have received NCQA accreditation (see "non-visit function") or payments made under shared savings arrangements that give providers an increased share of the savings based on performance (see "shared savings").
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 of when performance was measured). For example, incentive payments that were paid in calendar year 2013 for performance in calendar year 2012 should be reported. Claims for 2013 services that are in adjudication and not yet paid during the reporting period should not be included.
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, Diagnosis Related Groups (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.
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). This term and definition do not apply to CPR's New York Scorecard on Medicaid Payment Reform.

Non-FFS-based payment	Payment model where providers receive payment not based on the FFS payment system and 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. For the purposes of this data collection, health home payments and payments for NCQA accreditation for achieving PCMH status made under the Medicaid program are classified as non-visit functions.
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 health 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 the quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment. 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 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."
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 are 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	A payment reform program that incentivizes, requires, or rewards some component of 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 health 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 health 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; 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. "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, renal care specialists, etc. For the purposes of this data collection, specialists are not PCPs. See definition of "primary care physicians."