



2013 NATIONAL SCORECARD ON

Commercial Payment Reform 2.0

2019 UPDATE

METHODOLOGY REPORT

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Background

Since the early 2010s, changing how the United States health care system pays for health care has been a leading strategy to improve the quality of care and control health care costs. The Commonwealth Fund's January 2013 report, "[Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System](#)" identified provider payment reforms to promote value and accelerate delivery system innovation as one of the three strategies to stabilize spending growth, laying out specific policies to advance this area, such as the implementation of payment reforms across markets, with public and private payers working in concert.

To track progress in this area, Catalyst for Payment Reform (CPR), an independent non-profit working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace, set out to create the first national mechanism to track the implementation of payment reform. As the first step in the process, CPR convened a national advisory committee of employers, health plans, providers and payment reform experts in 2012 to provide guidance on the scope and definition of payment reform methods the first ever methodology for scoring progress on payment reform implementation. Grants from the Commonwealth Fund and the California HealthCare Foundation supported this work, culminating in the release of the 2013 National Scorecard on Commercial Payment Reform in March of 2013. The results set a baseline for the implementation of payment reform nationally. The [Washington Post](#), [USA Today](#), and [ModernHealthcare](#) covered the release.

In 2018, CPR evolved its approach with **Scorecard 2.0**. Scorecard 2.0 continues to measure how much payment reform there is and of what type. But 2.0 also examines 12 additional metrics to help shed light on whether payment reform correlates with improved health care quality and affordability across the health care system. CPR piloted Scorecard 2.0 at the state-level following a request for proposal process to select states interested in creating a baseline upon which to track future payment reform implementation. In December of 2018, CPR received a grant from the Robert Wood Johnson Foundation to apply the 2.0 approach to measuring what progress there has been with the implementation of payment reform and its impact on the health care system and consumers since CPR began tracking it. As part of this effort, CPR is updating the original 2013 National Scorecard with the 2.0 methodology.

This document describes the methodology for the data collection and analysis of *the 2013 National Scorecard on Commercial Payment Reform 2.0 - Updated*.

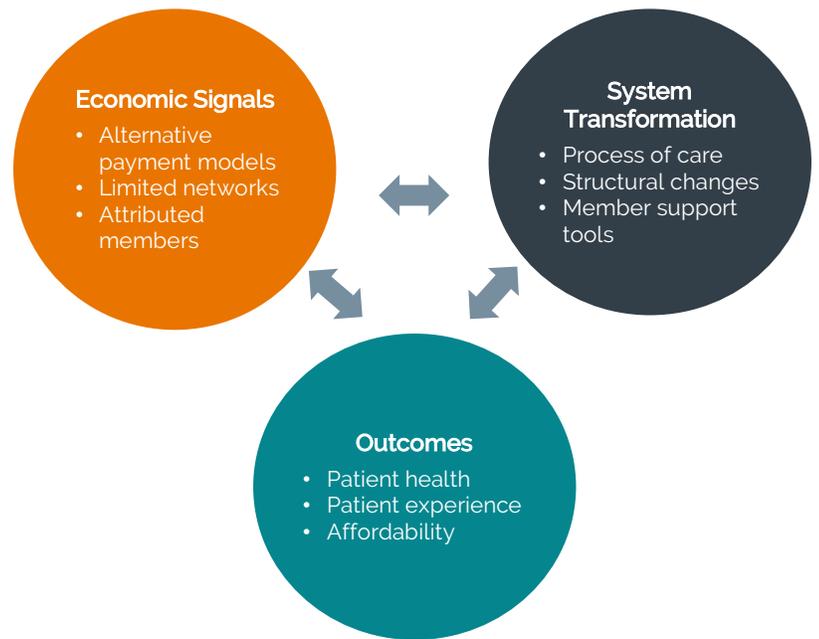
Methodology

General description of the domains and metrics in CPR's Scorecard on Payment Reform 2.0

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.”

Scorecard 2.0 Measurement Framework

For Scorecard 2.0, CPR adopted a non-linear framework that recognizes the complex interplay of factors within health care. The framework includes three domains: Economic Signals, System Transformation, and Outcomes. Some metrics span across domains, and the placement of metrics into specific domains is only intended to help group them.



The first domain, Economic Signals, includes the original Scorecard metrics that assess how much provider payment is flowing through each payment type.

CPR created these metrics in 2012 in preparation for executing the first National (2013) and California Scorecards (2013). The 1.0 metrics quantify the following health plan characteristics in three areas:

- 1) Dollars in Payment Reform Methods and Status Quo – These metrics measure the dollars flowing through payment reform methods, such as shared savings, shared risk, capitation, bundled payment, etc. that have quality components, as well as the status quo payment methods, like traditional fee-for-service, other legacy payments such as case rates, and other methods devoid of quality components.
- 2) Attributed Members – This metric gauges the volume of patients treated by providers with payment reform contracts. The percentage of patients impacted by payment reform contracts is calculated by counting members *attributed* to a particular provider.
- 3) Provider Participation – These metrics show the proportion of payments (in-network and out-of-network) made to hospitals and providers that is value-oriented.

The second domain, System Transformation, addresses the ways in which health plans and health care providers respond to Economic Signals. This response can be structural (e.g., offering online member support tools) or process-oriented (e.g., making sure every person with diabetes receives at least one HbA1c test annually).

The third domain, Outcomes, includes measures that track whether changes in the first two domains lead to the intended results in health care quality and cost. Outcomes include clinical

results (such as the rate of hospital-acquired pressure ulcers) and patient-reported results (such as health-related quality of life).

When selecting the metrics to include in 2.0, CPR contracted with Discern Health and received input from a new multi-stakeholder national advisory committee. The multi-stakeholder advisory committee included employers, health plans, providers, and payment reform experts, and provided guidance on criteria for inclusion which metrics most aptly met certain. The Advisory Committee used the following criteria to guide the metric selection process:

- 1) Balance: the metrics should be balanced across populations (e.g., chronically ill vs. acutely ill), care settings (e.g., inpatient vs. outpatient), and measure domains (roughly equal numbers of metrics within each of the three domains);
- 2) Volume: the metrics should capture system performance for large numbers of patients and for which there are significant cost implications;
- 3) "Leading Indicator" status: the chosen measures should be indicators of broader changes in health care;
- 4) Feasibility: data must be available at the state-level and should strive to align with other data collection efforts;
- 5) Parsimony: the number of metrics is potentially unlimited. The goal of the Scorecard is to provide an overview of health system change; a limited number of relevant measures can achieve this goal.

Based on these considerations, CPR selected the Scorecard 2.0 metrics (see [Section 4](#)). As a proof of concept, CPR piloted the 2.0 methodology in Colorado, New Jersey, and Virginia in 2018.

Data collection:

CPR collaborated with National Alliance of Health Care Purchaser Coalitions (formerly National Business Coalition on Health) to use data collected through its eValue8 health plan survey, an annual 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 the National Alliance worked collaboratively to add the payment reform questions needed to populate the Scorecard to the 2013 eValue8 RFI. Where possible, the two organizations used existing eValue8 questions and definitions, and developed or added definitions as 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.

All payment reform data in the National Scorecard on Payment Reform came from health plans. In 2013, 57 health plans responded to the eValue8 RFI. These 57 plans represented

approximately 104 million covered lives in the commercial market, which was approximately 67 percent of total commercially-insured lives in the US.¹ (In 2012, a total of 155 million Americans under age 65 had employer-based coverage and 18 million had individual coverage).² Based on their commercial market share in 2012, three out of the top five health plans and six out of the top 15 health plans were represented in the Scorecard.³ Again, participation in eValue8 is voluntary and, as such, not all health plans participated and not all health plans responded to every question. 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 have been more capable of implementing new forms of payment than their smaller peers. The results also include data from HMOs, which could impact the findings.

For the data points that are not specific to the dollars flowing through different payment methods, CPR sourced the majority of the metrics in the System Transformation and Outcomes domains from publicly available sources. CPR worked with national organizations who own and/or publish data. Specifically, CPR obtained four Healthcare Effectiveness Data and Information Set (HEDIS®)⁴ metrics via a custom data request to the National Committee of Quality Assurance (NCQA). CPR sourced two metrics from the Commonwealth Fund [Scorecard on Health System Performance Data Center](#), a publicly-available resource that tracks the movement of 40+ state-level benchmarks overtime. The two Commonwealth metrics featured in this Scorecard include one metric from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS),⁵ and one metric from the National Immunization Survey (NIS).

¹ The representativeness of the data cited here is based on sources used by CPR when the Scorecard was originally published in 2013- see Employee Benefits Research Institute source below. However, this source is no longer accessible. Using an updated source from the Henry J. Kaiser Family Foundation, 104 million covered lives represents approximately 63% of commercially-insured population in 2012. Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2017, Available at: <https://www.kff.org/other/state-indicator/total-population/> Accessed on March 6, 2019.

² Employee Benefits Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey" September 2012, p.5. Available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2012_No376_Sources1.pdf

³ National Association of Insurance Commissioners and Citi Research.

⁴ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

⁵ HCAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). See section 7 for Notice of Disclaimer & Copyright Information.

Modifications to Metrics for the Updated 2013 National Scorecard on Commercial Payment Reform:

CPR created the 1.0 metrics in 2012 and updated them in 2015 while creating Commercial and Medicaid Scorecards on Payment Reform for New York. CPR made the following minimal modifications in preparation for updating the 2013 National Scorecard:

- Similar to CPR's New York Scorecards on Payment Reform and the 2018 state Scorecards on Payment Reform 2.0, CPR added a metric that sums all of the value-oriented payment methods that are built on top of Fee-For-Service (FFS) to illustrate the role FFS plays as the base for payment methods such as shared savings, pay-for-performance, among others.
- To focus on payment arrangements that include quality components, CPR opted to not republish the Payment Reform - Non-FFS Payment without Quality metric in the 2019 update of the National Scorecard on Payment Reform.
- To reflect the evolving nature of payment reform activity, CPR stopped delineating between Non-FFS Shared Savings and FFS-based Sharing Savings as separate payment methods. Based on the reality of what CPR has found in the marketplace, CPR now categorizes shared savings payment methods as exclusively FFS-based.
- Whereas the 2013 National Scorecard on Payment Reform sourced the NCQA Plan All Cause Readmissions (PCR) measure from plan responses to the eValue8 RFI, CPR has replaced the original result for this metric by reporting results from a custom analysis provided directly by NCQA. See definition on page 10 for more information.
- Given that The Leapfrog Group began publicly reporting the Nulliparous, Term, Singleton in Vertex Position Cesarean Birth Rate only in 2015,⁶ CPR was unable to source a national figure for this measure reflective of data from calendar year 2012.

Limitations:

Health plan participation:

While eValue8 was the only national health plan RFI in 2013 and captured 67% of the commercial covered lives in the US, it did not have participation by 100% of health plans in the US, and not every participating health plans responded to every RFI question. For the number of plans included in the numerator and denominator for each Scorecard metric, see the Metric Methodology that follows. The Scorecard findings may also be biased by self-selection -- health plans actively pursuing payment reform may be more likely to respond to the payment reform questions, which could bias the results.

⁶ The Leapfrog Group, Maternity Care Report 2019. Available at: <https://www.leapfroggroup.org/maternity-care-report-2019>. Accessed November 13, 2019.

Potential Variation in the Interpretation of the Metrics:

CPR and the National Alliance worked to facilitate consistent interpretation of the metrics by health plans through offering precise definitions, training sessions, written instructions, and discussions with individual health plans seeking clarification. However, interpretation of the metrics could still vary across health plans. Additionally, the same health plan may have interpreted the metrics differently over the different years of data collection due to staffing changes.

Geography:

While several of the nation's largest health plans that span significant geographies provided data for their entire commercial business, health plan participation in eValue8 is influenced also by whether the National Alliance's member business coalitions ask health plans to submit data for their markets. Therefore, responses can concentrate on certain geographic areas and not others. For eValue8 2013, five business coalitions requested health plan participation; some business coalitions opt to request health plan participation every other year. In 2013, most responses came from the West (34%) and the East (29%).

Verification of Self-Reported Data:

The process of collecting and analyzing data included efforts to ensure consistent and accurate reporting; however, due to resource and time restraints, there were no audits or other processes to verify the data.

Health Plan Data System Challenges:

Some health plans stated that they had data system challenges with reporting payment dollars according to the defined payment methods — for many, it was a manual process to develop new system queries and sort data. Such data system limitations can also result in health plans drawing from slightly different periods of time to report their data.

Populations Represented in Data:

While CPR only selected metrics that capture large populations of patients and families, it should be noted that the populations represented by each metric vary. Additionally, CPR does not draw a causal relationship between the payment methods in use in 2012 and the results on the metrics that assess health care quality and affordability in 2012.

Metrics

Scorecard on Payment Reform Metrics, originally developed by Catalyst for Payment Reform in 2013 ("1.0 Metrics")

METRIC	NUMERATOR	DENOMINATOR
<p>Payment reform penetration - dollars: Percent of total dollars paid through value-oriented payment reform programs in CY 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through payment reform programs (with quality) in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>Dollars under the status quo: Percent of total dollars paid through legacy (traditional) FFS payment and other methods devoid of quality metrics in CY 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through contracts that do not contain quality components (e.g., Legacy fee-for-service, Diagnosis Related Groups (DRGs), case rates, per diem hospital payments, bundled payment without quality, etc.) in CY 2012	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>Dollars in shared risk with quality programs: Percent of total dollars paid through shared risk with quality programs in CY 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through shared risk programs with quality in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>Dollars in shared savings with quality programs: Percent of total dollars paid through shared savings with quality programs in CY 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through shared savings with quality programs in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>Dollars in bundled payment programs with quality: Percent of total dollars paid through bundled payment programs with quality in CY 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through bundled payment programs with quality in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>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 2012 or most recent 12 months.</p> <p>21 plans contributed data to calculate this metric</p>	Total dollars paid to providers through partial or condition-specific capitation with quality components in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.
<p>Dollars in fully capitated arrangements with quality (global payment): Percent of total dollars paid through fully capitated payments with quality components in CY 2012 or most recent 12 months.</p>	Total dollars paid to providers through fully capitated payments with quality components in CY 2012 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Dollars in pay-for-performance programs: Percent of total dollars paid through pay-for-performance (P4P) programs in CY 2012 or most recent 12 months.

Total dollars paid to providers through FFS plus Pay-For-Performance programs in CY 2012 or most recent 12 months.

Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Dollars in non-visit function payments to providers: Percent of total dollars paid for non-visit functions in CY 2012 or most recent 12 months.

Total dollars paid for non-visit functions in CY 2012 or most recent 12 months.

Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.

21 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 2012 or most recent 12 months that were not captured in previous questions.

Total dollars paid for other types of performance-based incentive programs in CY 2012 or most recent 12 months that were not captured in previous questions.

Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Value-oriented dollars that are not based on fee-for-service: Percent of value-oriented dollars paid through payment reform with quality programs that are not based on fee-for-service.

Total dollars paid to providers through payment reform methods categorized as non-FFS, including: bundled payment, full capitation, partial or condition-specific capitation, and payment for non-visit functions.

Total dollars paid to providers through payment reform programs (with quality) in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

At risk value-oriented dollars: Percent of value-oriented dollars paid through payment reform with quality programs that place doctors and hospitals at financial risk for their performance.

Total dollars paid to providers through bundled payment, partial or condition specific capitation, full capitation, or shared risk programs that are value-oriented (with quality).

Total dollars paid to providers through payment reform programs (with quality) in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Not at risk value-oriented dollars: Percent of value-oriented dollars paid through payment reform with quality programs that DO NOT place doctors and hospitals at financial risk for their performance.

Total dollars paid to providers through shared savings, pay-for-performance, non-visit functions, and other types of performance-based contracts are value-oriented (with quality).

Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Payment reform - Balancing payments to primary care: Total dollars paid to Primary Care Providers and Specialists (outpatient and inpatient) for all commercial members in CY 2012.

Total dollars paid to primary care providers (outpatient and inpatient) in CY 2012 or most recent 12 months.

Total dollars paid to primary care providers and specialists (outpatient and inpatient) in CY 2012 or most recent 12 months.

21 plans contributed data to calculate this metric

Total dollars paid to specialists (outpatient and inpatient) in CY 2012 or most recent 12 months.

<p>Attributed members: Percent of 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 health plan members attributed to a provider with a payment reform program contract in CY 2012 or most recent 12 months (reported as member months).</p>	<p>Total number of health plan members enrolled in CY 2012 or most recent 12 months.</p>
<p>35 plans contributed data to calculate this metric</p>		
<p>Provider participation - Primary care providers: Percent of total dollars paid to primary care providers through payment reform programs (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid (or percent of dollars) to primary care providers through payment reform programs (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to primary care providers (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>
<p>21 plans contributed data to calculate this metric</p>		
<p>Provider participation - Specialists: Percent of total dollars paid to specialists through payment reform programs (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid (or percent of dollars) to specialists through payment reform programs (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to specialists (outpatient and inpatient) in CY 2012 or most recent 12 months.</p>
<p>21 plans contributed data to calculate this metric</p>		
<p>Provider participation - Hospitals (in-patient): Percent of total dollars paid to hospitals (inpatient) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid (or percent of dollars) to hospitals (inpatient) through payment reform programs in CY 2012 or most recent 12 months.</p>	<p>Total dollars paid to hospitals (inpatient) in CY 2012 or most recent 12 months.</p>
<p>21 plans contributed data to calculate this metric</p>		
<p>Transparency Metrics: Percent of health plans that offered key value-oriented information within their member support tools in CY 2012 or most recent 12 months. Multiple metrics displayed as percentages (each numerator divided by the denominator).</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.), users of 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>57 plans contributed data to calculate this metric.</p>		

Other metrics, selected by Catalyst for Payment Reform in 2017 ("2.0 Metrics")

All-Cause Readmissions (National risk adjusted readmission rate derived from the Plan All-Cause Readmissions: Observed-to-Expected Ratio) [NQF 1768]: The national risk adjusted readmission rate, derived from the Observed-to-Expected Ratio of hospital admissions that are readmissions for any diagnosis within 30 days of discharge for commercially covered members 18-64 years

of age, captures the percent of hospitalizations that are followed by another hospitalization within 30 days based on the nations' case mix (combined results of HMO & PPO plans). NCQA, Custom Analysis, Reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered

trademark of the National Committee for Quality Assurance (NCQA).

Childhood Immunizations: Children ages 19-35 months who received all recommended doses of seven vaccines: 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP/DT/DTP) vaccine; at least 3 doses of poliovirus vaccine; at least 1 dose of measles-containing vaccine (including mumps-rubella (MMR) vaccine); the full series of Haemophilus influenzae type b (Hib) vaccine (3 or 4 doses depending on product type); at least 3 doses of hepatitis B vaccine (HepB); at least 1 dose of varicella vaccine, and at least 4 doses of pneumococcal conjugate vaccine (PCV). A metric from the National Immunization Surveys (NIS). Carla L. Black, PhD, David Yankey, MS, Maureen Kolasa, MPH, Immunization Services Div, National Center for Immunization and Respiratory Diseases, CDC. Available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6236a1.htm>

Controlling High Blood Pressure (NQF 18): The percentage of commercially covered patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) for members 18-59 years of age and whose BP was <140/90 mm Hg for members 60-85 years of age with a diagnosis of diabetes or whose BP was <150/90 mm Hg for members 60-85 years of age without a diagnosis of diabetes (combined results of HMO & PPO plans). A higher rate indicates better performance. NCQA, Reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a

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HbA1c Poor Control (Diabetes - Hemoglobin A1c Poor Control) (NQF 59): Percent of commercially covered members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year (combined results of HMO & PPO plans). A lower rate indicates better performance. NCQA, Reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HbA1c Testing (Comprehensive Diabetes Care- HbA1c Testing) (NQF 057): Percent of commercially covered members 18 to 75 years of age with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test performed during the measurement year (combined results of HMO & PPO plans). A higher rate indicates better. NCQA, Reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Health-Related Quality of Life: Adults ages 18-64 who report fair/poor health. Analysis of data from the 2012 Behavioral Risk Factor

Surveillance System (BRFSS) (CDC). A lower rate indicates better performance. Analysis conducted in STATA by Emma Wager, Catalyst for Payment Reform, November 2019.

Home Recovery Instructions (Information About Recovery at Home): Proportion of adult patients who responded to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) post-hospitalization that yes, they were given information about what to do during their recovery at home. Summary of HCAHPS Survey Results

[Hcahpsonline.org/HCAHPS_Executive_Insight](http://hcahpsonline.org/HCAHPS_Executive_Insight). [January 2012 -December 2012 Discharges]. Centers for Medicare & Medicaid Services, Baltimore, MD. Accessed on November 13, 2019.

Hospital-Acquired Pressure Ulcers (Hospital-Acquired Stage III & IV Pressure Ulcers): Rate of hospital-acquired stage III & IV pressure ulcers per 1,000 adults. A lower rate indicates better performance. Analysis by AHRQ for the Partnership for Patients (PFP) program. Cited in the online document "Updated Information on the Annual Hospital-Acquired Condition Rate: 2011 and 2012." Content last reviewed January 2018. Agency for Healthcare Research and Quality, Rockville, MD.

<https://www.ahrq.gov/hai/pfp/hacrate2011-12.html> Accessed October 31, 2019

Preventable Admissions (Prevention Quality Overall Composite, Prevention Quality

Indicator (PQI) 90): PQI overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection. A lower rate indicates better performance. Analysis by Fingar KR (Truven Health Analytics), Barrett ML (M.L. Barrett, Inc.), Elixhauser A (AHRQ), Stocks C (AHRQ), Steiner CA (AHRQ) of HCUP State Inpatient Databases (SID) data. *Trends in Potentially Preventable Inpatient Hospital Admissions and Emergency Department Visits*. HCUP Statistical Brief #195. November 2015. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb195-Potentially-Preventable-Hospitalizations.pdf>. Accessed on October 31, 2019.

Unmet Care Due To Cost: Percent of adults age 18 and older who reported a time in the past 12 months when they needed to see a doctor but could not because of cost. Analysis of data from the 2012 Behavioral Risk Factor Surveillance System (BRFSS) (CDC). A lower rate indicates better performance. Analysis conducted in STATA by Emma Wager, Catalyst for Payment Reform, November 2019.

Definitions

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.

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 PCMHs 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 health care

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.

Commercial market: Commercial business includes self-funded and fully-insured large group, small group, individual, state employee/retiree business, and exchange business. Commercial spending includes medical, behavioral health, and pharmacy to the extent possible. Dental and vision services are excluded.

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, when the service was rendered, or when performance was measured). For example, incentive payments that were paid in calendar year 2017 for performance in calendar year 2016 should be reported. Claims for 2016 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."

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.

Member support tools: Tools (e.g. online) 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 built 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 or condition-specific 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.

Alternatively, 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.

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. For the purposes of this data, plan members will be counted by number of months each unique member was covered by health plan during the reporting period.

Primary care providers: A primary care provider is a generalist clinician who provides care to patients at the point of first contact and takes continuing responsibility for providing the patient's care. Nurse practitioners and physician assistants working in a primary care capacity are also considered primary care providers. Such a provider must have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. For the purposes of this data collection, primary care providers are not specialists. See definition of "specialists."

Providers: Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities (e.g. hospitals), 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) 2016. If, due to timing of payment, sufficient information is not available to answer the questions with the requested reporting period of calendar year 2016, 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. If this election is made, all answers 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 built upon 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 built 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 clinicians have a recognized expertise in a specific area of medicine. For physicians, 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, renal care specialists, etc. Nurse practitioners and physician assistants working in a non-primary care setting are also considered specialists. For the purposes of this data collection, specialists are not primary care providers. See definition of "primary care providers."

Status quo payments: Includes all payment not tied to quality, including legacy FFS-payments, which is a 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 status quo payments. Full capitation without quality, or a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, is also categorized as a status quo payment. In this model, 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.

Total dollars: The total estimated in- and out-of-network health care spend (e.g. annual

payment amount) made to providers in calendar year (CY) 2012 or most recent 12 month.

About the Funders



The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy dedicated solely to health. RWJF is working to build a national Culture of Health. Its goal is to help raise the health of everyone in the United States to the level that a great nation deserves, by placing well-being at the center of every aspect of life. In its focus area of Health Care Cost and Value, RWJF is engaging health care providers, policymakers, and consumer groups in efforts to provide the right health care at the right price, stem rising health care costs, and improve overall health outcomes for individuals, families and communities. Learn more at www.rwjf.org.

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. The California Health Care Foundation works to ensure that people have access to the care they need, when they need it, at a price they can afford. Learn more at www.chcf.org.

The Commonwealth Fund — among the first private foundations started by a woman philanthropist, Anna M. Harkness — was established in 1918 with the broad charge to enhance the common good.

Today, the mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. Learn more at www.commonwealthfund.org.

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