



# 2018 VIRGINIA SCORECARD ON Medicaid Payment Reform Methodology Report

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## Background

As health care spending continues to grow for both public and private purchasers, many stakeholders nationwide see payment reform as an important strategy for improving the quality and cost of health care. State leaders know that a strong economy is linked to an efficient health care system that delivers value to businesses and residents. To this end, both the public and private sectors are working to make fundamental changes to payment and expand them over time.

As the pioneer in tracking payment reform since 2013, Catalyst for Payment Reform (CPR) is proud to introduce the next phase of its work with **Scorecard 2.0**. Like CPR's previous [national](#) and [state-level](#) Scorecards on Payment Reform, Scorecard 2.0 continues to measure how much payment reform there is and of what type. Building on this base, 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. Through this analysis, CPR aims to understand the progress towards CPR's goal that by 2020 at least 20 percent of payments to doctors and hospitals are made through payment methods *proven* to improve the quality and affordability of health care.

With grant funding from the Laura and John Arnold Foundation and the Robert Wood Johnson Foundation, CPR piloted the Scorecard 2.0 methodology at the state level in Colorado, New Jersey, and Virginia, with the help of local organizations in each state. In Virginia, the Virginia Center for Health Innovation and the Virginia Association of Health Plans served as joint, local sponsors for the effort.

### Background on Local Sponsors

Incorporated in January 2012 following a recommendation from Gov. Robert McDonnell's Virginia Health Reform Initiative, the Virginia Center for Health Innovation (VCHI) seeks to facilitate innovation by convening key stakeholders and securing the resources to accelerate value-driven models of wellness and healthcare throughout Virginia. Among its many innovative projects, the most notable for its alignment with this Scorecard is the 2018 Virginia Health Value Dashboard, which includes three of the Scorecard 2.0 metrics, and seeks to highlight opportunities to improve health care value in the Commonwealth.

The Virginia Association of Health Plans (VAHP) gives Virginia's health plans a voice in promoting quality and affordable health care through advocacy, communications, education, and research services.

Together, the two organizations responded to CPR's Request for Proposals in July 2017 with a proposal to pilot the Scorecard 2.0 methodology and create a baseline to help track the implementation of payment reform in Virginia and inform discussions among stakeholders about where Virginia needs to make further progress.

This document describes the methodology for the data collection and analysis of *the Virginia Scorecard on Payment Reform 2.0 – Medicaid Scorecard*.

## Methodology

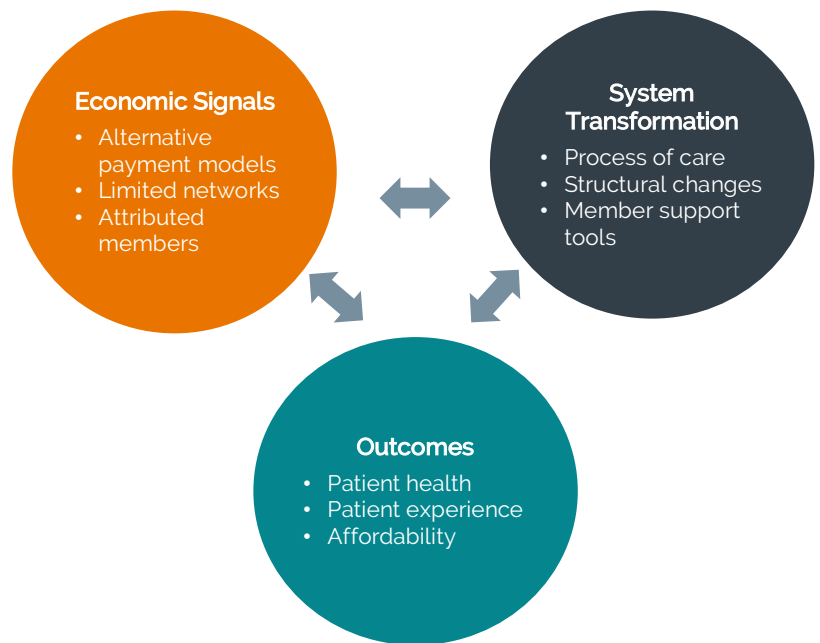
### General description of the domains and metrics in CPR's Scorecard on Payment Reform 2.0:

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."*

For Scorecard 2.0, CPR has 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 measures focused on payment reform types and volume. CPR created these original metrics in 2012 based on commercial health plan data and with input from a national advisory committee 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:

#### Scorecard 2.0 Measurement Framework



- 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 address quality, 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.

In addition to the original 1.0 metrics, CPR created another Economic Signal measure, new to 2.0, to benchmark the presence and use of limited networks in the state. Limited networks send economic signals to both providers and patients and are pathways that health plans and purchasers are pursuing to contain costs while maintaining or improving quality of care.

CPR defines a limited network, often referred to as a "narrow network," as a product, within a health plan's portfolio of offerings, that contains a network of providers with fewer providers (hospitals, specialists and/or primary care physicians) than the health plan's broadest network. While McKinsey & Company created an earlier definition of a narrow network, CPR rejected its approach because the definition focuses solely on a threshold of hospitals, rather than looking at other providers in a network. For the purposes of this Scorecard, a tiered network in which consumers typically have access to a health plan's broadest network but providers are placed into tiers with different levels of associated consumer cost sharing, is not a limited network; however, a Health Maintenance Organization (HMO) product is a limited network.

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). CPR created a new metric to count the number of shared-risk contracts health plans executed in Virginia in 2016. In order to take on shared risk, providers – whether they are an independent physician group or an integrated health system – may need to transform how they deliver care. By jointly examining the dollars flowing through shared risk payments that factor quality into the payment (a metric within the Economic Signal domain) with the total number of shared risk contracts that participating health plans had in place, stakeholders can gauge the prevalence of shared risk arrangements.

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 multi-stakeholder national advisory committee. The multi-stakeholder advisory committee included employers, health plans, providers, and payment reform experts, and provided guidance on which metrics most aptly met certain criteria for inclusion. The following criteria guided the selection of metrics:

- 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 final Scorecard 2.0 measures (see [Section 4](#)) and piloted the effort in Virginia using the methodology described below.

## Virginia Methodology

CPR sourced the majority of the metrics in the System Transformation and Outcomes domains from publicly available sources. Where possible, CPR worked with Virginia Health Information (VHI), the manager of Virginia's All-Payers Claim Database, to obtain and analyze certain state benchmarks. For other metrics, CPR worked with national organizations who own and/or publish data. Specifically, CPR obtained three Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup> metrics via a custom data request to the National Committee of Quality Assurance (NCQA). CPR sourced four metrics from the 2018 Commonwealth Fund [Scorecard on Health System Performance](#), a publicly-available resource that tracks the movement of 40+ state-level benchmarks, most recently with 2016 data. The four Commonwealth metrics featured in this Scorecard include two metrics from Behavioral Risk Factor Surveillance System, one metric from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS),<sup>2</sup> and one metric from the National Immunization Survey (NIS).

CPR obtained the Hospital-Acquired Stage III & IV Pressure Ulcers rate courtesy of [The Leapfrog Group](#), a non-profit organization that advocates for hospital transparency and collects, analyzes, and disseminates hospital data to inform consumer choice and value-oriented purchasing. This metric represents data from the 2017 Leapfrog Hospital Survey. Using the publicly available [Leapfrog Group Compare Hospitals](#) website (accessed on April 3, 2018), CPR calculated the response rate of hospitals in Virginia who reported pressure ulcer rates (66% responded to the pressure ulcer rate question, and 34% declined to respond).

## Modifications to Domains and Metrics for the Virginia Scorecard on Medicaid Payment Reform:

CPR originally created the 1.0 metrics in 2012 and updated them in 2015 while completing the New York Commercial and Medicaid Scorecards on Payment Reform. CPR made additional

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<sup>1</sup> The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

<sup>2</sup> HCAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). See section 7 for Notice of Disclaimer & Copyright Information.

updates in preparation for the Virginia Scorecard. CPR made minimum modifications to the metrics and limited the modifications to those that would reduce health plan reporting burden and/or reflect the changing nature of payment reform activity.

With that in mind, CPR made the following modifications to the metrics:

- CPR expanded the definition of the health plans' total dollars paid to providers, which serves as the denominator for the 1.0 metrics, to include out-of-network dollars as opposed to exclusively in-network dollars. The rationale for including out-of-network payments in the denominator is that some payment reforms models hold in-network providers accountable for out-of-network referrals and spending. Health plans are trying to influence the out-of-network spend more than they have historically. Going further, in payment reform programs where providers are responsible for the total cost of care, in-network providers may be accountable for out-of-network spending, and the out-of-network dollars will be included in the numerator. For consistency of capturing dollars in both the numerator and denominator, and because health plans are now in a better position to influence out-of-network spending through payment reform, CPR modified the denominator, which also aligns with the denominator used by the [Health Care Payment Learning and Action Network](#) (HCP-LAN).
- CPR originally intended to use the AHRQ Patient Safety Indicator Pressure Ulcer Rate (PSI 03) metric in Scorecard 2.0; however, this metric was not available due to delays imposed by the transition from ICD-9 to ICD-10 coding. As a replacement, CPR looked to The Leapfrog Group for a matching metric, using The Leapfrog Group's own methodology. However, it should be noted that The Leapfrog Group discontinued the use of this metric for its 2018 Hospital Survey, citing the difficulties that hospitals reported due to the transition to ICD-10.
- Similarly, CPR and the Virginia Health Information chose to publish 2015 data for the AHRQ Prevention Quality Overall Composite PQI 90 metric as 2016 data was not able to be risk-adjusted in time for publishing Virginia's Scorecard.
- Similar only to CPR's New York Scorecards on Payment Reform, 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 continuing role FFS plays in Virginia.
- To reduce health plan reporting burden, CPR combined all payment methods not tied to quality into one question. After identifying the dollars in the different payment methods that are tied to quality, health plans classified the remainder of their total payments as payments not tied to quality, also known as "status quo" payments.

#### Data collection:

CPR collaborated with the local sponsors, VCHI and VAHP, to collect data from Medicaid managed care organizations (MCOs), the health plans that contract with the state Medicaid agency to serve the Medicaid market. The data and results are intended to set a baseline to help track the implementation of payment reform in Virginia and inform stakeholders about where the Commonwealth still needs to make progress.



CPR created the 2018 Virginia Scorecard on Medicaid Payment Reform from data it collected through an online survey to which five health plans responded. The data on value-oriented payment represent the *total* dollars paid through payment reform programs, including the base payment method, as opposed to just the incentive portion of the payment when health care providers meet quality and efficiency standards.

### **Data sources and instructions:**

All health plan data in the Virginia Scorecard on Medicaid Payment Reform come from MCOs reporting calendar year (CY) 2016 data or the most recent 12 months for which they have data available. Six (6) health plans were invited to complete the survey and four (4) completed it. These four plans cover approximately 714,000 lives in the Medicaid market, which represents 58% of the Medicaid enrollees in Virginia. The 2018 Scorecard on 2016 data is the most comprehensive snapshot to date of payment reform activity occurring in the Medicaid market in the Commonwealth of Virginia.

The survey instructions inform health plans that their responses will populate a Virginia Scorecard on Payment Reform for the Medicaid market. The instructions explain that the Scorecard will report aggregated health plan data to preserve confidential plan information. In the case of multi-method payment reform programs, such as a care coordination fees (defined as non-visit functions) combined with pay-for-performance and shared savings, CPR instructs health plans to report the total amount paid across these methods, including the base fee for service payments, as dollars through the “dominant,” or primary, method of payment, which CPR defines as the “most advanced” payment method (shared savings would be the primary payment method in this example).

### **Limitations:**

#### Health Plan Participation is Voluntary:

Not all health plans VCHI and VAHP invited to participate chose to do so. As a result, the findings may be biased by self-selection; health plans actively pursuing payment reform may be more likely to respond to the survey, potentially driving results upward.

#### Potential Variation in the Interpretation of the Metrics:

CPR worked to facilitate a consistent interpretation by health plans of the terms and payment methods for reporting through precise definitions, training sessions, written instructions, and discussions with individual health plans seeking clarification. However, the interpretation of the metrics could still vary across health plans.

#### Verification of Self-Reported Data:

The data collection and analysis process included steps to attempt to ensure consistent reporting; however, rigorous verification of the data through audits or other processes was not performed due to resource and time restraints.

#### 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 different periods of time to report their data.

#### Populations Represented in Data:

While CPR only selected metrics that capture large populations of Virginia patients and families, it should be noted that the populations represented across all metrics are not identical.

Additionally, CPR does not draw a causal relationship between the payment methods executed in 2016 and Virginia's 2016 results on the quality and affordability metrics.

## Medicaid Metrics

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

METRIC	NUMERATOR	DENOMINATOR
Payment reform penetration - dollars: Percent of total dollars paid through value-oriented payment reform programs in CY 2016 or most recent 12 months.	Total dollars paid to providers through payment reform programs (with quality) in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars under the status quo: Percent of total dollars paid through legacy (traditional) FFS payment and other methods devoid of quality metrics in CY 2016 or most recent 12 months.	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 2016	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 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 2016 or most recent 12 months.	Total dollars paid to providers through shared risk programs with quality in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars in shared savings with quality programs: Percent of total dollars paid through shared savings with quality programs in CY 2016 or most recent 12 months.	Total dollars paid to providers through shared savings with quality programs in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars in bundled payment programs with quality: Percent of total dollars paid through bundled payment programs with quality in CY 2016 or most recent 12 months.	Total dollars paid to providers through bundled payment programs with quality in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
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 2016 or most recent 12 months.	Total dollars paid to providers through partial or condition-specific capitation with quality components in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.



Dollars in fully capitated arrangements with quality (global payment): Percent of total dollars paid through fully capitated payments with quality components in CY 2016 or most recent 12 months.	Total dollars paid to providers through fully capitated payments with quality components in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars in pay-for-performance programs: Percent of total dollars paid through pay-for-performance (P4P) programs in CY 2016 or most recent 12 months.	Total dollars paid to providers through Pay-For-Performance programs in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars in non-visit function payments to providers: Percent of total dollars paid for non-visit functions in CY 2016 or most recent 12 months.	Total dollars paid for non-visit functions in CY 2016 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
Dollars in other types of performance-based contracts: Percent of total dollars paid through other types of performance-based incentive programs in CY 2016 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 2016 or most recent 12 months that were not captured in previous questions.	Total dollars (in-network and out-of-network) paid to providers for Medicaid enrollees in CY 2016 or most recent 12 months.
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 2016 or most recent 12 months.
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 2016 or most recent 12 months.
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 Medicaid enrollees in CY 2016 or most recent 12 months.
Payment reform - Balancing payments to primary care: Total dollars paid to Primary Care Providers and Specialists (outpatient and inpatient) for all Medicaid enrollees in CY 2016.	Total dollars paid to primary care providers (outpatient and inpatient) in CY 2016 or most recent 12 months. Total dollars paid to specialists (outpatient and inpatient) in CY 2016 or most recent 12 months.	Total dollars paid to primary care providers and specialists (outpatient and inpatient) in CY 2016 or most recent 12 months.
Attributed members: Percent of Medicaid enrollees attributed to a provider participating in a payment reform contract in CY 2016 or most recent 12 months.	Total number of Medicaid enrollees attributed to a provider with a payment reform program contract in CY 2016 or most recent 12 months (reported as member months).	Total number of health plan members enrolled in CY 2016 or most recent 12 months.

Provider participation - Primary care providers: Percent of total dollars paid to primary care providers through payment reform programs (outpatient and inpatient) in CY 2016 or most recent 12 months.	Total dollars paid (or percent of dollars) to primary care providers through payment reform programs (outpatient and inpatient) in CY 2016 or most recent 12 months.	Total dollars paid to primary care providers (outpatient and inpatient) in CY 2016 or most recent 12 months.
Provider participation - Specialists: Percent of total dollars paid to specialists through payment reform programs (outpatient and inpatient) in CY 2016 or most recent 12 months.	Total dollars paid (or percent of dollars) to specialists through payment reform programs (outpatient and inpatient) in CY 2016 or most recent 12 months.	Total dollars paid to specialists (outpatient and inpatient) in CY 2016 or most recent 12 months.
Provider participation - Hospitals (in-patient): Percent of total dollars paid to hospitals (inpatient) through payment reform programs in CY 2016 or most recent 12 months.	Total dollars paid (or percent of dollars) to hospitals (inpatient) through payment reform programs in CY 2016 or most recent 12 months.	Total dollars paid to hospitals (inpatient) in CY 2016 or most recent 12 months.

## Health Plan Metric developed by Catalyst for Payment Reform in 2017 for Scorecard on Payment Reform 2.0

METRIC	NUMERATOR	DENOMINATOR
<b>Shared Risk Contracts:</b> Number of shared risk contracts paired with total dollars flowing through shared risk with quality programs.	Number of shared risk with quality contracts that health plans had in effect in CY2016 or most recent 12 months in Virginia paired with the total dollars paid to providers through shared risk programs with quality in CY 2016 or most recent 12 months.	

### Other Metrics

**All-Cause Readmissions** (State-level risk adjusted readmission rate derived from the Plan All-Cause Readmissions: Observed-to-Expected Ratio) [NQF 1768]: The state-level 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-insured (combined results of HMO & PPO plans) members 18- 64 years of age, captures the percent of hospitalizations that are followed by another hospitalization within 30 days based on Virginia's case mix. This metric is not applicable to Medicaid. NCQA, Custom Analysis, 2017 HEDIS®

**Cesarean Sections** (Perinatal Care- Cesarean Birth) (NQF 0471): percent of nulliparous women [women who have not borne offspring] with a term [37 completed weeks or more], singleton baby [one fetus] in a vertex [head first] position [NTSV] who deliver via cesarean section. A lower rate indicates

better performance with the Leapfrog Group's target rate being 23.9% or lower. The Virginia Health Information (VHI) analysis of 2016 birth records from the Virginia Department of Health. VHI used standardized data elements to successfully link 87.8% of these records to the VHI's Patient Level Data (PLD). Using the algorithm provided by the Joint Commission, VHI was able to calculate the 2016 Virginia NTSV cesarean section rate, provided to CPR in September 2018. For more information, see: <http://www.vhi.org/> and [http://www.leapfroggroup.org/sites/default/files/Files/leapfrog\\_castlight\\_maternity\\_care\\_FINAL.pdf](http://www.leapfroggroup.org/sites/default/files/Files/leapfrog_castlight_maternity_care_FINAL.pdf)

**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 influenza 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). Radley et al. analysis of data from the 2016 NIS-PUF (CDC, NCIRD). A higher rate indicates better performance with the United States average being 71% in 2016 and performance ranging from 58%-85% across all states. Published in Commonwealth Fund Scorecard on State Health Performance, May 2018. Available at <https://interactives.commonwealthfund.org/2018/state-scorecard/>

**Controlling High Blood Pressure (NQF 18):** Percent of patients 18 to 85 years of age, enrolled in Medicaid, 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. A higher rate indicates better performance with the United States average being 56.5% across Medicaid HMO plans in 2016. NCQA, 2017 HEDIS®

**HbA1c Poor Control (Diabetes - Hemoglobin A1c Poor Control) (NQF 59):** Percent of Medicaid enrollees 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. A lower rate indicates better performance with the United States average being 43.3% across Medicaid HMOs plans in 2016. NCQA, 2017 HEDIS®

**HbA1c Testing (Comprehensive Diabetes Care- HbA1c Testing) (NQF 057):** Percent of Medicaid enrollees 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. A higher rate indicates better performance with the United States average being 86.7% across Medicaid HMO plans in 2016. NCQA, 2017 HEDIS®

**Health-Related Quality of Life:** Adults ages 18-64 who report fair/poor health. Radley et al. analysis of data from the 2016 Behavioral Risk Factor Surveillance System -BRFSS (CDC, NCCDPHP). A lower rate indicates better performance with the United States average being 16% in 2016 and performance ranging from 10%-24% across all states. Published in Commonwealth Fund Scorecard on State Health Performance, May 2018. Available at <https://interactives.commonwealthfund.org/2018/state-scorecard>

**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. Radley et al. analysis of 2013 and 2016 HCAHPS as administered to adults discharged from acute care hospitals; data retrieved from 4th Quarter 2017 and 4th Quarter 2014 Hospital Compare (CMS). A higher rate indicates better performance with the United States average being 87% in 2016 and performance ranging from 82%-91% across all states. Published in Commonwealth Fund Scorecard on State Health Performance, May 2018. Available at <https://interactives.commonwealthfund.org/2018/state-scorecard/>

**Hospital-Acquired Pressure Ulcers (Hospital-Acquired Stage III & IV Pressure Ulcers):** Rate of hospital-acquired stage III & IV pressure ulcers per 1,000 adult, inpatient discharges. A lower rate indicates better performance with the Leapfrog Group's standard being 0 per 1,000 inpatient discharges. The Leapfrog Group analysis of 2017 Leapfrog Hospital

Survey, based on data from 1/1/16 – 6/30/17, provided to CPR by request in March 2018. For more information, see: [www.leapfroggroup.org/sites/default/files/Files/Castlight-Hospital-Acquired\\_Conditions\\_Report%202017\\_round4%5B3%5D.pdf](http://www.leapfroggroup.org/sites/default/files/Files/Castlight-Hospital-Acquired_Conditions_Report%202017_round4%5B3%5D.pdf)

**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, with the national rate being 1,457.5 in 2012 (as cited by New Jersey Department of Health- Office of Health Care Quality Assessment, December 2016). The

Virginia Health Information (VHI) analysis of 2015 (Q1-Q3) VHI's Patient Level Data (PLD) using AHRQ WinQI software 6.0.2. Non-Virginia residents were excluded from the analysis, and the rate was adjusted to reflect only the first 3 quarters of 2015, provided to CPR in September 2018. For more information, see: <http://www.vhi.org/>

**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. Radley et al. analysis of 2016 BRFSS [CDC, NCCDPHP]. Published in Commonwealth Fund Scorecard on State Health Performance, May 2018. A lower rate indicates better performance with the United States average being 13% in 2016 and performance ranging from 7%-19% across all states. Available at [interactives.commonwealthfund.org/2018/state-scorecard/](http://interactives.commonwealthfund.org/2018/state-scorecard/)

## 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.

**Limited network:** A product, within a health plan's portfolio of offerings, that contains a network of providers with fewer providers (hospitals, specialists and/or PCPs) than the health plan's broadest network.

**Medicaid market:** The Medicaid market segment includes a health plan's business with a state to provide health benefits to Medicaid eligible individuals. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible). Data submitted for this survey should exclude the following: health care spending for dual-eligible beneficiaries, health care spending for long-term care (LTC), and spending for dental and vision services.

**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. Non-specified services remain reimbursed under fee-for-service. OR 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 risk contract:** A payment arrangement contract between a health plan and a provider (see definition of provider) where the provider has agreed to a shared risk payment method (see definition of shared risk) for the care, or a subset of the care, they provide to health plan members. For the purposes of this survey, the number of contracts should be counted; not the number of providers covered by the contract.

**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) 2016 or most recent 12 month.

## About the Funders



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