



2019 NEW YORK SCORECARD ON

Commercial Payment Reform 2.0

Methodology Report

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Commissioned by:



**Department
of Health**



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.

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, thereby creating the first ever methodology for scoring progress on payment reform implementation. By 2014, CPR issued two National Commercial Scorecards on Payment Reform and two California Commercial Scorecards on Payment Reform. Through support from the Commonwealth Fund and the California HealthCare Foundation, these Scorecards were the first of their kind to track the progress of reforms to health care payment and to set a baseline nationally and in California.

Building off the National and California Scorecards, in 2014, the New York State Health Foundation commissioned CPR to prepare a New York Scorecard on Payment Reform for the commercial market. At the time, the Foundation's priorities included expanding health care coverage, building healthy communities, expanding primary care capacity and access, and advancing payment reform. The goal of the project was to quantify the different payment reforms occurring in New York and to create a baseline for tracking the implementation of payment reform in New York going forward.

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 additional metrics to help shed light on whether payment reform correlates with improved health care quality and affordability across the health care system. In 2018, with funding from the Robert Wood Johnson Foundation and Arnold Ventures, CPR piloted the Scorecard 2.0 methodology at the state level in Colorado, New Jersey, and Virginia.¹ In August 2018, the New York State Department of Health (NYS DOH)/Health Research, Inc.² with the collaboration of the New York State Department of Financial Services (DFS) commissioned CPR to apply the 2.0 approach in New York. The goal was to evaluate the impact of the [State Innovation Model](#) by measuring payment reform implementation alongside quality and affordability indicators as well as to look at what progress had been made since the first New York Scorecard on Commercial Payment Reform was published in 2015.

This document describes the methodology for the data collection and analysis of the 2019 New York Scorecard on Commercial Payment Reform 2.0.

¹ All of CPR's state and national scorecards can be downloaded from the [Scorecards on Payment Reform](#) section of CPR's website.

² Health Research, Inc. is a not for profit corporation organized and existing under the laws of the State of New York.

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.”

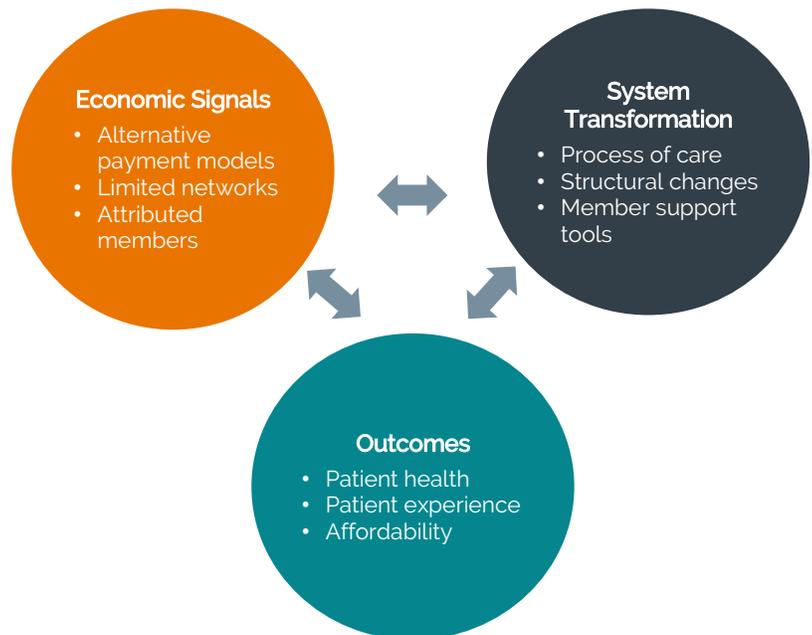
For Scorecard 2.0, CPR adopted a non-linear framework that recognizes the complex interplay of factors within health care. The framework includes three domains: Economic Signals, System Transformation, and Outcomes. Some metrics span across domains -- the placement of metrics into specific domains is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

Scorecard 2.0 Measurement Framework



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 patients diagnosed with hypertension whose blood pressure was adequately controlled) 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 which metrics most aptly met certain criteria for inclusion. 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 the New York State Department of Financial Services (DFS) to collect data from health plans providing commercial coverage in New York. DFS issued a request for information pursuant to Section 308 of the New York Insurance Law to ensure participation by all commercial health plans. In its request letter to health plans, DFS indicated it would use the CPR metrics to serve as an evaluation tool to measure the impact of the State Innovation Model to date, using an expanded set of metrics from those that CPR used to develop the original 2015 New York Scorecard on Commercial Payment Reform. Plans offering only Essential Plan coverage were exempt from participating.

CPR created the 2019 New York Scorecard on Commercial Payment Reform from data it collected through an online survey to which 14 commercial 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 data in the New York Scorecard on Commercial Payment Reform came from health plans reporting calendar year 2018 data or the most recent 12 months for which they had data available. Fourteen (14) commercial health plans completed the survey, submitting data that represents virtually all commercially fully- and self-insured lives in New York in 2018, making the 2019 Scorecard the most comprehensive snapshot of payment reform activity in the commercial market in New York in 2018. 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 commercial market. The instructions explained that the Scorecard would 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 instructed health plans to report the total amount paid across these methods, including the base fee-for-service payments, 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).

For the metrics examining quality of care and affordability in New York, CPR sourced the majority from either publicly available sources or worked with national organizations who own and/or publish data. Specifically, CPR obtained seven Healthcare Effectiveness Data and Information Set (HEDIS®)³ metrics from the Quality Assurance Reporting Requirements program of the New York Department of Health's Office of Quality and Patient Safety. These data are available on Health Data NY (an Open Data website where the State of New York publicly disseminates payer-level data). CPR sourced one HEDIS metric through a custom data request to the National Committee of Quality Assurance (NCQA). Additionally, CPR sourced one metrics from the Commonwealth Fund [Scorecard on Health System Performance Data Center](#), a publicly-available resource that tracks the changes of 40-plus state-level benchmarks over time.

The majority of the quality of care and affordability data represent statewide performance specific to New York's population with commercial health coverage. CPR has noted any metrics that are not specific to those with commercial coverage in the 2018 Commercial Scorecard infographic. To compare New York's quality and affordability performance to that of the national average, please refer to the descriptions of each metric in this methodology report.

³ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Modifications to Metrics for the 2019 New York Scorecard on Commercial Payment Reform:

CPR created the 1.0 metrics in 2012 and updated them in 2015 while creating the 2015 Commercial and Medicaid Scorecards on Payment Reform for New York. CPR made the following minimal modifications to update the 2019 New York Commercial Scorecard:

- Similar to CPR's 2015 New York Scorecards on Payment Reform, CPR includes a metric that sums all of the value-oriented payment methods that are built on a Fee-For-Service (FFS) base to illustrate the role FFS plays in payment methods such as shared savings and pay-for-performance, among others. This metric is reported as a percent of total dollars in the 2019 Scorecard.
- To focus on payment arrangements that include quality components, CPR did not collect data on Non-FFS Payment without Quality for the 2019 New York Scorecard on Commercial Payment Reform. CPR reports the dollars flowing through any payment method not tied to quality as status-quo payments and no longer distinguishes between Non-FFS and FFS-based status quo payments.
- To reflect the evolving nature of payment reform activity, CPR ceased delineating between Non-FFS Shared Savings and FFS-based Sharing Savings as separate payment methods. Based on increased knowledge of plans' contracting practices, CPR now categorizes shared savings payments as exclusively FFS-based.
- 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 in-network dollars *and* out-of-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. Today, 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).
- To better align with the New York State Innovation Model (SIM) grant and primary care focused sections of the VBP Roadmap, CPR replaced one of the 2.0 metrics with three quality metrics that are included in New York State's own quality monitoring program. Specifically, the 2019 Scorecard does not include the Hospital-Acquired Pressure Ulcer Rate metric that CPR uses in its other scorecards but does include the following three metrics: Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening.
- CPR did not include the Preventable Admissions metric (Prevention Quality Overall Composite, Prevention Quality Indicator (PQI) 90) for the 2019 Scorecard because data reflective of the New York State's average Commercial HMO and PPO payer performance is not yet available. The most current data available is for calendar year 2016. CPR recommends that stakeholders in New York monitor the Commonwealth Fund [Health](#)

[System Data Center](#) as new results are made available for a comparable metric, “preventable hospitalizations ages 18-64.”

- The All-Cause Readmissions metric comes from a custom analysis of HEDIS® 2019 data provided by NCQA for the purposes of this Scorecard. It represents a state-level, risk adjusted readmission rate derived from the “Plan All-Cause Readmissions (PCR): Observed-To-Expected Ratio” measure. To produce this readmission rate, NCQA calibrated each commercial health plan’s observed-to-expected readmissions ratio, standardized each plan’s ratio to a rate, and then calculated New York’s state-level, weighted average.
- Results from measurement year 2018 were not available for the following metrics at the time of publishing:
 - Cesarean Birth Delivery for Women with Low-Risk Pregnancies, sourced from America’s Health Rankings.
 - Home Recovery Instructions, sourced from Commonwealth Fund Health System Data Center.
 - Unmet Care Due to Cost, sourced by analyzing the NY Department of Health Behavioral Risk Factor Surveillance System data.
 - Health-Related Quality of Life sourced by analyzing the NY Department of Health Behavioral Risk Factor Surveillance System data.

Limitations:

Health plan participation:

While the 2019 New York Scorecard on Commercial Payment Reform represents data covering virtually 100% of commercial covered lives, it does not include health plan payment reform efforts in the Essential Plan program. CPR excluded the Essential Plan program to improve the ability to compare the 2019 and 2015 New York Scorecards on Commercial Payment Reform. The Essential Plan program began in 2014. Because the 2015 Scorecard analyzed data from 2013, it did not capture activity in the Essential Plan program. Additionally, payments made directly from self-funded purchasers to providers are not necessarily included in the results.

Potential Variation in the Interpretation of the Metrics:

CPR 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. 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.

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 some, 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. Additionally, some health plans were unable to provide data for all the metrics. The metrics that do not include data from all responding plans are noted in Section 3: Metrics.

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 2018 and the results on the metrics that assess health care quality and affordability in 2018.

Metrics

Scorecard on Payment Reform Metrics, originally developed by Catalyst for Payment Reform in 2012 ("1.0 Metrics")

METRIC	NUMERATOR	DENOMINATOR
Payment reform penetration - dollars: Percent of total dollars paid through value-oriented payment reform programs in Calendar Year (CY) 2018 or most recent 12 months for which data were available.	Total dollars paid to providers through payment reform programs (with quality) in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 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 2018 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 2018	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 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 2018 or most recent 12 months.	Total dollars paid to providers through shared risk programs with quality in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 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 2018 or most recent 12 months.	Total dollars paid to providers through shared savings with quality programs in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 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 2018 or most recent 12 months.	Total dollars paid to providers through bundled payment programs with quality in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 or most recent 12 months.
Dollars in partial or condition-specific capitation with quality: Percent of total dollars paid through	Total dollars paid to providers through partial or condition-specific capitation with quality	Total dollars (in-network and out-of-network) paid to providers for

partial or condition-specific capitation with quality components in CY 2018 or most recent 12 months.	components in CY 2018 or most recent 12 months.	commercial members in CY 2018 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 2018 or most recent 12 months.	Total dollars paid to providers through fully capitated payments with quality components in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 or most recent 12 months.
Dollars in pay-for-performance programs: Percent of total dollars paid through pay-for-performance (P4P) programs in CY 2018 or most recent 12 months.	Total dollars paid to providers through FFS plus Pay-For-Performance programs in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 or most recent 12 months.
Dollars in non-visit function payments to providers: Percent of total dollars paid for non-visit functions in CY 2018 or most recent 12 months.	Total dollars paid for non-visit functions in CY 2018 or most recent 12 months.	Total dollars (in-network and out-of-network) paid to providers for commercial members in CY 2018 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 2018 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 2018 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 2018 or most recent 12 months.
Value-oriented dollars that are not based on fee-for-service (as a percent of total dollars): Percent of total 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 in CY 2018 or most recent 12 months.
Value-oriented dollars based on fee-for-service (as a percent of total dollars): Percent of total dollars paid through payment reform with quality programs based on fee-for-service.	Total dollars paid to providers through payment reform methods categorized as FFS-based, including: pay-for-performance, shared savings, and shared risk.	Total dollars paid to providers in FY 2018.
At risk value-oriented dollars (as a percent of 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 2018 or most recent 12 months. Excludes dollars paid through payment reform programs classified as "Other."
Not at risk value-oriented dollars (as a percent of 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 2018 or most recent 12 months. Excludes dollars paid through payment reform programs classified as "Other."

<p>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 2018.</p>	<p>Total dollars paid to primary care providers (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>	<p>Total dollars paid to primary care providers and specialists (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>
<p>Attributed members: Percent of plan members attributed to a provider participating in a payment reform contract in CY 2018 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 2018 or most recent 12 months.</p>	<p>Total number of health plan members enrolled in CY 2018 or most recent 12 months.</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 2018 or most recent 12 months. NOTE: Percentages reported indicate the percentage of dollars paid through payment reform contracts for patient care provided. The percentage does not reflect the percentage of providers knowingly participating in a payment reform program. NOTE: Only 13 out of the 14 participating health plans provided data for this metric.</p>	<p>Total dollars paid (or percent of dollars) to primary care providers through payment reform programs (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>	<p>Total dollars paid to primary care providers (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>
<p>Provider participation - Specialists: Percent of total dollars paid to specialists through payment reform programs (outpatient and inpatient) in CY 2018 or most recent 12 months. NOTE: Percentages reported indicate the percentage of dollars paid through payment reform contracts for patient care provided. The percentage does not reflect the percentage of providers knowingly participating in a payment reform program. NOTE: Only 13 out of the 14 participating health plans provided data for this metric.</p>	<p>Total dollars paid (or percent of dollars) to specialists through payment reform programs (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>	<p>Total dollars paid to specialists (outpatient and inpatient) in CY 2018 or most recent 12 months.</p>
<p>Provider participation - Hospitals (in-patient): Percent of total dollars paid to hospitals (inpatient) through payment reform programs in CY 2018 or most recent 12 months. NOTE: Percentages reported indicate the percentage of dollars paid through payment reform contracts for patient care provided. The percentage does not reflect the percentage of providers knowingly participating in a payment reform program. NOTE: Only 13 out of the 14 participating health plans provided data for this metric.</p>	<p>Total dollars paid (or percent of dollars) to hospitals (inpatient) through payment reform programs in CY 2018 or most recent 12 months.</p>	<p>Total dollars paid to hospitals (inpatient) in CY 2018 or most recent 12 months.</p>

Health Plan Metrics, developed by Catalyst for Payment Reform in 2018 for Scorecard on Payment Reform 2.0

METRIC	NUMERATOR	DENOMINATOR
<p>Transparency Metrics: The number of health plans that offered price, quality, and/or treatment decision information within their online member support tools in CY 2018 or most recent 12 months. Only applicable to commercial Scorecard.</p>	<p>Total number of health plans that offered each of the following in CY 2018 or most recent 12 months: member support tool with customized price information; member support tool with customized quality information; member support tool featuring treatment option decision support. One numerator for each.</p>	<p>Total number of health plans that provided member support tools in CY 2018 or most recent 12 months and that responded to commercial survey in New York.</p>
<p>Shared Risk Contracts: Number of shared risk contracts paired with total dollars flowing through shared risk with quality programs.</p>	<p>Number of shared risk with quality contracts that health plans had in effect in CY 2018 or most recent 12 months in New York paired with the total dollars paid to providers through shared risk programs with quality in CY 2018 or most recent 12 months.</p>	
<p>Limited Networks: Percent or number of plans that offered a limited network product, and the percent of members who enrolled in those products. For the purposes of this survey, limited network is defined as 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. Only applicable to commercial Scorecard.</p>	<p>Plans that respond Yes, they offered at least one limited network product in New York in CY 2018 or most recent 12 months.</p>	<p>Total number of plans that responded to commercial survey in New York.</p>
	<p>Number of members enrolled in those products.</p>	<p>Total commercial members in the participating health plans that offered limited network products.</p>
		<p>Total commercial health plan members represented in data overall.</p>
<p>NOTE: Only 13 out of the 14 participating health plans provided data for this metric.</p>		

Other metrics, selected by Catalyst for Payment Reform in 2018 ("2.0 Metrics")

All-Cause Readmissions: The New York 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 New York's case mix. The analysis combines results of Health Maintenance Organizations (HMO) & Preferred Provider Organizations (PPO) plans serving the commercial market.

A lower rate indicates better performance with the national average being 8.2% in 2018.⁴ 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).

Breast Cancer Screenings: The percentage of women, ages 50 to 74 years, with commercial coverage, who had a

⁴ CPR sourced the national average through a custom data request to NCQA.

mammogram anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year. Women with a history of bilateral mastectomy are excluded from this metric. A higher rate indicates better performance with the national average being 72% across commercial HMO and PPO plans in 2018.⁵ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY on December 19, 2019.

Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at health.data.ny.gov.

Cervical Cancer Screenings: The percentage of women, ages 24 to 64 years, with commercial coverage, who had had cervical cytology performed every 3 years or women, ages 30 to 64 years, who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. Women with a history of hysterectomy with no residual cervix are excluded from this analysis. A higher rate indicates better performance with the national average being 74% in 2018.⁶ HEDIS® is a registered

trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY on December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at health.data.ny.gov.

Chlamydia Screenings: The percentage of sexually active women ages 16 to 24 years, with commercial coverage, who were appropriately screened for chlamydia as documented through either administrative data or medical record review at least once in the previous calendar year. Sexual activity is determined through both claim data (patients reporting sexual activity, pregnancy, pregnancy testing, and other STD screenings) and pharmacy data (prescription contraceptive use). Women who were given a pregnancy test prior to an X-ray or isotretinoin prescription, but had no other records indicating sexual activity, were excluded from this analysis. A higher rate indicates better performance with the national average being 49% in 2018.⁷ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at health.data.ny.gov.

Childhood Immunizations: Children age two, with commercial coverage, 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 higher rate indicates better performance. The 2018 national average for commercially-covered lives is not available at the time of publication. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting

Requirements, accessed through Health Data NY on December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at health.data.ny.gov.

Controlling High Blood Pressure: 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. A higher rate indicates better performance with the national average being 55% in 2018.⁸ Due to changes in measure description that occurred in 2014, results for this measure cannot be trended before and after 2014. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY on December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO

⁸ Ibid.

and PPO denominator values. Statewide average data was used for each metric. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at health.data.ny.gov.

HbA1c Poor Control (Diabetes - Hemoglobin A1c Poor Control): 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. A lower rate indicates better performance with the national average being 34% in 2018.⁹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY on December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

HbA1c Testing (Comprehensive Diabetes Care- HbA1c Testing): 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. A higher rate indicates better performance with the national average being 91% in 2018.¹⁰ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). For purposes of this analysis, the commercially insured population is defined as the total number of HMO and PPO enrollees. CPR analysis of New York State Department of Health, based on Quality Assurance Reporting Requirements, accessed through Health Data NY on December 19, 2019. Comprehensive commercial rates were generated by dividing the sum of the HMO and PPO numerator values by the sum of the HMO and PPO denominator values. Statewide average data was used for each metric. Data from New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

⁹ Ibid.

¹⁰ Ibid.

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. New York's Essential Plan, 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).

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) 2018. If, due to timing of payment, sufficient information is not

available to answer the questions with the requested reporting period of calendar year 2018, 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) 2018 or most recent 12 month.

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