



2015 NEW YORK SCORECARD ON
Medicaid
Payment Reform 2.0
2020 UPDATE

Methodology Report

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Updated release commissioned by:



The original Scorecard was funded through a grant by the New York State Health Foundation.



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 Scorecards on Commercial Payment Reform and two California Scorecards on Commercial Payment Reform. Through support from the Commonwealth Fund and the California HealthCare Foundation, these Scorecards were the first of their kind to track 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 Medicaid 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 to create a baseline for tracking the implementation of payment reform in the Medicaid market 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 Medicaid Payment Reform published in 2015. As part of this effort, CPR is updating the original 2015 New York Medicaid Scorecard with the 2.0 methodology.

This document describes the methodology for the data collection and analysis of *the 2015 New York Scorecard on Medicaid Payment Reform 2.0 - Updated*.

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.”

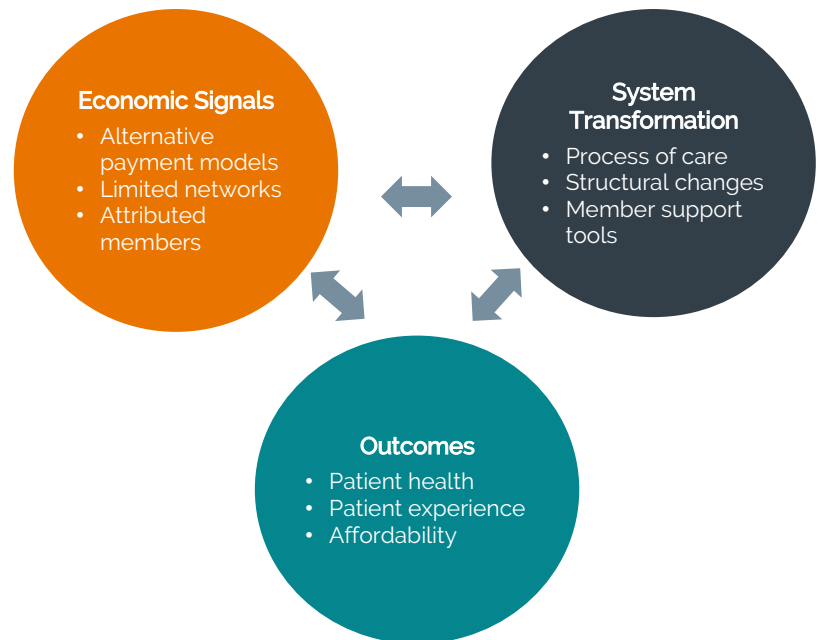
For Scorecard 2.0, CPR adopted a non-linear framework that recognizes the complex interplay of factors within health care. The framework includes three domains: Economic Signals, System Transformation, and Outcomes. Some metrics span across domains, and the placement of metrics into specific domains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

The first domain, Economic Signals, includes the original Scorecard metrics that assess how much provider payment is flowing through each payment type. CPR created these metrics in 2012 in preparation for executing the first National (2013) and California Scorecards (2013). The 1.0 metrics quantify the following health plan characteristics in three areas:

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

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

Scorecard 2.0 Measurement Framework



³ CPR expanded the payment reform metrics, including those on provider participation, to include out-of-network payments in 2018. The 2015 Scorecard results do not include out-of-network spending.

online member support tools) or process-oriented (e.g., making sure every person with diabetes receives at least one HbA1c test annually).

The third domain, Outcomes, includes measures that track whether changes in the first two domains lead to the intended results in health care quality and cost. Outcomes include clinical results (such as the rate of 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 criteria for inclusion which metrics most aptly met certain. The Advisory Committee used the following criteria to guide the metric selection process:

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

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

Data collection (as documented in the original 2015 New York Scorecard on Medicaid Payment Reform):

CPR collaborated with the New York State Department of Financial Services (DFS) to collect data from both Commercial and Medicaid health plans. DFS issued a request for information pursuant to Section 308 of the New York Insurance Law to ensure participation by Medicaid health plans. Plans covering only long-term care services, behavioral health, or services for the dually eligible (Medicaid and Medicare) population were not subject to the mandate. In its request letter to health plans, DFS indicated it would use the CPR metrics as a baseline from which to track each insurer’s move from volume- to value-oriented payment over the next five years as planned in

New York's Delivery System Reform Incentive Payments (DSRIP) program. The data and results were intended to inform stakeholders about where New York still needs to make progress.

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

Data Sources and Instructions:

All data in the New York Scorecard on Medicaid Payment Reform come from health plans reporting calendar year 2013 data or the most recent 12 months for which they have data available. Fifteen (15) Medicaid health plans completed the survey. These 15 plans cover approximately 3,989,244 Medicaid beneficiaries in the New York market, which represented virtually all of the Medicaid-insured lives in New York in 2013 that were within the scope of the survey. The 2015 Scorecard is the most comprehensive snapshot of health plan payment reform activity occurring in the Medicaid market in New York in 2013. See Section 3: [Metrics](#) for additional information.

The CPR survey instructions informed health plans that it would use their responses to populate a New York Scorecard on Payment Reform for the Medicaid market. The instructions explained that the Scorecard would report 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, 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).

For the metrics not about dollars flowing through different payment methods, CPR sourced the majority from 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®)⁴ 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).⁵ Additionally, CPR sourced one metric from the Commonwealth Fund [Health System Data Center](#), a publicly-available resource that tracks the movement of 40+ state-level benchmarks overtime. For more information on sources for each metric, see Section 3.

⁴ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA. See section 7 for Notice of Disclaimer & Copyright Information.

⁵ For more information on the Quality Assurance Reporting Requirements, see: <https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-Beginning/vbkk-tipq>

The majority of the quality of care and affordability data represent statewide performance specific to New York's population with health coverage through Medicaid. CPR has noted any metrics that are not specific to those with Medicaid coverage in the 2015 Medicaid 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.

Modifications to Metrics for the Updated 2015 New York Scorecard on Medicaid 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 modifications to update the 2015 New York Scorecard on Medicaid 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 Scorecard.
- To focus on payment arrangements that include quality components, CPR is not including data on Non-FFS Payment without Quality for the Updated 2015 New York Scorecard on Medicaid 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 contemporary knowledge of plans' contracting practices, CPR now categorizes shared savings payments as exclusively FFS-based. However, to maintain consistency with the original 2015 New York Scorecard on Medicaid Payment Reform, CPR is including the percent of dollars reported as Non-FFS Shared Savings in its calculation of the proportion of total dollars flowing through Non-FFS based value-oriented payments.
- To better align with the New York State Health Improvement Plan (SHIP) 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 Updated 2015 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 reports certain 2.0 metrics only in the commercial payment reform scorecards as these are not applicable to the Medicaid market. Specifically, the Commonwealth Fund's "preventable hospitalizations ages 18-64," which is a comparable metric to the Agency for Healthcare Research and Quality's Prevention Quality Overall Composite- Prevention Quality Indicator 90, is not available for the Medicaid market. In addition, the National Committee for Quality Assurance (NCQA) HEDIS measure, "Plan All Cause Readmissions" is not applicable for the Medicaid market for the data years analyzed. CPR published a similar metric to the HEDIS® "Plan All Cause Readmissions" metric, derived from data submitted to eValue8, in the original 2015 New York Scorecard on Medicaid Payment

Reform. CPR has excluded this metric in the updated version to improve consistency with the 2018 and 2019 versions of the Medicaid Scorecard.

Limitations:

Variation in interpretation of metrics:

Although CPR clearly defined the categories for payment methods, how each plan interpreted what payment dollars to report in each category may vary. There is a chance that the values plans reported may not represent the exact dollars attributed to each payment reform program due to misclassification of specific programs.

Ability to trend Scorecards

In 2018, 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. Moreover, 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). However, this change is not reflected in the Updated 2015 New York Scorecard on Medicaid Payment Reform and thus trending between the 2015 Scorecard and the 2018 and 2019 New York Scorecard on Medicaid Payment Reform results should be considered with caution.

In addition, the metrics related to Provider Participation in Value-Oriented Payments – percent of value-oriented payments to specialists and primary care physicians include outpatient payments only and are not comparable to the 2018 and 2019 results.

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.

Health plan participation:

CPR included Medicaid health plans operating during 2013 in the data collection process. For the purposes of this analysis, CPR excluded plans exclusively offering long-term care coverage, dual coverage (both Medicaid and Medicare), or behavioral health coverage.

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.

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 2013 and the results on the metrics that assess health care quality and affordability in 2013.

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 CY 2013 or most recent 12 months.	Total dollars paid to providers through payment reform programs (with quality) in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 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 2013	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 or most recent 12 months.
Dollars in shared risk with quality programs: Percent of total dollars paid through shared risk with quality programs in CY 2013 or most recent 12 months.	Total dollars paid to providers through shared risk programs with quality in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 or most recent 12 months.	Total dollars paid to providers through shared savings with quality programs in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 or most recent 12 months.	Total dollars paid to providers through bundled payment programs with quality in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 or most recent 12 months.	Total dollars paid to providers through partial or condition-specific capitation with quality components in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 or most recent 12 months.	Total dollars paid to providers through fully capitated payments with quality components in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 or most recent 12 months.
Dollars in pay-for-performance programs: Percent of total dollars paid through pay-for-performance (P4P) programs in CY 2013 or most recent 12 months.	Total dollars paid to providers through FFS plus Pay-For-Performance programs in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 or most recent 12 months.
Dollars in non-visit function payments to providers: Percent of total dollars paid for non-visit functions in CY 2013 or most recent 12 months.	Total dollars paid for non-visit functions in CY 2013 or most recent 12 months.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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 2013 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 2013 or most recent 12 months that were not captured in previous questions.	Total dollars (in-network) paid to providers for Medicaid members in CY 2013 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: FFS-based shared savings, bundled payment, full capitation, partial or condition-specific capitation, and payment for non-visit functions.	Total dollars paid to providers in CY 2013 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. (Note: Any FFS-based Shared Savings reported in original 2015 Scorecard has been excluded.)	Total dollars paid to providers in CY 2013 or most recent 12 months.
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 2013 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 Medicaid members or most recent 12 months. Excludes dollars paid through payment reform programs classified as "Other."
Payment reform - Balancing payments to primary care: Total dollars paid to Primary Care Providers	Total dollars paid to primary care providers (outpatient) in CY 2013 or most recent 12 months.	Total dollars paid to primary care providers and specialists

and Specialists (outpatient) for all Medicaid members in CY 2013.	Total dollars paid to specialists (outpatient) in CY 2013 or most recent 12 months.	(outpatient) in CY 2013 or most recent 12 months.
Attributed members: Percent of plan members attributed to a provider participating in a payment reform contract in CY 2013 or most recent 12 months.	Total number of health plan members attributed to a provider with a payment reform program contract in CY 2013 or most recent 12 months.	Total number of health plan members enrolled in CY 2013 or most recent 12 months.
Provider participation - Primary care providers: Percent of total dollars paid to primary care providers through payment reform programs (outpatient) in CY 2013 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.	Total dollars paid (or percent of dollars) to primary care providers through payment reform programs (outpatient) in CY 2013 or most recent 12 months.	Total dollars paid to primary care providers (outpatient) in CY 2013 or most recent 12 months.
Provider participation - Specialists: Percent of total dollars paid to specialists through payment reform programs (outpatient and inpatient) in CY 2013 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.	Total dollars paid (or percent of dollars) to specialists through payment reform programs (outpatient and inpatient) in CY 2013 or most recent 12 months.	Total dollars paid to specialists (outpatient) in CY 2013 or most recent
Provider participation - Hospitals (in-patient): Percent of total dollars paid to hospitals (inpatient) through payment reform programs in CY 2013 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.	Total dollars paid (or percent of dollars) to hospitals (inpatient) through payment reform programs in CY 2013 or most recent 12 months.	Total dollars paid to hospitals (inpatient) in CY 2013 or most recent 12 months.

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

Breast Cancer Screenings: The percentage of women, ages 50 to 74 years, with Medicaid coverage, who had a 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 United States average being 58% across Medicaid Managed Care Organization (MCO) plans.⁶ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from the New York State

⁶ CPR sourced Medicaid MCO national averages for HEDIS® metrics from NCQA's [State of Health Care Quality](https://www.ncqa.org/State-of-Health-Care-Quality) website.

Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

Cervical Cancer Screenings: The percentage of women, ages 24 to 64 years, with Medicaid 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 United States average being 60% across Medicaid Managed Care Organization (MCO) plans. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Reported for measurement year 2014 (HEDIS 2015) as this metric was not reported in HEDIS 2014 due to significant specification changes. Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

Cesarean Sections (Perinatal Care- Cesarean Birth): 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. Note that figure reported represents New York general population and is not specific to New Yorkers with Medicaid coverage. A lower rate indicates better performance with the Leapfrog Group's target rate being 23.9% or lower. The United States average in 2014 was 26%. This metric reflects 2014 data as 2013 is not available. Analysis by America's Health Rankings, United Health Foundation

of CDC ONDER Online Database, Natality public-use data, 2014. The New York and national average are available at: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/low_risk_cesarean/state/NY?edition-year=2017.

Chlamydia Screenings: The percentage of sexually active women ages 16 to 24 years 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 United States average being 55% among Medicaid Managed Care Organizations (MCOs). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from the New York State Department of Health Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

Childhood Immunizations: Children age two, with Medicaid 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 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 higher rate indicates better performance with the United States average being 71% among Medicaid Managed Care Organizations (MCOs). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

Controlling High Blood Pressure: The percentage of patients 18 to 85 years of age, with Medicaid coverage, who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure. A higher rate indicates better performance. Due to changes in measure description that occurred in 2014, results for this measure cannot be trended before and after 2014. A higher rate indicates better performance with the United States average being 57% among Medicaid Managed Care Organizations (MCOs). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from the New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

HbA1c Poor Control (Diabetes - Hemoglobin A1c Poor Control): Percent of patients 18-75 years of age with diabetes (type 1 and type 2), with Medicaid coverage, whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or

was missing a result, or if an HbA1c test was not done during the measurement year (combined results of HMO & PPO plans). A lower rate indicates better performance with the United States average being 46% among Medicaid Managed Care Organizations (MCOs). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from the 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 patients 18 to 75 years of age with diabetes (type 1 and type 2), with Medicaid coverage, who had a hemoglobin A1c (HbA1c) test performed during the measurement year. A higher rate indicates better performance with the United States average being 84% among Medicaid Managed Care Organizations (MCOs). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Data from New York State Department of Health's Quality Assurance Reporting Requirements, available for download at www.health.data.ny.gov.

Health-Related Quality of Life: Percent of adults age 18 and older with Medicaid health coverage who report fair/poor health. Analysis of data from the 2017 Behavioral Risk Factor Surveillance System (BRFSS) (CDC). Respondents were considered to have Medicaid coverage if the answer to the questions "What is the primary source of your health care coverage?" or "What type of health care coverage do you use to pay for most of your medical care?" was "Medicaid or Medical Assistance," or "Medicaid or other

state program." A lower rate indicates better performance with the United States average being 38% among patients with Medicaid coverage. Analysis for both the New York and national averages was conducted in STATA by Emma Wager, Catalyst for Payment Reform, November 2019.

Home Recovery Instructions (Information About Recovery at Home): Proportion of adult patients who responded to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) post-hospitalization that yes, they were given information about what to do during their recovery at home. 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. Note that figure reported represents New York general population and is not specific to New Yorkers with Medicaid coverage. A higher rate indicates better performance with the average being 86% across the United States. Radley et al. analysis of 2013 HCAHPS as administered to adults discharged from acute care hospitals; data retrieved from Hospital Compare (CMS).

Published in Commonwealth Fund Health System Data Center, accessed November 20, 2019. The New York and national average are available at <https://datacenter.commonwealthfund.org/topics/hospital-discharge-instructions-home-recovery>.

Unmet Care Due To Cost: Percent of adults age 18 and older with Medicaid health coverage who reported a time in the past 12 months when they needed to see a doctor but could not because of cost. Analysis of data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) (CDC). Respondents were considered to have Medicaid coverage if the answer to the questions "What is the primary source of your health care coverage?" or "What type of health care coverage do you use to pay for most of your medical care?" was "Medicaid or Medical Assistance," or "Medicaid or other state program." A lower rate indicates better performance with the United States average being 17% for patients with Medicaid coverage. Analysis for both the New York and national averages was conducted in STATA by Emma Wager, Catalyst for Payment Reform, November 2019.

Definitions

Attribution: Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purpose of calculating health care costs/savings or quality of care scores for that population. "Attributed" patients can include those who choose to enroll in, or do not opt out of, an accountable care organization (ACO), patient centered medical home (PCMH), or other delivery models in which patients are attributed to a provider with a payment reform contract.

Bonus payments based on measures of quality and/or efficiency: Payments made that reward providers for performance in quality and/or efficiency relative to predetermined benchmarks, such as meeting pre-established performance targets, demonstrating improved performance, or performing better than peers. Bonus payments can include programs that pay providers lump sum payments for achieving performance targets (quality and/or efficiency metrics). Bonus payments can also include payments tied to a provider's annual percentage increase in FFS payments based on their achievement of performance metrics. Bonus payments do NOT include Medicaid health home payments or payments made to PCMHs that have received NCQA accreditation (see "non-visit function"), or payments made under shared-savings arrangements that give providers an increased share of the savings based on performance (see "shared savings").

Bundled payment: Also known as "episode-based payment," bundled payment means a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given

treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

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.

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, 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.

Alternatively, a fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.

Payment reform: Refers to a range of health care payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.

Plan members: Health plan's enrollees or plan participants. For the purposes of this data, plan members will be counted by number of months each unique member was covered by health plan during the reporting period.

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

Providers: Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities (e.g. hospitals), including ancillary providers.

Quality/Quality components: A payment reform program that incentivizes, requires, or rewards some component of the provision of

safe, timely, patient-centered, effective, efficient, and/or equitable health care.

Reporting period: Reporting period refers to the time period for which the health plan should report all of its data. Unless otherwise specified, reporting period refers to calendar year (CY) 2016. If, due to timing of payment, sufficient information is not available to answer the questions with the requested reporting period of calendar year 2016, the health plan may elect to report for the time period on the most recent 12 months with sufficient information and note the time period. If this election is made, all answers should reflect the adjusted reporting period.

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

Shared savings: Provides an upside-only financial incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering

providers a percentage of any realized net savings. "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be built on a FFS payment system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and will vary based on provider performance.

Specialists: Specialist clinicians have a recognized expertise in a specific area of medicine. For physicians, they have undergone formal residency and/or fellowship training programs and have passed the specialty board examination in that field. Examples include oncologists, ENTs, cardiologists, renal care specialists, etc. Nurse practitioners and physician assistants working in a non-primary care setting are also considered specialists. For the purposes of this data collection, specialists are not primary care providers. See definition of "primary care providers."

Status quo payments: Includes all payment not tied to quality, including legacy FFS-payments, which is a payment model where providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. For the purposes of the CPR Scorecard, Diagnosis Related Groups (DRGs), case rates, and per diem hospital payments are considered status quo payments. Full capitation without quality, or a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, is also categorized as a status quo payment. In this model, payments may or may not be adjusted for patient risk, and there are no payment adjustments based on measured

performance, such as quality, safety, and efficiency.

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

amount) made to providers in calendar year (CY) 2013 or most recent 12 month.

Beginning in 2018, CPR expanded the definition of Total Dollars to include out-of-network payments.

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