



# Leader Perspectives

on the impact and future of payment reform in New York State

*A report to accompany the*  
2018 and 2019 NEW YORK  
SCORECARDS ON PAYMENT  
REFORM 2.0

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*Compiled and prepared by*  
Catalyst for Payment Reform  
Andréa Caballero, MPA  
Lea Tessitore, MBA, MSB  
Alejandra Vargas-Johnson

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**Department  
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## Introduction to Scorecard on Payment Reform 2.0

Nearly a decade after the passage of the Patient Protection and Affordable Care Act, the search for value is still front and center in the nationwide discussion on health care. Looking to curb spending and give residents access to high-quality care from high-quality providers, states across the country have been innovating and implementing strategies designed to meet these goals. New York is a state leading the charge as one of eleven in 2014 to receive a Round Two Model Test Award State Innovation Models (SIM) grant from the Centers for Medicare and Medicaid Innovation (CMMI) to implement a State Health Innovation Plan (SHIP). By implementing a SHIP, New York has shown its commitment to planning, designing, testing, and evaluating new health care payment and delivery models. Furthermore, in 2014 the State also received a groundbreaking waiver allowing it to reinvest \$8 billion in federal savings generated by previous Medicaid Redesign Team (MRT) reforms. The waiver enabled comprehensive Medicaid delivery and payment reform through a Delivery System Reform Incentive Payment (DSRIP) program. With these reforms underway, New York is looking to the future of health care in the state. In 2018, the New York State Departments of Health (NYSDOH) and Financial Services (NYSDFS) commissioned Catalyst for Payment Reform (CPR) to produce 2018 and 2019 New York Scorecards on Payment Reform 2.0, which track payment reform in the commercial and Medicaid markets in 2017 and 2018, respectively.<sup>1</sup>

Catalyst for Payment Reform (CPR) is a national, 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. Since 2013, CPR has pioneered tracking the amount and types of payment reforms at the national and state levels. In 2017, CPR added to its original Scorecard on Payment Reform methodology with metrics that evaluate how well the health care system is performing regarding the quality and affordability of care. CPR piloted Scorecard 2.0 in Colorado, New Jersey, and Virginia in 2018.

CPR recognizes that the health care system is incredibly adaptive and success with one payment reform program may not be scalable or may have negative ramifications elsewhere as health care providers seek to maintain their revenue. While Scorecard 2.0 cannot identify direct causal relationships between payment reforms and health care quality and cost, a view of the New York health care system at a higher "altitude" yields important insights.

To supplement the quantitative data in the 2018 and 2019 New York Scorecards on Payment Reform (which track progress since a baseline Scorecard from 2015), CPR interviewed health care leaders in the state to obtain qualitative information about payment reform and its impact on the New York health care market. With the combination of the Scorecards and this Leader Perspectives Report, CPR and New York State aim to understand the progress the State has made toward reforming payment and improving the value of care.

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<sup>1</sup> Scorecards reflect data from the prior year. For example, the 2018 Scorecard on Payment Reform 2.0 is based on data from the 2017 calendar year.

## Interview Methodology

This paper summarizes the perspectives CPR captured through semi-structured interviews with 20 health care leaders across academic institutions (2), consumer organizations (3), health plans (3), multi-stakeholder groups (1), provider associations (3), large health systems (2), organizations that purchase health care coverage for a population (3), and regulatory agencies (3).

Both the NYSDOH and the NYSDFS helped CPR identify health care leaders across stakeholder groups to ensure CPR captured a wide range of perspectives. To preserve the integrity of the insights and the confidentiality of the participants, this report does not identify the individuals or organizations who participated but, instead, notes which stakeholder group provided each insight. CPR thanks all participants for their candor and the time they took to share their expertise and views.

CPR conducted the semi-structured interviews by phone over five months (May – September 2019); most interviews lasted approximately one hour. In advance of each interview, CPR provided interviewees with a guide describing the project, the methodology, and the interview questions. CPR's program director, Andréa Caballero, and senior project and research manager, Lea Tessitore, led and facilitated the interviews.

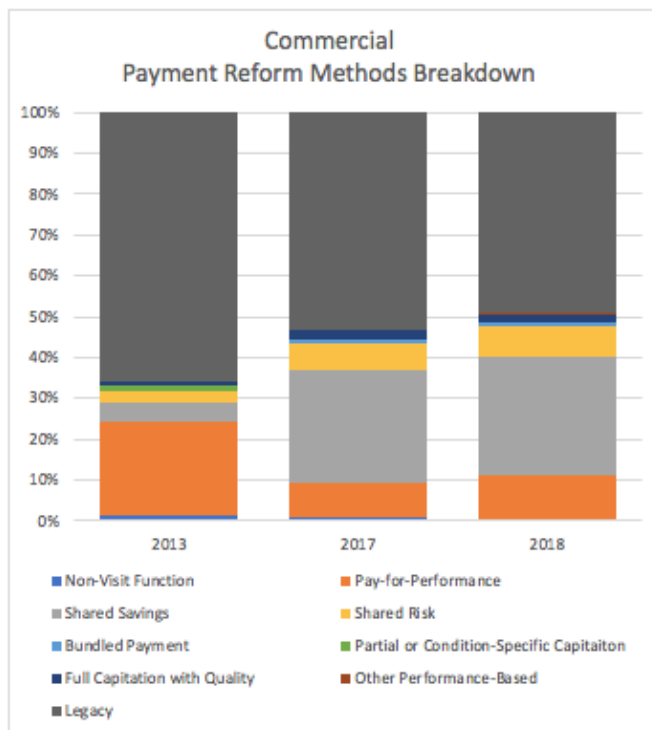
Upon completion of the interviews, CPR analyzed the responses and identified key themes. The remainder of this report lays out the findings in the same sequence the interviews used and compares findings from the interviews with the data from the Scorecards.

## Comments on the Quantitative Findings

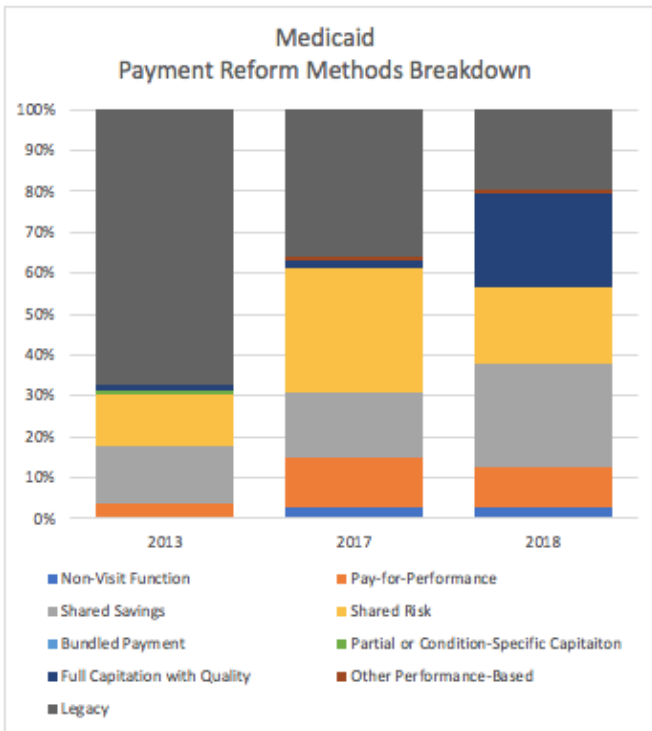
This report is accompanied by four quantitative Scorecards: two on New York's commercial market (2018 and 2019) and two on New York's Medicaid market (2018 and 2019), which showcase how much and what types of payment reform occurred in the Empire State in 2017 and 2018.

### Payment Methods – Commercial

The most prevalent value-oriented payment method in the commercial market in New York in both CY 2017 and 2018 was shared savings. Twenty-eight percent (27.8%) and twenty-nine percent (28.9%) of health care dollars flowed through shared savings arrangements those years, respectively. The second most prominent value-oriented payment method in the commercial market in both CY 2017 and 2018 was pay-for-performance (P4P) at eight percent (8.4%) and



eleven percent (10.8%), respectively. The least prevalent value-oriented payment method in the commercial market in CY 2018 (excluding dollars in other types of performance-based contracts) was partial or condition-specific capitation at 0.2%, followed by payments for non-visit functions (0.5%) and bundled payments (0.7%). The least prevalent method in CY 2017 (excluding dollars in other types of performance-based contracts) was partial or condition-specific capitation (0.2%), followed by bundled payments (0.8%) and payments for non-visit functions (0.8%).



### Payment Methods – Medicaid

In CY 2018, the most prevalent value-oriented payment method in New York’s Medicaid market was shared savings; twenty-five percent (25.3%) of dollars flowed through this type of arrangement. The second most prominent value-oriented payment method in CY 2018 was full capitation at 23.3%, followed by shared risk at 18.7%. The least prevalent method in CY 2018 was payments for non-visit functions at 2.6%, followed by pay-for-performance at 9.8%. In CY 2017, the most prevalent value-oriented payment method in the Medicaid market was shared risk – thirty percent (30.4%) of health care dollars flowed through shared risk arrangements. The second most prominent value-oriented payment method was shared savings at 15.7% in CY 2017, while the least prevalent method in CY 2017, again excluding dollars in other

types of performance-based contracts, was full capitation at 2.0%, followed by payments for non-visit functions (2.7%).

### Macro-Indicators

When examining New York’s quality and affordability against national averages using the metrics selected by CPR’s multi-stakeholder advisory committee as indicators of payment reform’s impact, it is clear that New York has improved health system performance. Looking at performance on these indicators using 2018 data, New York Medicaid managed care performed better than the national average in all seven metrics for which data are available. On some indicators, New York Medicaid performed 10 or more percentage points better than the national average. For example, only 31% of Medicaid patients with diabetes had poorly controlled blood sugar compared to 41% nationally (HbA1c poor control metric). While impressive compared to the national figure, the result suggests there is additional room for improvement. With 92% of Medicaid enrollees with diabetes receiving an annual HbA1C test, there is hope that, in tandem with continued investment in and experience with payment reform, patient outcomes for this population will continue to improve.

Meanwhile, New York's commercial health plans performed better than or the same as the national average in seven out of the eight metrics for which data are available. The one exception is the rate of patients with diabetes who received at least one blood sugar (HbA1c) test annually, coming in just one percentage point worse than the national average. Health plans serving New York's commercial sector screened 64% of women ages 16-24 for chlamydia compared to the national average of 44%. New York's commercial sector also outperformed the national average in the rate of patients with hypertension who have adequately controlled blood pressure (57% statewide average in New York compared to 55% nationally).

Scorecard 2.0 uses the Unmet Care Due to Cost measure from the Behavioral Health Risk Factor Surveillance System survey to evaluate the affordability of health care from the patient's perspective. The proportion of patients in New York who reported unmet care due to cost in both the Medicaid and commercial sectors in 2017 (the most recent year for which data are available) was lower than the national average. For adults with commercial coverage, 8.2% went without care due to cost in New York compared to 9.6% nationally, while 12% with Medicaid coverage reported unmet care due to cost compared to 15% nationally.

## Impressions of Payment Reform Penetration in New York

To ground the interviewees in the present, CPR referenced the findings from the 2015 New York Scorecard on Payment Reform. Using 2013 data from health plans, the Scorecard showed that 34% of payments in the commercial market and 33% of payments in the Medicaid market were value-oriented, meaning they included quality components.<sup>2</sup> CPR asked interviewees how they thought the payment landscape in New York had changed since 2013. Nearly all expressed that there had been movement toward more value-oriented payment. The vast majority felt this movement was attributable to the implementation of the DSRIP Program, including the New York State Roadmap for Medicaid

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<sup>2</sup> Note that these payments include the base payment as well as the incentive component. For additional details, please reference the accompanying Methodology Report.

The New York State Department of Health (NYSDOH) implemented the Quality Assurance Reporting Requirements (QARR) in 1994. QARR is a public reporting system based on measures of quality established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), with additional New York State (NYS) specific measures.

New York State embraces quality measure alignment and strives to align quality measures across national and state programs and initiatives. At the state level, QARR measures are used in many state initiatives such as the NYS Prevention Agenda, the Delivery System Reform Incentive Payment (DSRIP) Program, the State Innovation Model (SIM) Advancing Primary Care Initiative, and Value-Based Payment (VBP) programs. Further information on QARR measures can be found [here](#).

Payment Reform (the VBP Roadmap), a specific DSRIP initiative.<sup>3</sup> Interviewees also mentioned the SIM/SHIP grant as a driving factor in the growth of value-oriented payment. One interviewee stated that “It’s [the health care system] moved even further in the direction of VBP, particularly in Medicaid due to the Roadmap which puts pressure and financial incentives on plans,” while another noted that “In Medicaid there has been DSRIP, so there is a real move toward VBP, and on the commercial side there was SHIP, so there was real eagerness to improve and benchmark primary care.”

Some interviewees felt that within the movement toward value-oriented payment, there was also a shift to shared risk. A leader from a regulatory agency said the inquiries they receive about shared risk arrangements have increased, while a representative from an academic institution observed that payers are implementing more incentives and quality metrics, while those with incentives already in place are moving toward risk. A provider/large health system representative estimated that “on the hospital payment side, we have seen a significant increase in all hospital payments having some incentive for quality and/or efficiency. Since 2014, we had total cost of care-based risk for about 25% of the patients who came through our primary care...and now we have some level of total cost of care based-risk for around 89% of the patients who get their primary care from us. So, there has been huge growth from there not really being any meaningful population-based risk arrangements in 2014.” Some respondents estimated that the commercial and Medicaid markets have transitioned to 50% or more percent of dollars flowing through value-oriented payment arrangements.

Lastly, stakeholders observed how progress on payment reform is linked to market dynamics and affected by regional market characteristics. A regulatory agency representative noted that the relationship between payers and providers has evolved as a result of the movement toward value-oriented payment, leading to a greater desire to align programs and innovate care delivery. As a result, the need to align and prioritize quality measures across payers has come to the forefront. Another stakeholder thought that value-oriented payment has resulted in independent physician practices being absorbed by larger systems because the operating costs of reform can be burdensome. The same interviewee also stated that if reform was working the way it was intended to, the opposite would occur in the market – there would be more healthy, independent practices, with generally less consolidation. A health plan leader observed that in highly competitive provider markets in the state, such as in New York City, hospitals are more willing to engage in value-oriented payment arrangements due to greater negotiating leverage on the part of the health plans.

## Is Payment Reform Gaining Momentum in New York?

When asked whether payment reform is gaining momentum in the state, almost all leaders see payment reform continuing its current momentum in the next year (most respondents) or even gaining steam. The majority of respondents identified that the state, health plans, providers, and others have made significant progress on value-oriented payment due to the SIM grant and DSRIP waiver but felt that as the funding for these activities ends, the future of reform is unclear. Given the significant investments in implementing VBP, stakeholders do not believe that the system will regress or backtrack on its progress. However, there is

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<sup>3</sup> [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/)

uncertainty as to what comes next. A purchaser representative noted that while reform efforts in the public sector may slow, the private sector might continue to move the dial. Why did interviewees think momentum would grow? They expressed that “the move toward value is a train that has already left the station” and value-oriented payment is now a goal for many hospitals. Stakeholders also argued two sides of the same coin – one thought that the potential for renewed DSRIP funding would speed up payment reform efforts, while another thought that if federal funding was lost, the state would push to get to value-oriented payment even faster.

Almost all leaders see payment reform continuing its current momentum in the next year or even gaining steam. The majority of respondents identified that, while the State, health plans, providers, and others have made significant progress on value-oriented payment due to the SIM grant and DSRIP waiver, now that the funding for these activities is ending, the future of reform is unclear.



Other interesting nuances include the point that while momentum may continue or increase, this may not result in faster proliferation of value-oriented contracts with providers. For instance, providers may be enthusiastic about reform but not fully aware of the nature of the incentive programs for which they are signing up (e.g. shared risk). Continuing this point, another interviewee observed that the level of excitement and readiness amongst providers varies significantly across the market, which impacts the speed of reform. Interviewees also pointed to a mismatch between the energy, efforts, and push for payment reform and the evidence that reforms reduce costs or improve quality.

CPR followed up by asking the leaders to identify which payment methods might have the most

momentum. Shared savings was the most popular answer, followed by pay-for-performance, and shared risk. Interviewees also mentioned bundled payment, noting that it has already been implemented for certain types of care (e.g. orthopedic care) and seems visible on the horizon. Regarding why shared savings, pay-for-performance, and shared risk are gaining momentum, leaders noted how quality incentives have become more prevalent across the board, and that these types of payments are prescribed in the VBP Roadmap for Medicaid. In addition, interviewees collectively expressed a natural progression from one method to the next. Pay-for-performance is easy to understand, making it approachable as a starting point for providers to participate in payment reform. Shared savings is the next logical progression as it builds upon fee-for-service payments by adding quality and spending targets. Once a provider gains experience with tracking their performance against these targets, particularly if they have performed well, they may feel confident that they can succeed under more advanced payment models that include financial risk, such as shared



risk, capitation, or bundles. Some respondents noted, however, that there is a hesitancy around taking on shared risk and it has negative connotations for some providers.

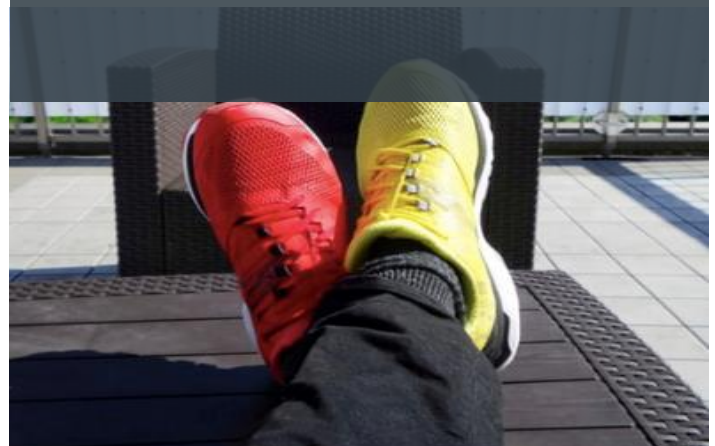
## Can Payment Reform Improve the Quality of Health Care in New York?

We next asked interviewees if payment reform could enable New York to improve the quality of its health care and how. Given myriad ways to define and measure health care quality, CPR asked participants to apply their own definition when surmising whether payment reform could improve quality in the state. Interviewees' definitions of quality included performance against quality measures (most popular definition), patient experience or satisfaction with care, or efficient or coordinated care. The vast majority of respondents believe that payment reform *can* improve the quality of health care. Common reasons they cited include that paying based on performance on quality measures and outcomes aligns incentives. In other words, if providers see that meeting quality metrics improves their bottom line, they will feel the incentive to keep meeting goals, and as a result, quality may improve. Tying payment to quality performance can also encourage providers to focus on areas where they perform more poorly. To these points, a leader from a health care purchasing organization stated that "when there are metrics that create incentives for improvement, it creates opportunities for providers to partner, have discussions, and get better reporting."

A major caveat surfaced around the distinction between whether payment reform *can* improve quality of care and whether payment reform *will* improve quality of care. Regarding the lack of evidence that reforms are working, many interviewees expressed that payment reform has the potential to improve quality but has not yet done so. An oft-cited impediment to payment reform achieving this goal is the proliferation of performance measures, or the lack of a standard measure set. As one provider representative noted, providers "can't get into the weeds on quality with 50 quality measures – no one can focus on that." This representative further noted that it is also difficult to align measures across contracts during negotiation with health plans. And if each contract focuses on different metrics, it will be difficult to improve quality across populations and across the state.

Many interviewees also noted that with so many variables in the health care ecosystem, it is hard to isolate payment

A major caveat surfaced around the distinction between whether payment reform *can* improve quality of care and whether payment reform *will* improve quality of care. Tied to the view above regarding the lack of evidence that reforms are actually working, many interviewees expressed that while payment reform has the potential to improve quality, it has not done so thus far.



reform as the cause of better quality. Social determinants of health and plan member behavior are also factors, among others. Interviewees with a provider perspective also recommended that providers be more actively involved in the design and implementation of payment reforms and quality measures.

When asked which payment methods could improve health care quality, a handful of respondents thought that bundled payments had the most potential, as bundles help providers think broadly about managing an episode of care or a condition and which services can together create efficiencies. In the words of a health plan representative, bundled payment “forces creativity.” A leader from a large health system remarked that bundles remind providers that “we don't get paid for this [certain services],” underscoring that providers should only deliver the care that patients need and nothing more. Some leaders felt prospective bundles, as opposed to retrospective, would work well, but that the current health care infrastructure and administrative capabilities are not set up well for this model.

After bundled payment, interviewees were split over whether reforming the physician fee schedule, implementing capitation, or shared risk would best improve quality. Shared savings was less popular, though many interviewees did not distinguish between shared savings and shared risk, seeing them as two sides of the same coin. Interviewees felt that changes to the fee schedule would allow high-value services currently undervalued to receive higher payments, thereby improving access to them. Views on capitation were that it offers flexibility in how providers care for patients and expend resources. Optimism for shared risk centered on providers having “skin in the game” and, consequently, incentives to improve quality.

Interestingly, when asked whether payment reform will noticeably improve the quality of care in the next three years, respondents were split. Reasons cited in favor include that the passage of time allows programs to mature and become more aligned. Among those who did not think there would be noticeable improvement, they felt there was not enough momentum for reform, the timeframe would be too short to see real change (or that the health care system moves too slowly), and that the evidence does not support its success.

## Can Payment Reform Improve the Affordability of Health Care in New York?

CPR asked interviewees if they thought payment reform could improve the affordability of health care in New York, allowing interviewees to define “affordability” on their own terms. Respondents defined affordability in various ways, including affordability for individual consumers (out-of-pocket costs, premiums), total cost to the purchaser, and affordability at the system level. Almost all leaders believed that payment reform can improve affordability. A common rationale was that payment reform increases transparency and the data available to payers, providers, and consumers alike. Respondents viewed transparency as having many positive effects, such as inciting market competition, because shedding light on health care prices would drive them down, exposing and eliminating some of the more egregious cost drivers (i.e. grossly overpriced providers and services), identifying and eliminating waste to create efficiencies, and allowing greater understanding by consumers of prices prior to receiving care.

"...We, and a lot of other networks, are in multiple shared savings contracts that hold us responsible for total cost of care and we have downside risk on a number of those contracts. So, if costs go up more than budget, then we have to write a check at the end of the year, so we care about that. Bending the cost curve – this is not something a health system would have ever cared about before these contracts came along..." – leader from a large health system

Prices, a representative from a large purchasing organization argued, are an "immediate and measurable element of the health care system – something we can look at and adjust right away, as opposed to quality." Separate from fostering greater price transparency, another respondent from a large health system observed that payment reform "forces networks and health systems to care about the affordability of health care in a way they didn't have to before...it's one thing about lamenting trends and another thing to have accountability for it. We, and a lot of other networks, are in multiple shared savings contracts that hold us responsible for total cost of care and we have downside risk on a number of those contracts. So, if costs go up more than budget, then we have to write a check at the end of the year, so we care about that. Bending the cost curve – this is not something a health

system would have ever cared about before these contracts came along, but we do now because we are responsible for total cost of care, so now we have a number of strategies and are working with physicians to implement them. To me this is really good for the health system."

Leaders made a distinction between whether payment reform *can* improve affordability of care and whether it *will*. For example, payment reforms that establish target budgets incentivize providers to meet quality standards as well as spending expectations. With everyone in alignment, there is greater potential to improve affordability, though it is not a guarantee. However, a couple of leaders suggested that unless payment reform addresses prices or unit costs, it will be difficult to tackle affordability – price is the root issue.

Others added that the impact may not be as great as desired, or may not be measurable or significant, as so many factors simultaneously influence cost trend and affordability. An additional caveat was that payment reform has not led to long-term savings, although costs may be higher without it in the short term. Another noteworthy nuance is the relationship between the consolidation of health care providers and rising prices.<sup>4</sup> A representative from a consumer organization described how the movement to value-oriented payment is driving further consolidation and higher prices as smaller, less sophisticated practices lacking experience with payment reform flock to larger systems and become "feeder practices."

When CPR asked interviewees which payment methods seem to have the most potential to improve the affordability of care, respondents chose capitation. There was a three-way tie, following capitation and "other," between bundled payment, shared risk, and changing the physician fee schedule. Interviewees felt capitation focuses on the "big picture," creating

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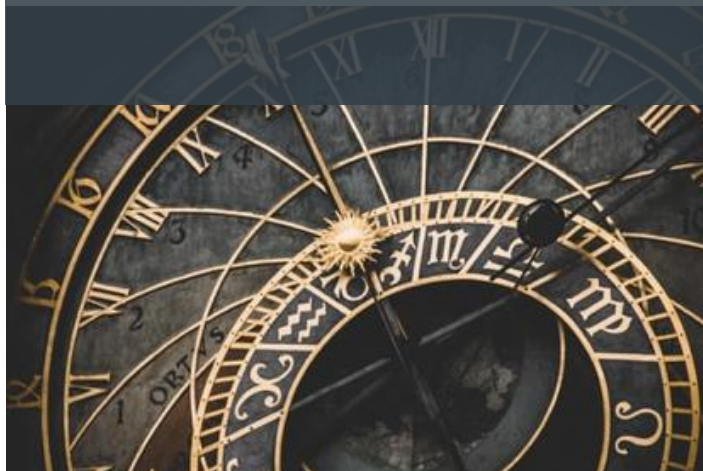
<sup>4</sup> <https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/>

strong incentives to control cost and inappropriate utilization, leading to efficiencies. Interviewees chose "other" mainly because they were unsure if any of the payment methods identified in the Scorecards could make health care more affordable. Leaders selected changes to the fee schedule because they perceive prices as the true drivers of cost. However, they cautioned that providers may increase volume of services delivered to make up for lost revenue if these changes are not done thoughtfully. As one health plan representative stated, "the fee schedule is like a balloon – push down price in one area and providers just offset by doing more of that service." Leaders thought bundled payments could level off some high-end expenses, and be applied to a variety of clinical conditions, and allow providers to have more predictable revenue. Lastly, interviewees who selected shared risk said it represents "skin in the game" and fosters accountability for spending and outcomes.

When asked whether payment reform will noticeably improve the affordability of care in the next three years, most interviewees were doubtful. They believe the health care system responds slowly and not enough time will have passed to see noticeable change. "Noticeably' is the key" said a health plan representative. "It [the system] will show some progress, but not sure if the needle will move that far. We are at, or approaching, a tipping point, such that in three to five years out will come the watershed when people will 'get it.' A lot of stuff is in the mix, payment reform is a part of this." An additional insight came from a regulatory agency representative, who cautioned that "if we let our value-based payment model progress and we don't make massive changes to the various factors that constitute the model...we'll be able to see a noticeable difference in the efficiency of care. But if we make changes before we allow the system to adjust itself after having been in VBP, then we won't have allowed ourselves to 'get to the end of it'

or allowed the system to change...providers assess how they did at the end of a performance period, and upon that assessment, they adjust how they deliver care. At that point, that is where the benefits of the VBP model occur. So, we need to be disciplined and allow the system to adjust – if we don't give providers time to adjust to value-based payment, we will never really realize the benefits." Other stakeholders offered the opinion that reform and the savings it generates are not enough to reach patients, and that there are too many changing (and contributing) variables in the health care system to pinpoint its impact.

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## The Role of Network and Benefit Design

The use of network and benefit design to direct patients to certain providers is gaining traction nationwide amidst continuous pressure to lower health care costs. Narrow networks, or limited networks, offer an economic signal that purchasers and payers can use to bring down health care costs.<sup>5</sup> According to the Henry J. Kaiser Family Foundation's 2019 Employer Health Benefits Survey, almost a quarter of large employers (5,000 or more workers) are offering a narrow network plan product.<sup>6</sup> Consequently, CPR asked stakeholders about their views of limited networks in New York.

Interviewees suggested that consumer appetite for limited networks is very low, and that these types of products may create access issues. In addition, interviewees questioned the quality of providers in narrow networks, noting that the products may contain costs but not improve quality. To this point, a purchaser representative found that limited networks "are very unattractive and unpopular with people because they want broad choice." The individual remarked that employers could better implement these products with more proof points that providers in the limited network truly are the best; consumers may assume the limited network pushes them toward lower quality and lower cost providers. Without a better standard for network quality, it is hard for employers to make a case for limited networks. Moreover, according to a multi-stakeholder organization "the market still demands some ability to go outside of networks. This will persist. Incentives may get stronger, but absolute [limited] networks will likely never exist." Regarding limited networks being inadequate and diminishing access to care, respondents noted that consumers, who may or may not understand network restrictions, may go out of network or to expensive sources of care (e.g. emergency rooms) to meet their needs and find themselves with huge, out-of-network bills. Moreover, a regulatory agency representative noted that there is data showing that narrow networks attract healthier people, implying that they may not suit the needs of sicker people. Limited networks may also be unable to meet specific health care needs. One representative of a consumer organization raised the point that women's health, mental health, and LGBTQ-confident providers are difficult to find in general, and limited networks only compound this issue.

Returning to the topic of market dynamics, many interviewees referenced provider market power and the existence of anti-steering language in provider contracts that makes it difficult to exclude dominant providers from a network. As a health system representative put it, "there is a need to give purchasers choices of different network configurations so they can find what meets their needs...limited networks are potential tools for driving improved value in care – both higher quality and greater affordability. In every other industry, if you deliver more affordable 'whatever,' you are rewarded with greater market share, and in health care that is almost entirely not the case. You can be significantly more affordable, but without the presence of limited networks, tiered benefits, or reference prices, etc. you can't actually be rewarded with market share." The representative went on to note that three major providers in New York City have "iron-clad anti-steering, anti-tiering language – which in health care is unethical. It's anti-competitive and ought to be illegal...and New York has some of the strictest language in the country...It's bad for patients, bad for society...and bad

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<sup>5</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20180208.408967/full/>

<sup>6</sup> <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>

for New York." Echoing this sentiment, a purchaser representative noted that limited networks provide an opportunity for higher quality care and lower costs, but many contracts contain anti-steering language and there is currently not a legislative ban on this language which may contribute to the problem.

## Conclusion

The New York Scorecards on Payment Reform 2.0 show how much and what types of payment reforms have been implemented in New York State and correlate these findings to the impact reforms are potentially having on patient outcomes, access, and affordability. However, to understand the impact of payment reform fully to date and to anticipate payment reform's future, it is critical to consider what leaders in the state, across the major stakeholder groups, think about it. In closing comments, leaders suggested that the future of reform is in question and that there is uncertainty as to what comes next. Some stakeholders stressed that the "consistency of the approach [to reform] over the long term is important in order to build a truly reformed health system." If New York has too many course corrections and changes, it will end up "disrupting stakeholders' efforts across the board, creating the appearance of a bait and switch that creates distrust for the next initiative." Furthermore, consistency of commitment to funding and program design will ultimately bring more stakeholders, particularly providers, on board.

However, that doesn't mean there isn't room for change. Some interviewees stressed the need for the State to put pressure on the "right components of the system." While there is a lot of activity around getting health plans to move toward value, there also needs to be effort around getting provider systems and hospitals to move to value-oriented models as well – getting providers to meet health plans halfway and "play ball." Other respondents are looking for the state to incorporate the member or patient perspective and social determinants of health in reforms. As one health plan representative stated, "When we talk about payment reform, we only talk about the MCOs [managed care organizations] and the providers, but guess what? None of this exists without the person that actually needs the care. The component about human behavior is left out, even though it is the key."

Lastly, a regulatory leader acknowledged that multi-payer efforts are extremely difficult to achieve. The interviewee noted that "value-based payment is a grand experiment...the nation is trying to move in that direction, but it hasn't been long enough to see the results just yet. We are at a really important time now where there has been a lot of experimentation, but we need independent evaluations to show what works...More time is needed for the experiment to bear good results and go even bigger, to see that ROI and move things further."

With some significant experience now under its belt, insights from the 2015, 2018 and 2019 Scorecards on Payment Reform, and the perspectives of diverse leaders, the State can continue its pursuit of higher value health care for New Yorkers and chart its next steps for payment and delivery reforms.