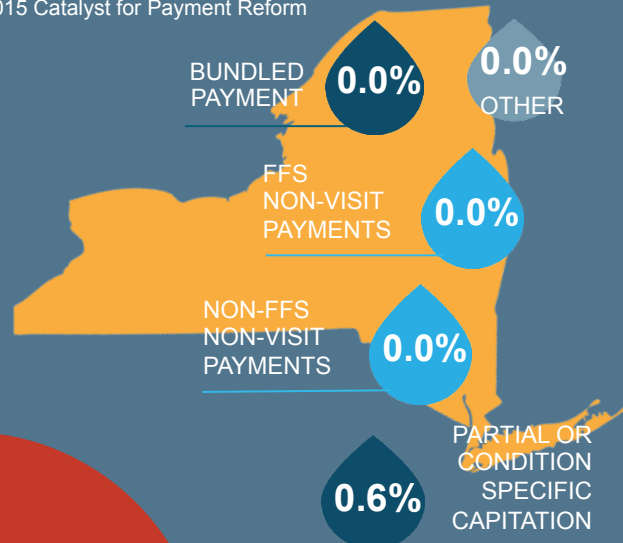


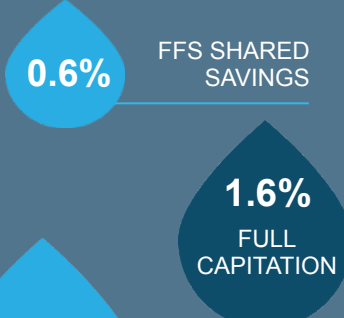
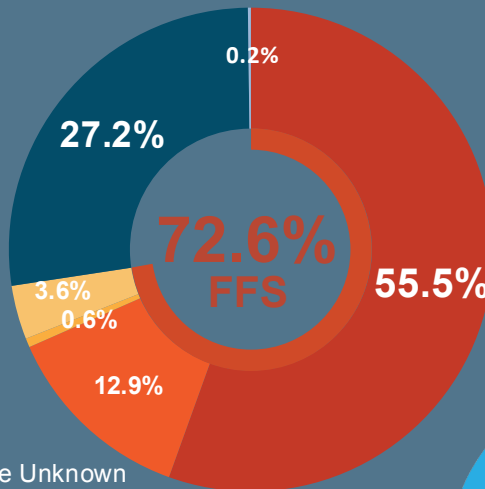
2015: 33%

NEW YORK SCORECARD ON Medicaid Payment Reform



How Much Does New York Still Rely on FFS?

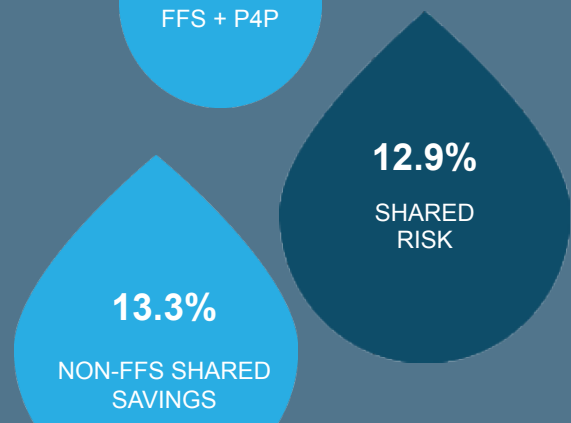
- Traditional FFS
- FFS Shared Risk
- FFS Shared Savings
- FFS + P4P
- Non-FFS
- Other: Payment Type Unknown



What Portion of Value-Oriented Payments Places Doctors and Hospitals at Financial Risk for Their Performance?

46% "at risk"

54% "not at risk"



31% of all hospital payments

16% of all outpatient specialist payments

64% of all outpatient primary care physician payments

are value oriented

32.7%

of the total payments made to doctors and hospitals are value-oriented



CATALYST FOR PAYMENT REFORM

Benchmarks for Future Trending

Is Payment Reform Reaching Patients? Attributed Members



Percent of Medicaid beneficiaries attributed to a provider participating in a Medicaid payment reform contract, such as those members who choose to enroll in, or do not opt out of, an accountable care organization, patient centered medical home or other delivery models in which patients are attributed to a provider.

56% MEDICAID AVERAGE

Share of Total Dollars Paid to Primary Care Physicians and Specialists

Of the total outpatient payments made to physicians, 58% are paid to specialists and 42% are paid to PCPs. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.



Hospital Readmissions*

8%

?

of hospital admissions are readmissions

for any diagnosis within 30 days of discharge, for members 18 years of age and older

2013

2014

2015

2016

2017

2018

2019

2020

* Derived from data submitted to eValue8 using NCQA's all-cause readmission measure. Not an official NCQA Benchmark.

Non-FFS Payments and Quality

Quality *is* a factor in

57%

of non-FFS payments



Quality is *not* a factor in

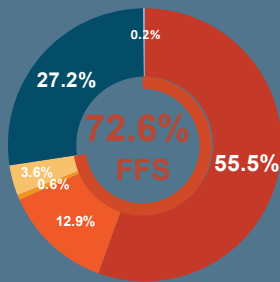
43%

of non-FFS payments

How to Interpret the Scorecard Results

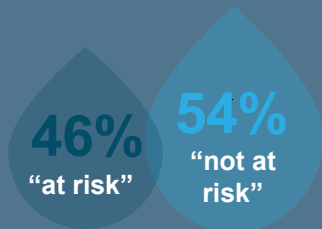


The results of the New York Medicaid Scorecard on Payment Reform are in, and **33%** of all Medicaid payments are value-oriented—either tied to performance or designed to cut waste. Traditional fee-for-service (FFS), bundled, capitated and partially capitated payments without quality incentives, make up the remaining **67%**. These data are from calendar year 2013 or the most recent 12 months. The use of value-oriented payment is growing rapidly; now we need to determine whether it makes health care better and more affordable.



FFS remains the dominant base method of payment, even when it contains a quality incentive. Of all the Medicaid payments made in New York, **72.6%** are still based on FFS. Only **27.2%** use a non-FFS based payment method. The payment type is unknown for **0.2%** of payments.

Payment reform can take many forms, whether it is based on FFS or not, but tracking the degree to which FFS is still used as a base method of payment can help us understand where we are in the evolution of payment reform. In New York, a little over 55.5% of payments are still traditional FFS, without any quality components. An additional 17% of payments are still based on FFS but include some quality component. In Medicaid, 27.2% of payments are not based on FFS. Payment methods categorized as non-FFS include: bundled payment, full capitation, partial or condition-specific capitation, and payment for non-FFS non-visit functions. All of these may or may not have quality components.



Of the 33% of Medicaid payments that are value-oriented, just under half put providers at financial risk for their performance. Fifty-four percent of payments still offer providers a financial upside only, with no downside financial risk.

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Tracking New York's Progress on Payment Reform was commissioned by the New York State Health Foundation. Utilizing the National Business Coalition on Health's (NBCH) eValue8 health plan survey tool, the project was conducted in partnership with the New York State Health Foundation, NBCH, the Northeast Business Group on Health, the New York Department of Financial Services, and the New York Department of Health. CPR thanks these organizations, NBCH Director Foong-Khwan Siew, CPR Program Director Andréa Caballero, and the health plans that provided data for the Scorecard for their significant contributions to this project.

