What is the Scorecard on New York Payment Reform and what does it tell us?

The Scorecard on New York Payment Reform is actually two scorecards that track the implementation of value-oriented payments in the Medicaid and commercial sectors of health care.

Commissioned by the New York State Health Foundation, the project was conducted by the nonprofit Catalyst for Payment Reform. The two scorecards are based on surveys conducted in 2014 of 10 commercial health plans and 15 Medicaid health plans that gathered information about their payment methods during 2013 or the most recent 12 month period for which data were available.

The scorecards found that:

	Commercial	**Medicaid**
Percentage of payments tied to value (designed to boost the quality of care).	34.1%	32.9%
Percentage of payments that place health care providers at financial risk for their performance (they stand to lose financially if they overspend or do not meet quality targets).	14.7%	46%
The most common form of value-oriented payment.	23.1% *Pay-for-Performance (typically fee-for-service with a bonus for meeting quality or efficiency goals)*	13.3% *Non-fee-for-service based payment with shared savings agreement (typically to support either patient centered medical homes or accountable care organizations)*
Percentage of payment arrangements that contain "shared risk," which means providers are financially responsible for any financial losses and have the opportunity to gain financially if there are any savings.	2.8% *In the commercial sector, this method would typically be used in an agreement with an accountable care organization*	12.9% *Provider-owned Medicaid health plans are in a good position to hold providers financially responsible for exceeding cost targets*

What is value-oriented payment?

When Catalyst for Payment Reform uses the term value-oriented payment, we mean payment methods that reflect or are designed to improve the quality and safety of care along with payment methods designed to spur efficiency and reduce unnecessary spending. If a payment method only addresses efficiency, it is not considered value-oriented. It must include a quality component. The metrics (numerators and denominators) we used to define value-oriented payment in the Scorecard can be found here (link to methodology).

How will these scorecards be used?

The scorecards help provide a baseline for stakeholders in the Empire State against which they can track their progress on payment reform going forward.

What is "payment at risk?"

When payment to providers is "at risk," it means providers could gain or lose income depending on whether they meet quality or efficiency measures and how much they spend on patient care. Under some payment methods, such as pay-for-performance, providers can earn additional revenue for meeting certain quality and/or efficiency standards.

For the purposes of this Scorecard, these "at-risk" arrangements include:

- bundled payment
- full capitation (also known as global payment)
- partial-capitation/condition-specific capitation
- shared-risk payment arrangements (typically arrangements where providers are financially responsible for any financial losses and have the opportunity to gain financially if there are any savings)

While positive incentives can create motivation for providers to improve quality and reduce waste, two-sided risk, where the provider also stands to lose income, may create an even stronger incentive.

What accounts for the differences we see between Medicaid and the commercial sector?

We see more payment "at-risk" in Medicaid. This is likely due to a higher prevalence of provider-owned health plans, which may be more likely to structure payment contracts that pose financial risk to providers. More study is needed to understand the differences in the "at risk" payments in both sectors.

How did CPR collect these data?

The Scorecard was derived from data collected through the National Business Coalition on Health's eValue8 health plan survey platform. Ten commercial health plans and 15 Medicaid health plans completed the survey.

To collect data from both the commercial and Medicaid health plans via the survey, CPR collaborated with the New York State Department of Financial Services (DFS). DFS issued a request for information pursuant to Section 308 of the New York Insurance Law to ensure participation by all health plans within the scope of the survey.

For more information, please see the "Data Collection Survey" and "Data Sources and Instructions" sections of the methodology documents.

How does the Scorecard on New York Payment Reform compare to CPR's National Scorecard on Payment Reform?

CPR's 2014 National Scorecard on Payment Reform measured value-oriented payment in the commercial sector across the nation and identified that 40 percent of payments were value-oriented (compared to 34.1 % of payments by New York commercial health plans and 32.9 % of payments by New York's Medicaid plans).

CPR's National Scorecard is based on 2013 data from the annual eValue8 survey of commercial health plans conducted by the National Business Coalition on Health. In New York, CPR used the eValue8 survey platform to collect the data from the commercial and Medicaid plans. The consistent methodologies allow us to compare New York's commercial sector results to our national results.

Why is there a fee-for-service metric on the New York Scorecards, but not CPR's National or California Scorecards?

The New York State Health Foundation, which commissioned the scorecards, and other stakeholders in New York, place a strong emphasis on moving away from fee-for-service as a base form of payment. CPR collects data on the use of fee for service and was able to provide this analysis to address the unique request in New York.