



NEW YORK HEALTH CARE COST AND QUALITY INITIATIVES

Payment Reform Survey

*A look at pilot programs by
New York health insurers to move to
value-based provider payments
and other initiatives to reduce health care costs
and improve quality*

**New York State Department of Financial Services
July 2014**

TABLE OF CONTENTS

Contents

- Executive Summary*..... 4
- Introduction*..... 11
 - Survey Methodology 12
 - Survey Respondents..... 14
- Value-Based Payment Programs*..... 15
 - 1. “The Numbers” 15
 - Number of Value-Based Payments Models, Statewide 15
 - Number of Insurers Offering Each Value-Based Payment Models 15
 - Number of Programs Offered by Each Insurer..... 16
 - Providers Impacted 16
 - Members Impacted..... 16
 - Implementation Dates..... 17
 - Lines of Business Impacted..... 17
 - Types of Health Care Services Impacted 18
 - 2. Inventory of Payment Reform Programs (based on 2012 data)..... 19
 - 3. Variation in Insurers’ Programs..... 25
 - Geographic Variation 25
 - Variation in Quality Measurements 27
 - Variation in Attribution Methodologies..... 28
 - 4. Early Results: Evidence of Savings and Better Quality 29
 - Evidence of Savings 29
 - Quality Impact 29
 - 5. Barriers to Reform 30
- Value-Based Insurance Design and Patient Engagement*..... 32
 - Inventory of Value Based Insurance Designs (based on 2012 data) 33
- Other Payer Initiatives* 36
 - Transparency Initiatives..... 36
 - Electronic Health Records Incentive Programs..... 39
 - Non-Payment For Specific Services..... 39

Conclusions and Recommendations.....41
Appendix A: Definitions.....44
Appendix B: Payment Reform Survey.....46
Appendix C: Non-payment standards.....49

Executive Summary

New York is committed to the “Triple Aim”: better health, better quality and lower costs. New York health insurers and providers have initiated efforts to reduce rising medical costs and to increase the quality of medical services provided to patients. These nascent efforts are promising, and insurers and providers should be praised for their efforts. Many of the initiatives, however, are small scale and are not consistent or coordinated.

This report documents and analyzes health insurers' payment reform efforts in New York. The report will help state agencies, legislators and other stakeholders identify successes, consider reforms that encourage innovation, increase standardization and multipayer alignment, and bring successful efforts to scale. In particular, this report will provide a baseline for the State Health Innovation Plan (SHIP), New York's blueprint for achieving the Triple Aim that is being developed by the New York State Department of Health (DOH), New York State Department of Financial Services (DFS), New York State Department of Civil Service, the New York State Division of Budget, and other agencies, in consultation with payers, providers, brokers, businesses and consumers.

Health Care Costs and Shortcomings of the Current System

The rising cost of health insurance in New York, like the rest of the nation, is unsustainable. U.S. health care costs are among the highest in the world, and New York's health care spending per capita is 22 percent higher than the U.S. average.

Health insurance premiums continue to rise, in large part, due to the increasing costs of medical care. While many factors contribute to this trend, one commonly recognized problem is the use of fee-for-service (FFS) payments to providers (“Fee-for-Service” and other terms are defined in Appendix A). Under FFS, insurers pay hospitals and physicians for each service that they perform. This payment structure rewards providers for performing more treatments and services without regard to the quality, efficiency or outcome of the procedures. Also, FFS payments are made separately to each physician or hospital that is treating a patient, without regard to whether the patient's care is coordinated among the various providers to ensure effective, efficient care delivery. Consequently, FFS payments can result in fragmented care and unnecessary costs due to overtreatment, inefficiency and waste.

Also, health care costs can vary widely, even within the same city or region. Consumers and their families often have little information about the cost or quality of health care providers, and are therefore left on their own to navigate a complex, fragmented system.

Many insurers have developed “value-based” provider payment models to supplement or replace FFS contracts. These pilot programs focus on linking provider reimbursement to quality and care coordination. Insurers have initiated a range of other programs, too, with a similar goal of reducing costs, improving quality and providing consumers with information to become actively engaged in health care decision making.

The Survey

To achieve the Triple Aim, it is crucial to understand the scope of current efforts at payment reform. DFS, in conjunction with DOH, conducted a survey in 2013 of New York commercial insurers' value-based provider payment programs and other value-based efforts in place in during 2012. Nineteen insurers and Health Maintenance Organizations (HMOs) licensed in New York completed the survey, which consisted of a standard questionnaire and follow-up interviews for clarification and further detail. The survey defined the types of payment programs, value-based insurance design and other terms, and relied on insurers' self reporting as to whether the program met the definitions. This report provides results of the survey and focuses on the following areas:

1. Value-Based Payment Programs.
2. Value-Based Insurance Design and Patient Engagement.
3. Other Payer Initiatives:
 - a) Price Transparency.
 - b) Electronic Medical Record Incentive Programs.
 - c) Non-Payment of Specific Services.

Findings

The following is a summary of the survey's findings:

1. **Value-Based Payment Programs**

- **76 innovative payment programs from 19 insurers.** Nineteen insurers, including all major health insurers in New York, responded to the survey, describing a total of 76 innovative payment programs statewide.
- **Variability.** While all of the major New York insurers are engaged in pilot programs to affect costs, they are developing those programs independently, resulting in inconsistent progress. This variability can make it difficult for providers to adopt changes because they may be paid by different payers with different programs, based on different quality metrics and performance criteria.
- **Few Providers Impacted.** Only an average of 15% of insurers' participating providers were impacted by value-based programs.
- **Few Consumers Impacted.** Only an average of 12% of insurers' members were impacted by value-based programs.
- **Most Programs Still Pay on FFS Basis.** Most insurers' programs (80%) make value-based or care coordination payments *in addition to* FFS payments.
- **Pay-for-Performance (P4P) Predominates.** Almost half of the value-based programs are "Pay-for-Performance" models, which give bonuses to providers for meeting pre-established benchmarks for care processes and patient health outcomes.
- **Some Evidence of Savings, But Most Yet to Be Measured.** Value-based programs are new, so few insurers are able to measure savings yet. But initial results are positive. Some

insurers reported both significant financial savings and improved quality of services. For instance, the Adirondack Medical Home Demonstration, a multi-payer patient centered medical home pilot program facilitated by DOH, decreased costs by \$45 per member per month (PMPM) for commercial insurance enrollees and \$31 PMPM for Medicaid managed care enrollees from 2009 to 2012. Medicaid FFS costs (actual) decreased by approximately \$3 PMPM over the same time period. The demonstration also helped increase the number of primary care providers in the area, increase the quality of primary care services and increase patient satisfaction scores.

- **Not Limited to HMOs.** Most of the value-based payment models are offered through HMO lines of business (56), but a significant number are offered in Preferred Provider Organizations (PPO) (45), HMO-Point of Service (HMO-POS) (45) and Exclusive Provider Organization (EPO) (39) lines of business.
- **Primary Care Focused.** Most of the value-based payment models offered in New York involve primary care services. Specialist services, hospitals (inpatient and outpatient), non-physician services and emergency room (ER) services are impacted to a lesser degree, and lab and radiology services impacted the least.
- **Variation in Programs**
 - **Regional Variation:** The value-based payment programs of the surveyed companies were more prevalent in urban areas, including the New York City, Albany and Buffalo areas. Rural areas had value-based programs.
 - **Variation in quality measures:** 79% of the value-based programs measure quality, and 25% risk adjust payments to providers. ("Risk adjustment" adjusts the providers' payment amounts to reflect the morbidity of providers' patients relative to each other so providers with sicker patients are not penalized with lower quality ratings). But there is wide variation in the quality measures. There are different measures used by different insurers, different sources of quality data and different types of providers expected to report on and meet measures. Also, because provider reimbursement contracts are negotiated independently from one another, quality measurements may be inconsistent from one contract to the next, even though the contracts address the same types of services.
 - **Variation in Attribution Methodologies:** "Attribution" is the process of assigning a patient or patient population to a specific provider, group of providers or health care facility. Insurers do not use consistent attribution methodologies.
- **Barriers to Reform:** Insurers identified three types of barriers to implementing value-based reforms:
 - Logistical Barriers. Approximately half of the barriers identified by the surveyed insurers concern logistical obstacles, including information technology (IT) constraints, health information availability, difficulty of providers to maintain National Committee for Quality Assurance (NCQA) certification and lack of staff skill.

- **Provider Participation.** Almost one third of the barriers identified by the surveyed insurers concern provider-specific obstacles, including provider or hospital reluctance to assume risk and providers' unwillingness to participate.
- **Patient Engagement.** Roughly 18% of the barriers identified by the surveyed insurers concern patient-specific reasons, including difficulty reaching the requisite member threshold, difficulty getting members to use primary care providers (PCPs) and low concentration of members with a particular provider.

Two New York State initiatives should help alleviate some of these barriers. DOH is developing an All Payer Database (APD), which will store claims information from all major public and private payers, such as insurance companies, Medicaid, Medicare, pharmacy benefit managers and third party administrators. The APD will provide an electronic platform for claims analysis, research and consumer transparency. DOH is also developing the Statewide Health Information Network of New York (SHIN-NY), a secure, state-wide electronic network that allows providers to share health records and coordinate care of patients who receive services from multiple providers.

2. Value-Based Insurance Design and Patient Engagement

"Value-Based Insurance Design," or VBID, refers to the use of health plan incentives to encourage enrollee use or adoption of high value health services, high performing health care providers, healthy lifestyle such as smoking cessation or increased physical activity. Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans such as a Health Savings Accounts. The survey showed that there is a fairly even distribution of programs that encourage wellness, health assessments, preventive screenings and doctor visits. The most common incentives were cash and reduced cost sharing.

3. Other Payer Initiatives

- **Transparency**

Transparency of data between payers and providers is a necessary foundation for successfully implementing value-based payment programs. Transparency allows providers to: (1) track patients' claims across other providers to coordinate care and (2) track the quality and cost of their own services.

Data transparency between payers, providers and patients also can transform care delivery and patient engagement by enhancing patients' ability to understand their potential out-of-pocket expenses and the quality of prospective or current providers, both of which will help inform patients' health care choices.

Many of the surveyed companies have some type of transparency program, but there is little consistency in (1) the types of data released (quality or cost, provider-specific or averages across different providers), (2) the recipients of the information (members, providers or public) and (3) the method of disclosure (internet, reports or telephone).

Limits on Transparency. Almost all insurers reported limits on transparency. Most insurers only report limited data sets, such as limited number of procedures, average billed charges (not

specific reimbursement rates), or data relevant only to a limited number of providers. Over half of the companies claimed that the information was disclosed only to providers and not to the public because the information was proprietary or subject to confidentiality clauses in provider contracts.

- **Electronic Health Records Incentive Programs**

Only five insurers reported that they had any incentives, promotions or other programs for participating providers to develop interoperable Electronic Health Record (EHR) systems. The use of some type of EHR system is crucial to the success of any payment reform effort. EHR systems allow providers to efficiently review the claims history of a patient from other providers and from different payers, enabling the provider to deliver care in the most efficient manner possible. EHR development is one of the biggest challenges, technologically and financially, for both payers and providers.

- **Non-Payment for Specific Services**

The survey collected data on participating provider contracts that included provisions for non-payment for specific services associated with complications that were preventable or potentially preventable, or services that were unnecessary (commonly referred to as “never” events, e.g. surgery on the wrong body part). All surveyed companies include “never” events in their contracts, but there is wide variation among the specific services listed.

Conclusions and Recommendations

Almost all health insurers in New York are developing value-based programs to help contain costs and promote quality. The scale of those programs, however, remains relatively small for most payers. Few enrollees and providers are impacted. Also, few programs are moving away from the FFS payment structure, but instead are adding shared savings, P4P payments or care coordination payments on top of FFS payments.

With insurers working independently, programs are not consistent – many employ different payment structures, quality measures, and attribution methodologies. And many of the programs are too new to determine how much savings they will generate. But some early results are encouraging, with some insurers beginning to show savings.

DFS is looking at ways to encourage and incentivize successful programs. Bringing pilot programs to scale requires substantial investments by insurers and providers. Expanding programs beyond individual payers will require standardization where possible so providers can economically administer programs from various payers. Multi-payer alignment will be a key to success. “Alignment” can take various forms, including dialogue, cooperation, collaboration, shared resources and strategic or operational agreement on principles and implementation.

Insurers cite logistical barriers to provider participation in reforms, such high investment costs. However, many of the recommendations below may help reduce those barriers, including standardized quality and attribution standards, increased transparency and an All Payer Database (APD). If payers know that they will receive a return on their investments through better standardized measures and increased data and transparency to evaluate risk and rewards and improved health, they may be more likely to invest in value-based payment programs.

Develop Standardized Scorecard.

Most insurer reform efforts are new pilot programs that do not impact a large number of members or providers. DFS, in conjunction with DOH and other stakeholders, should develop a scorecard to measure progress with consistent metrics to allow comparison and analysis of which programs work best. In turn, this would inform expansion of the programs to larger populations.

Standardize Quality Measures.

Insurer reform initiatives use a variety of quality measures. Providers, faced with differing quality measures from multiple insurers, may be unwilling or unable to participate in payment reforms efforts. Greater standardization of quality measures would facilitate transformation and increase efficiency on a system-wide basis. Some of the reported variation in quality measurements may make sense, at least at first, because certain metrics are provider-specific or program-specific. Insurers agree that increased standardization will help. DOH, in conjunction with DFS, other agencies and stakeholders, should continue to develop a common, core set of quality metrics. Consideration should be given to using established benchmarks, such as National Quality Foundation (NQF), Healthcare Effectiveness Data and Information Set (HEDIS), or Consumer Assessment of Health Providers and Systems (CAHPS), which would allow for national benchmarking. Also, standardized measures could allow provider-, community-, or payer-specific additions to the core set appropriate to the local needs.

Standardize Attribution Methodologies.

As with quality measures, insurers use a variety of attribution methods. Some of the variation stems from the types of services delivered. Hospitals and specialists will have different attribution methodologies than PCPs because of the differences in the way they deliver care. However, greater consistency through increased standardization among providers would increase efficiencies on a system-wide basis. Insurers similarly agree that increased standardization of attribution methodologies will be helpful. DOH, in conjunction with DFS and other state agencies, should work with stakeholders to help standardize attribution methodologies.

Increase Transparency.

Providers need meaningful data, across all payers, to efficiently serve their patient populations and to measure their own success in a value-based payment environment. Similarly, consumers need access to understandable data about their providers and insurers in order to make meaningful choices about their health care. An all payer claims database (APD) would allow development of both quality and cost information and metrics necessary for patients and consumers to actively engage in health care delivery. The APD is particularly important with the increased prevalence of high deductible health plans and the focus on actuarial value of the “metal levels” of health plans under the federal Affordable Care Act. DFS should work with DOH and other state agencies as well as stakeholders to increase the transparency of data for consumers and providers. DFS and DOH already have received a “Grant to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle III” from the U.S. Department of Health and Human Services to help develop a web-based platform to make available data on costs and quality of health care services.

Increase Value-Based Insurance Design.

Patients will become more engaged in their health care delivery if they have financial incentives to do so. These incentives can decrease cost sharing if a patient goes to higher quality providers, or simply provide financial incentives to patients to lead a healthier lifestyle. Many insurers already have such programs, but expanding them would increase savings. DFS should work with insurers, providers and consumer groups to develop standards to help encourage and expand use of value-based insurance design options.

Standardize “Never” Events.

Non-payment for specific services varies among the insurers surveyed. DFS, in conjunction with DOH and other state agencies as well as stakeholders, should work to standardize and expand the list of “never” events to increase savings and increase efficiencies among providers.

Incentivize Use of Electronic Health Records.

Interoperable electronic health records (EHR) are the foundation of value-based payment programs and health care transformation. They allow tracking of services to patients by different providers, give insurers and providers quality of care information and enable insurers to link provider reimbursement to the quality of care. But infrastructure development requires investment and training. The survey results show that few companies provide incentives for providers to increase development and use of electronic health records. Because capital needs are high, all avenues of investments should be explored and shared. DFS, in conjunction with DOH and other state agencies as well as stakeholders, can develop targets for increased EHR investments and development.

Recognize Geographic Variation.

Because value-based programs are concentrated in certain geographic areas, DFS should continue to research whether particular programs are more successful in specific areas and whether there are specific conditions in those regions that lend themselves to success. Consideration should be given to expanding the successful programs statewide or to those areas of the state where there are fewer value-based programs.

Introduction

The growth in health care costs is unsustainable. Health insurance premiums continue to grow faster than inflation. More and more people cannot afford coverage. Fewer employers are offering coverage to employees. In New York and elsewhere, health care costs have far outstripped inflation. Many consumers and small businesses simply cannot afford health insurance. Some 2.2 million New Yorkers are uninsured. Approximately half of small businesses do not offer health insurance to employees. The federal Affordable Care Act (ACA) is helping, and almost 1 million people have enrolled through the NY State of Health, the Official Health Plan Marketplace. But the rate of health care cost increases is a weight on consumers and business that threatens to undermine our fragile economic recovery.

The underlying driver of this trend is the increasing costs of medical care. While many factors contribute to this trend, such as ever increasing research and expanding technology, this report focuses on the way that healthcare providers are paid for their services. One commonly recognized problem with the current payment and delivery system is the use of fee-for-service (FFS) payments to providers.¹ Under FFS, insurers pay hospitals and physicians for each service that they perform. The problem is that FFS payments create an incentive for providers to prescribe treatments and perform services, without regard to the quality, efficiency or outcome of the procedures. Also, FFS payments are made separately to each physician or hospital that is treating a patient, without regard to whether those providers are coordinating the patient's care to ensure effective, efficient care delivery. Consequently, FFS payment structures can result in fragmented care and unnecessary costs due to overtreatment, inefficiency and waste. Some experts estimate that up to 20% to 30% of our health care expenditures result from these types of waste and fragmented care delivery.²

A number of pilot programs are underway across the state to try to supplement or replace the FFS system with innovative "value based" or "pay-for-value" payment structures that link provider reimbursement to quality measurements and/or care coordination. The ACA includes funding for a number of pilot programs for Medicare recipients. Also, various commercial health insurance companies in New York are conducting or have conducted pilot programs that try to base payment on quality and care coordination.

The New York State Department of Financial Services (DFS), in conjunction with the New York State Department of Health (DOH), conducted a survey of New York health insurance companies' pay-for-value payment reform programs. The survey focused on five areas of reform:

- **Value-Based Payment Programs.** This category includes value-based provider payment models (other than FFS) that incentivize providers to increase quality of services, increase administrative efficiency, increase care coordination, and/or decrease costs. Innovative payment programs would include, but not be limited to, care coordination programs and any program where provider reimbursement is tied to the quality of the services provided.

¹ "What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth," Bipartisan Policy Center, September 2012.

² "Eliminating Waste in US Healthcare," Donald Berwick, Journal of the American Medical Association, April 11, 2012.

- **Value-Based Insurance Design and Patient Engagement**. This category focuses on the use of health plan incentives to encourage enrollee use or adoption of high value health services, high performing health care providers, or healthy lifestyle such as smoking cessation or increased physical activity. Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans such as a Health Savings Accounts.
- **Price Transparency**. This category focuses on companies' programs to promote cost, payment or quality transparency with providers and/or consumers.
- **Electronic Health Records**. This category focuses on incentives, promotions or other programs for participating providers to develop or adopt interoperable EHR systems.
- **Non-Payment of Specific Services**. The survey collected data on participating provider contracts that include provisions for non-payment for specific services associated with complications that were wholly preventable, unnecessary ("never events") or potentially preventable.

Survey Methodology

The survey consisted of two parts: (1) written questions about companies' innovative payment programs and other information and (2) a spreadsheet for quantitative information (see Appendix B). Both sets of requests were intended to collect consistent information that could be collated across the entire industry. Follow up interviews were also conducted with most of the companies responding.

One of the overarching goals of the survey was to identify extent of the pilot programs being conducted throughout the state. More specifically, the survey focused on the following five areas:

- **Quantitative information ("the numbers")**, including the number of programs, the number of impacted members and participating providers and the types of services impacted.
- **Variations in insurers' programs** in regards to geographic variation, quality metrics and attribution methodologies.
- **Results: savings and quality**, whether the programs had an impact on the cost of care for the attributed patient population or the quality of the services.
- **Barriers to reform** and provider participation and success of the programs.

For the purposes of consistency, the survey defined seven types of payment models:

Fee for Service (FFS) Payment: Payments to a provider, group of providers and/or health care facility based on a negotiated or payer-specified payment rate for every unit of service the provider delivers, without regard to quality, outcomes or efficiency.

Pay for Performance (P4P): Payments to a provider, group of providers and/or health care facility for meeting or exceeding pre-established benchmarks for care processes and patient health outcomes, such as primary care provider rewards for patients receiving recommended immunizations or hospitals scoring well on quality measures such as readmission rates or hospital acquired infection rates. Often paid in addition to FFS payments.

Care Coordination/Care Management Payments: Payments to a provider, group of providers and/or health care facility for a specified time period (e.g., monthly) to pay for care coordination and the infrastructure needed to enable care coordination, including health information technologies, disease registries, etc. For the purposes of this request, DFS requested information on three categories of care coordination payments: Patient Centered Medical Homes (PMHC), Accountable Care Organizations (ACOs) and programs that integrate physical and behavioral health (IPBH).

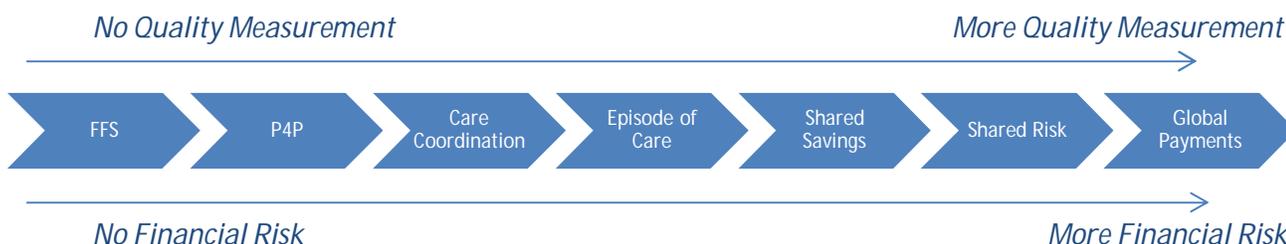
Episode-of-Care Payment: A single payment to a provider, group of providers and/or health care facility for all services to treat a given condition or to provide a given treatment, based on the expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time (also referred to as a Bundled Payment or Case Rate).

Shared Savings: A payment arrangement that provides an incentive for a provider, group of providers and/or health care facility to reduce unnecessary health care spending for a defined population of patients or for an episode of care by offering the provider a percentage of any realized net savings.

Shared Risk: A payment arrangement by which a provider, group of providers and/or health care facility accepts some financial liability for not meeting specified financial or quality targets. Examples include but are not limited to baseline revenue loss, loss for costs exceeding global or capitation payments, withholds that are retained, loss of bonus and adjustments to fee schedules. For the purposes of this survey, Shared Risk arrangements that also include a Shared Savings component were included in the Shared Risk category.

Global Payments: Prospective payment to a provider, group of providers and/or a health care facility for all or most of the care for an attributed group of patients over a specified period of time, such as month or year.

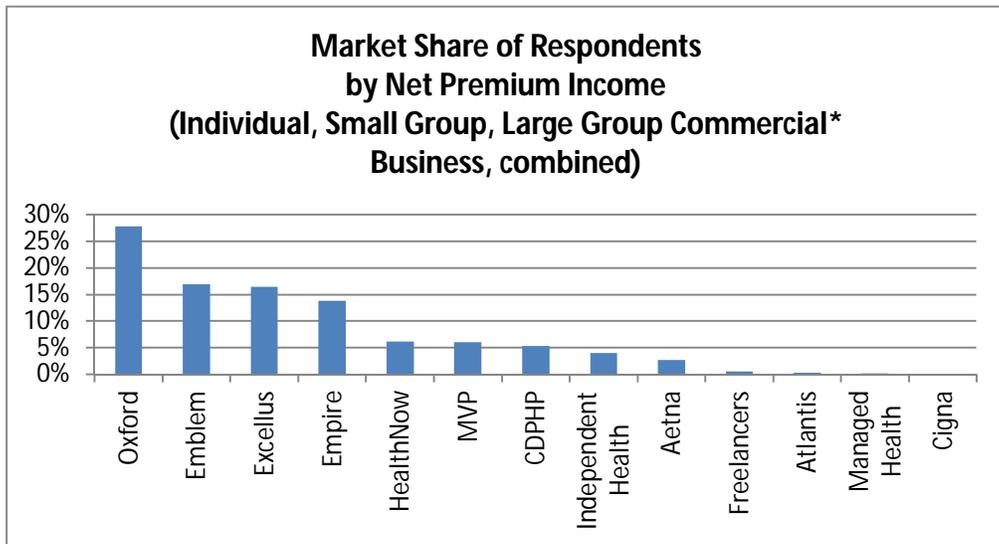
The graphic below presents a rough spectrum of payment models. FFS payments have no quality measurements and the least amount of financial risk to providers. As you move to the right, quality becomes more important. For Episode of Care payments and Shared Savings payments, the quality of the services provided is the basis for increased payments to the provider. With Shared Risk and Global Payments, the provider may share in the savings or may bear some financial risk if the quality of the services is below the established benchmark.



Survey Respondents

The following health insurance companies participated in the survey:

Aetna	Humana
Affinity	Independent Health
Amerigroup (Health Plus)	Managed Health
Amida	MetroPlus Healthplan
CDPHP	MVP
Emblem	Senior Whole Health
Empire	Touchstone
Excellus	United/Oxford
Freelancers	Univera Community Health
HealthNow	Wellcare
Hudson Health Plan	



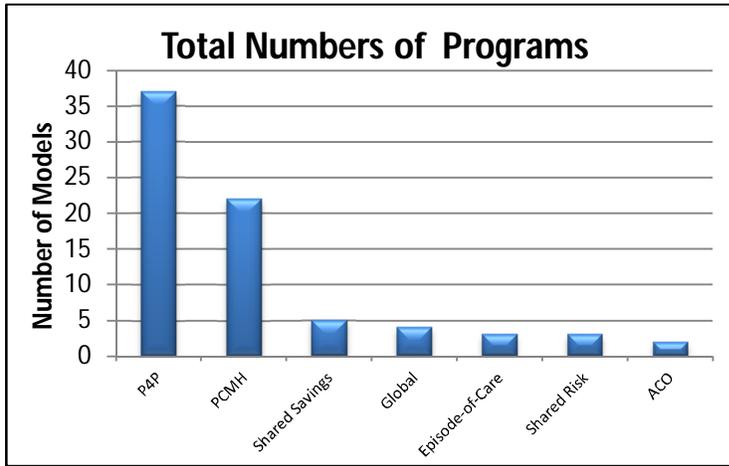
*This chart does not include Medicaid managed care companies that responded to the survey.

Value-Based Payment Programs

1. "The Numbers"

Number of Value-Based Payments Models, Statewide

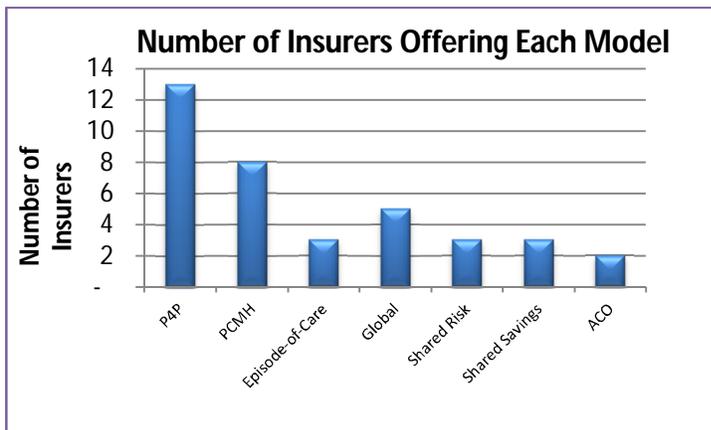
Nineteen companies responded to the DFS survey, reporting a total of 76 value-based payment models. These programs vary widely, each with varying degrees of involvement and investment from providers and insurers. Some programs simply pay providers for following specified best practices (P4P) while, at the other end of the spectrum, programs develop interconnecting care networks (known as accountable care organizations, or ACOs). The following chart indicates the total number of each type of payment model offered by the surveyed companies.



19 insurers have a total of 76 pilot programs. The most common value-based payment model currently implemented is P4P.

Note: Some of the payment models may have overlapping features. For instance, a P4P programs may include a shared savings component. For the purposes of this report, we have used the companies' designation of their programs as reported in their survey responses.

Number of Insurers Offering Each Value-Based Payment Models

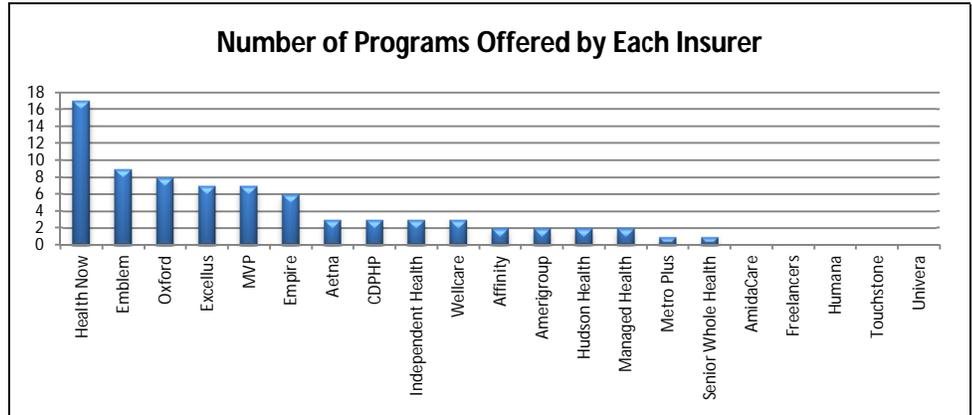


Most of the surveyed companies offer some type of P4P program. The least prevalent models are episode-of-care, shared risk, shared savings and ACO.

Number of Programs Offered by Each Insurer

The chart to the right indicates the number of value-based payment programs offered by each insurer. Most of the companies offer multiple programs.

Note: the number of programs may not be reflective of the size of the program. For instance, Healthnow has a large number of programs, but each program had less than 65 members.



Providers Impacted

15.7% of participating providers were impacted

Based on data reported in the survey, an average of only 15.7% of insurers' participating providers were impacted by payment reform programs. There was wide variation, with the smallest program impacting only 2.1% of the providers, to the highest impact of 43.3%.

Members Impacted

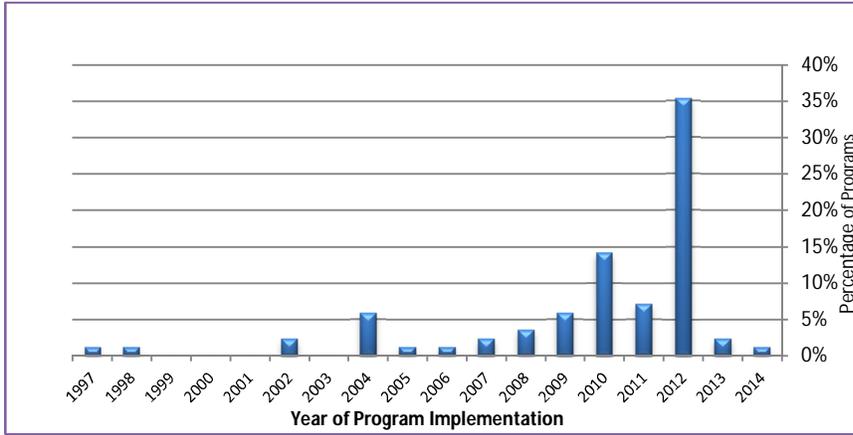
Based on data reported in the survey, only 12.5% of insurers' members were impacted by payment reform programs. The member impact for different insurers ranged from less than 1% to approximately 65%.

12.5% of members were impacted

Note: There is a certain amount of difficulty in accurately determining the number of providers and members impacted. Provider data submitted in response to the survey was at times inconsistent. Member data may also be inconsistent due to differing attribution methodologies (see "Variation in Attribution Methodologies," below), and some members may not be attributed to providers under payment reform programs. Also, some members may visit more than one provider, so it is difficult to establish a one-to-one correspondence between a member and a particular payment program. DFS worked with each insurer to determine that the estimates were reasonable.

Implementation Dates

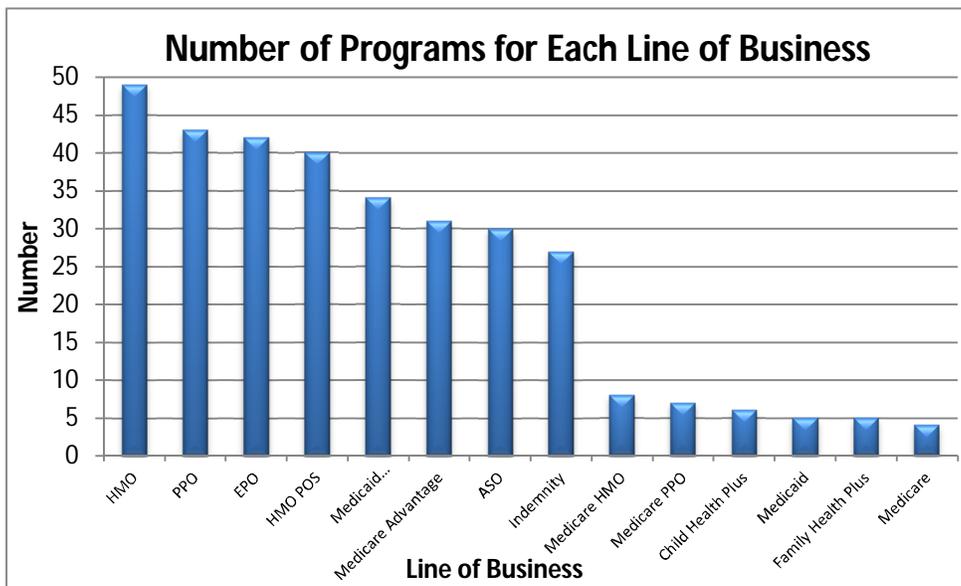
More than a third of innovative payment models were implemented in 2012, and very few programs were implemented before 2010. Many of the programs, therefore, have not been in place long enough to evaluate their success or to measure long term savings.



Most of the programs are new, so measuring savings is difficult. (But see "Savings" section below)

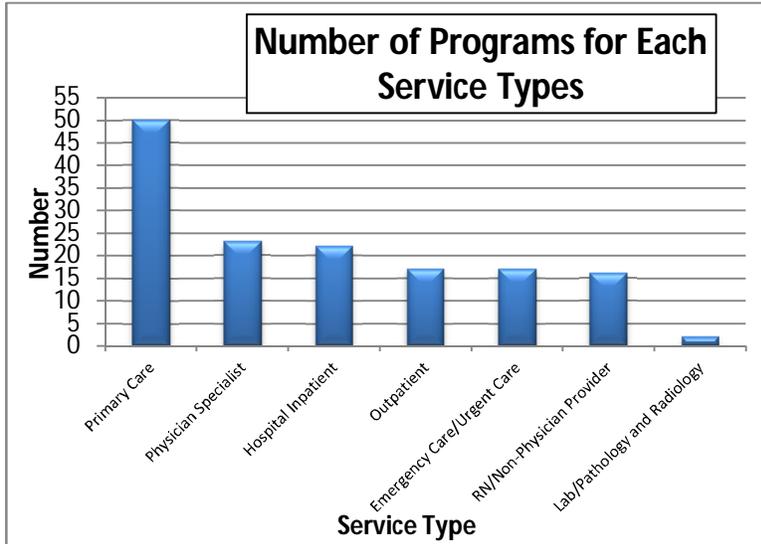
Lines of Business Impacted

The following chart reflects the lines of business identified by insurers as being impacted by their value-based payment programs. Most of the innovative payment models are offered through HMO lines of business, but there is also a significant number offered in PPO, HMO-POS and EPO lines of business, reflecting that the value-based payment programs are fairly evenly distributed across commercial lines of business.



Types of Health Care Services Impacted

The survey asked insurers to identify the types of health care services that were impacted by their value-based payment programs (DFS provided a standard list to choose from). Most of the innovative payment models offered in New York involve primary care services. Specialist services, hospitals (inpatient and outpatient), non-physician services and ER services are impacted to a lesser degree, and lab and radiology services impacted the least.



Most programs impact primary care providers

2. Inventory of Payment Reform Programs (based on 2012 data).

(MMC = Medicaid managed care; MA = Medicare Advantage)

Company	Program	Lines of Business	Summary	P4P	Coord' Care Payments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
Aetna	PCMH (Direct Contract)	Commercial MA	Contracts negotiated between physicians and Aetna.		✓					
Aetna	PCMH (Collaborations/Pilots)	Medicare	CMMI multi-payer initiative in the Hudson Valley .		✓					
Aetna	Physician Pay For Performance	Commercial MA	Payments for meeting clinical measures for efficiency and effectiveness.	✓						
Affinity	The Institute for Family Health	MA, MMC	Shared savings program, for meeting preventive and chronic care criteria.			✓				
Affinity	Greater Hudson Valley	MA, MMC	Shared savings program, for meeting preventive and chronic care criteria.			✓				
Amerigroup	Provider Pay for Performance	MMC	Payments for performing certain preventive care tests and screenings.	✓						
Amerigroup	Inspiris	MMC	A case management program with quality measures at the individual level.							✓
CDPHP	Enhanced Primary Care program (EPC)	Commercial MA, MMC	PMPM payment for cost of care. Quality incentive payments may be made for meeting certain performance measures.							✓
CDPHP	Physician Incentive Program (PIP)	Commercial MA, MMC	Payments are made to physicians for meeting certain quality measures on a per member basis.	✓						
CDPHP	Specialist Incentive Program (SIP)	Commercial MA, MMC	Payments are made to physicians for meeting certain quality measures on a per member basis.	✓						
Emblem Health	The Montefiore IPA	Not Provided	Incentives to physicians at certain medical groups to meet specific quality benchmarks for different conditions.	✓						
Emblem Health	Heritage New York IPA	Not Provided	Incentives to physicians at certain medical groups to meet specific quality benchmarks for different conditions.	✓						
Emblem Health	St. Barnabas Hospital	Not Provided	Incentives to physicians who meet specific quality benchmarks.	✓						
Emblem Health	Crystal Run Healthcare	Not Provided	Incentives to physicians who meet specific quality benchmarks.	✓						
Emblem Health	Allied Pediatrics	Not Provided	Incentives to physicians who meet specific quality benchmarks.	✓						

Company	Program	Lines of Business	Summary	P4P	Coord' Care Payments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
Emblem Health	North Shore-LIJ Health System	Commercial MA, MMC	Payments to hospitals for meeting quality benchmarks.	✓						
Emblem Health	Stellaris Health Network	Commercial	Payments to hospitals for meeting quality benchmarks.	✓						
Emblem Health	The New York Presbyterian Hospital Health System	Commercial MA, MMC	Payments to hospitals for meeting quality benchmarks.	✓						
Emblem Health	Chinese American Independent Practice Association	MA, MMC	Risk is shared between providers and Emblem for a defined population.				✓			
Empire	Patient Centered Medical Home Program	Commercial	Encourages PCPs to coordinate care with pmpm and incentive payments for meeting certain quality measures.		✓					
Empire	Adirondack PCMH	Commercial MA	Multi-payer initiative designed to encourage PCPs to increase preventive care, coordinate care, and manage chronic diseases by providing a pmpm payment.		✓					
Empire	THINC PCMH	Commercial	Encourage PCPs to assume more responsibility in patient care by including a pmpm payment.		✓					
Empire	Quality-In-Sights®: Hospital Incentive Program (Q-HIP®)	All	Payments to hospitals for practicing evidence based medicine and implementing best practice guidelines.	✓						
Empire	Anthem Quality in Sights (AQI)	Commercial	Payments to physicians for providing preventive care, screenings, and care management.	✓						
Empire	Empire Pay for Performance	All	Payments to physicians for performing certain procedures or meeting certain quality metrics.	✓						
Excellus	Adirondack Region Medical Home (AMH)	Commercial MMC	5 year multi-payer program to encourage PCPs to provide care management, providing pmpm payment plus incentive for meeting certain quality measures.		✓					
Excellus	Rochester Medical Home Initiative (RMHI)	Commercial MA, MMC	Five year pilot program to increase the role of PCPs in care management by providing a pmpm payment.		✓					
Excellus	Accountable Cost and Quality Agreement (ACQA)	Commercial	Program designed to align delivery system by creating quality measures and providing the opportunity for shared savings.					✓		

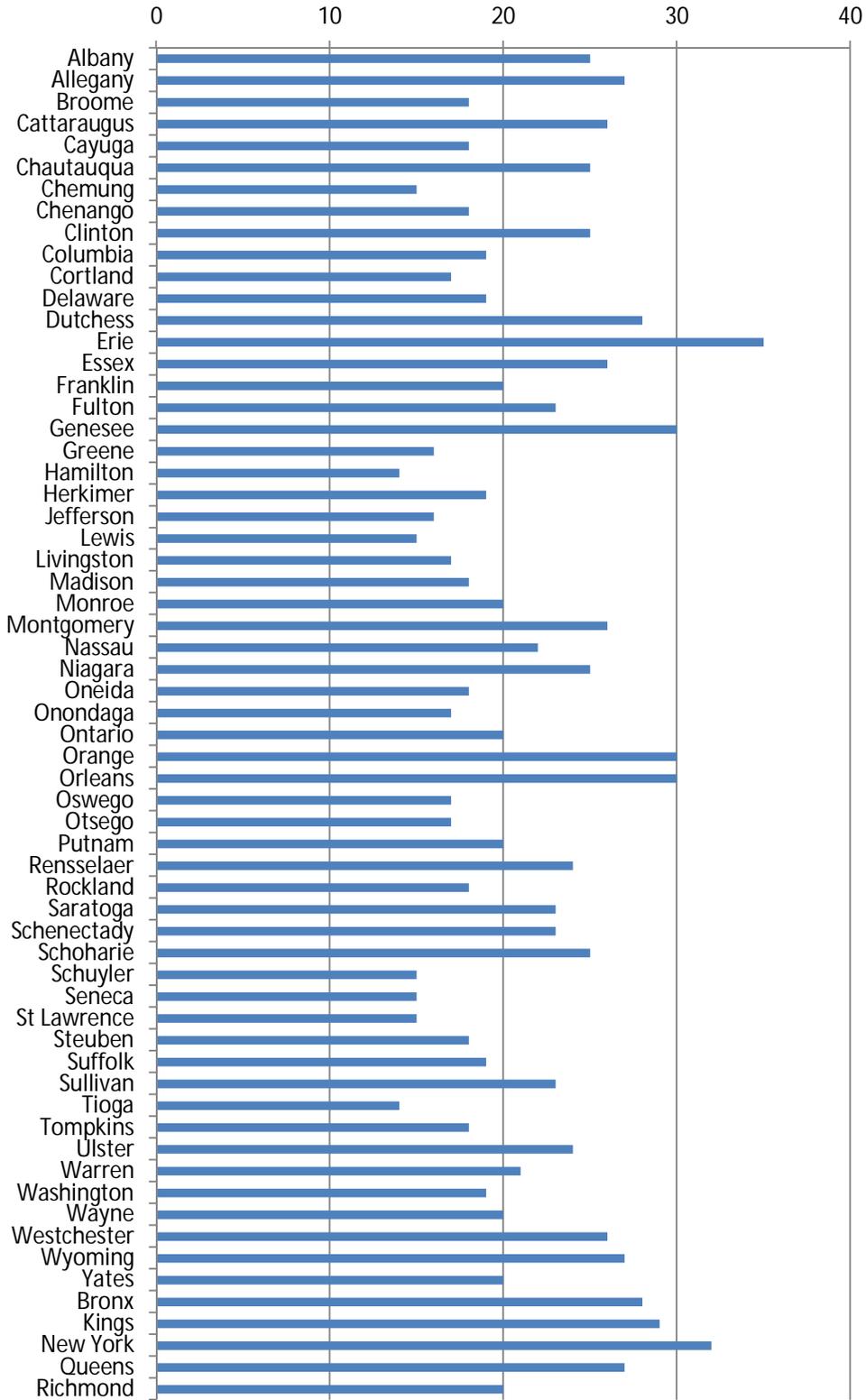
Company	Program	Lines of Business	Summary	P4P	Coord' Care Payments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
Excellus	Rewarding Physician Excellence (RPE) Chronic Disease Physician incentive Program (CDPIP)	Commercial MA	Program intended to improve care management and increase the quality and access of healthcare. Payments are made to physicians for meeting certain criteria.	✓						
Excellus	The Hospital Performance Incentive Program (HPIP)	Commercial MA, MMC	Program intended to increase quality and patient safety by providing hospitals with incentive payments for meeting certain nationally recognized measures.	✓						
Excellus	Small Hospital Incentive Program (SHIP)	Not provided	Program designed to increase patient safety by providing hospitals with incentive payments for meeting certain nationally recognized measures.	✓						
Excellus	Univera Healthcare/ Catholic Medical Partners Quality Program	Commercial MA	Incentive payments to the medical facility for meeting certain agreed upon facility and population measures.	✓						
HealthNow	Facility Quality Incentive Program	All	Incentive payments to facilities for meeting agreed upon national and state recognized quality measures.	✓						
HealthNow	Pay for Performance	All	Program designed to improve quality and patient outcomes by reducing variations in treatment.	✓						
HealthNow	Pay for Performance Behavioral Health Stand Alone	All	Incentive payments to qualified physicians scheduling mental health evaluations after an enrollee is discharged from the hospital.	✓						
HealthNow	Buffalo Cardiology and Pulmonary Associates (BCPA) Cardiac Wellness Program	All	Program to measure the impact of lifestyle changes on the rate of surgical intervention for an at risk population. Payments are made for decreasing surgical intervention rates for an attributed population.	✓						
HealthNow	Medically Oriented Gym	All	Program identifies high risk members and measures the effects of gym program on need for surgical intervention.	✓						
HealthNow	Low Back Pain Pilot	All	Program attempts to establish best practice guidelines for the treatment of low back pain.	✓						

Company	Program	Lines of Business	Summary	P4P	Coord' Care Payments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
HealthNow	Prometheus Bundled Payment Pilot Program Coronary Artery Bypass Graft (CABG)	Commercial Medicare	Program provides a single bundled payment for all services related to a Coronary Artery Bypass for up to 90 days after the procedure is performed.						✓	
HealthNow	Blue Circle Dietetics and Nutrition	All	Program encourages dieticians to provide education to enrollees about effects of nutrition on health outcomes.	✓						
HealthNow	Saratoga Cardiology Associates enhanced pay for performance	All	Program gives providers an opportunity for an increase in reimbursement rates if certain quality measures are met for the attributed population.	✓						
HealthNow	Delaware Pediatrics	All	Program provides infant health information to expecting parents.	✓						
HealthNow	Child and Adolescent Treatment Services (CATS) Dialectical Behavior Therapy (DBT) Case Rate	Commercial Medicare	Pays a case rate for all members that enter the Dialectical Behavior Therapy program.						✓	
HealthNow	Child Psychiatry Rapid Evaluation	Commercial Medicare	Pays a case rate for a rapid child psychiatric evaluation.						✓	
HealthNow	Patient Centered Medical Home	Commercial Medicare	Pays a pmpm amount for increased case management and the use of evidence based care for patients.		✓					
HealthNow	PCMH Initiative 1 Emergency Room/ After Hours	Commercial Medicare	Incentive payments to physicians that have after-hours appointments, to reduce emergency room visits.		✓					
HealthNow	PCMH Initiative 2 Decreasing Readmissions	Commercial Medicare	Payments to physicians that schedule follow-up appointments after patient discharge from hospital.		✓					
HealthNow	PCMH Government Programs	Medicaid	Pmpm payments to groups for Medicaid enrollees using them as their PCP.		✓					
HealthNow	PCMH Adirondack Park Demonstration	Commercial Medicaid	Multi-payer program to increase access to healthcare, lower costs, create an integrated healthcare system.		✓					
Hudson Health	NYS PCMH incentive for primary care	Commercial MA	A PCMH in conjunction with the New York Department of Health.		✓					
Hudson Health	Comprehensive Primary Care Initiative	Medicaid	Pmpm payments from CMS for meeting care management and quality measurements.		✓					
Independent Health	Primary Connection	Commercial MA	PCP receives a percentage of savings, calculated as total pmpm cost of care compared to budget.		✓	✓				

Company	Program	Lines of Business	Summary	P4P	Coord' Care Pay-ments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
Independent Health	Catholic Medical Partners Global Medical Budget Risk Model	Commercial MA	Payments for incorporating measures for several chronic conditions at the physician level (asthma, coronary artery disease, congestive heart failure, etc)				✓			
Independent Health	Practice Excellence	Commercial MA	P4P program focused on the treatment of certain chronic conditions.	✓						
Managed Health	Pay for Performance Quality Incentive Program for Hospital and Community Providers	MA	Encourages continued quality improvement and cost containment efforts among providers participating in MHI Medicare Advantage Network.	✓						
Managed Health	Provider Surplus Program for Participating Providers	MA	Providers share a pre-determined amount of risk with MHI and are rewarded for managing patients' care.				✓			
Metro Plus	Pay for Performance	MA	Payments for exceeding established benchmarks by a statistically significant margin.	✓						
MVP	Pay for Performance	Commercial MA	Performance metrics are utilized to set goals established by the Quality Improvement Committee.	✓						
MVP	Adirondack Region Medical Home Pilot	Commercial MA	Periodic payments to physicians based on the number of patients attributed to them.		✓					
MVP	Onondaga Patient Centered Medical Home	Commercial MA	Periodic pmpm payments with MVP's P\$P program for meeting medical home based measures.		✓					
MVP	Rochester Medical Home Initiative	Commercial MA	Payment to support alignment of practices with the medical home model to improve cost and quality.		✓					
MVP	University of Rochester Medical Center Integrated Medical Home Initiative	Commercial MA	Pmpm payments for chronic and preventive care, Rochester region.		✓					
MVP	Comprehensive Primary Care Initiative	Commercial MA	Multi-payer CMS pilot in the Capital District-Hudson Valley region; pmpm payments to providers.		✓					
MVP	MVMA Medical Home Initiative	Commercial MA	Demo in conjunction with Comprehensive Primary Care Initiative in the Capital District-Hudson Valley region.		✓					
Senior Whole Health	PCP Global Payment Capitation	Commercial MA	Preventative and primary care services included in monthly capitation payment to qualified physicians.							✓

Company	Program	Lines of Business	Summary	P4P	Coord' Care Payments	Shared Savings	Shared Risk	ACO	Episode of Care	Global
United/Oxford	Accountable Care Shared Savings Program	Commercial MA	FFS reimbursement plus the opportunity to earn incentive payments for improved performance against quality measures.	✓						
United/Oxford	Accountable Care Programs	Commercial MA	Program using proactive population health management strategies - quality, efficiency, operational measures.					✓		
United/Oxford	Basic Quality Programs UnitedHealthcare of New York (Medicaid Managed Care)	MMC	Measures National Quality Indicators and state measures and make payments if the measures are met.	✓						
United/Oxford	C&S Capitation Program UnitedHealthcare of New York (Medicaid Managed Care)	MMC	Medicaid, Child Health Plus, Family Health Plus; PCP paid a pmpm payment for all PCP services.							✓
United/Oxford	Hospital Performance Based Contracting	Commercial MA	Financial incentives to improve quality, efficiency operations based on nationally recognized standards.	✓						
United/Oxford	LabCorp Agreement	Commercial MA	Shared savings, based on redirection of outpatient lab services from non-network ancillary and hospital labs.			✓				
United/Oxford	Oxford Gain Sharing Program	Commercial MA	Groups measured against total cost of care and quality improvement measures; each group is eligible to earn payments based on active member enrollment.			✓				
United/Oxford	Physician Performance Based Contracting	Commercial MA	Performance based, value driven adjustment to reward providers for achieving performance measures	✓						
WellCare	Pay for Performance	Medicare Medicaid	Payments to physicians for meeting certain agreed upon clinical measures for efficiency and effectiveness.	✓						
WellCare	Shared Risk	Medicare Medicaid	Set financial and utilization benchmarks for members so providers can receive a percentage of savings.				✓			
WellCare	Patient Centered Medical Home (PCMH)	Medicare Medicaid	Pmpm payment to providers for each enrollee whose selected/assigned PCP is involved in a PCMH.		✓					

Number of Payment Reform Programs by County



Variation in Quality Measurements

79% of payment programs for which DFS received information measure quality in some way. However, there is wide variation in the number and types of quality measures used by the different programs. Based on survey responses and interviews with various companies, the reasons for the variations fell into the following five categories,

Most value-based programs measure quality, but metrics are not consistent.

Reasons for Variation

1. Source of measurements. Various independent entities publish quality measurements. The most common, according to the survey results, are Healthcare Effectiveness Data and Information Set (HEDIS) measures developed and maintained by the National Committee for Quality Assurance (NCQA). Even though many companies use HEDIS measures, some companies may use more or less HEDIS measures for their particular programs (which

may be the result of some of the other reasons outlined below).

Other sources of quality measures reported in the survey responses include:

- Centers for Medicare and Medicaid Services (CMS), which are often, but not always, based on HEDIS measures.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey of patients and consumers regarding physician care, maintained by the Agency for Healthcare Research and Quality (AHRQ).
- Hospital Care Quality Information from the Consumer Perspective (HCAHPS), a survey of patient perspectives on hospital care developed and maintained by AHRQ in conjunction with CMS.
- Quality Assurance Reporting Requirements (QARR), which includes HEDIS and other measures, developed and maintained by DOH.

2. Types of providers. Part of the reason for the diversity of quality measures is the differences in the providers whose quality is being measured. For instance, primary care physicians, hospitals and specialists have different types measures because of the different nature of the services that they deliver.

3. Scope of the value-based program. Differences in the scope of value-based payment programs will result variation in the quality measurements. Programs that focus on specific diseases or conditions such as diabetes or cardiovascular management will have quality measures specific to those conditions. Broader programs, such as those associated with hospital inpatient care, will have broader sets of quality measures.

4. Process vs outcome vs financial measures. Some of the value-based programs focus on whether providers follow certain processes, such as performing health screenings, immunization schedules, or contacting the PCP after a hospital admission. Other programs focus on outcome-based measures, such hospital readmission rates, risk adjusted inpatient length of stay or number of emergency room visits. Still other programs, such as Shared Savings programs, simply focus on financial results, such as a comparison of actual expenditures to budgeted expenditures. Processes, outcome and financial measures have different quality metrics associated with them.

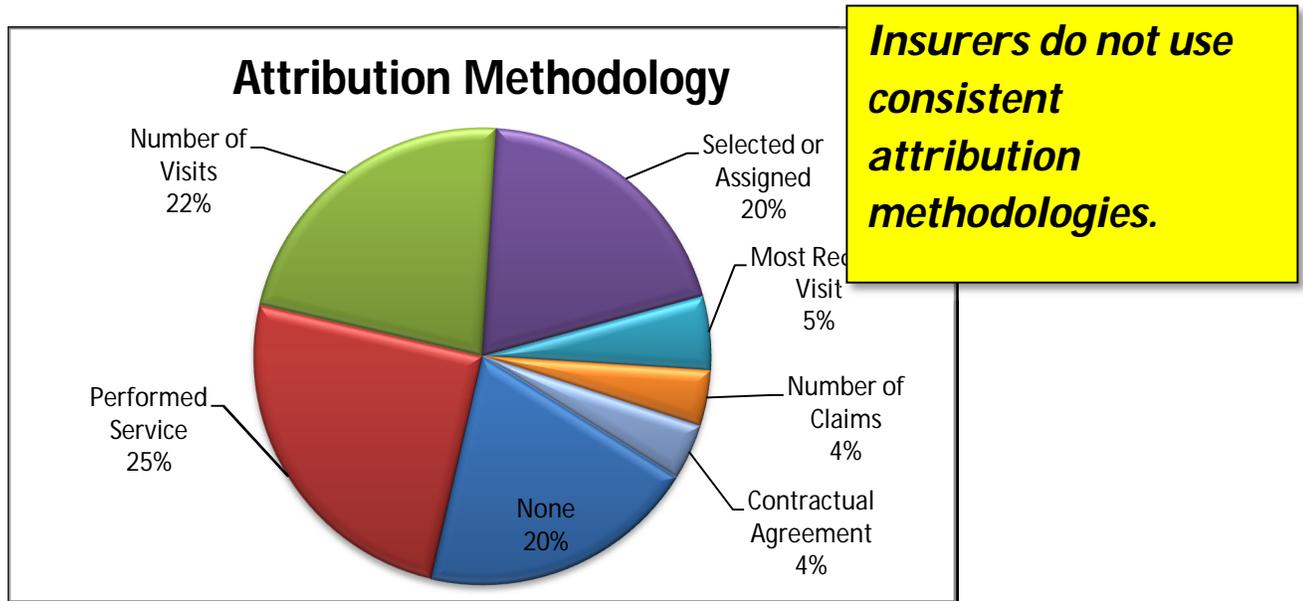
5. Provider contracts are separately negotiated. Value-based payment programs are usually delineated in the contract between the payer and provider. A particular payer may negotiate these

contracts separately with each provider or provider group, particularly if the provider group is a large entity such as a hospital or large independent practice association (IPA). This process helps craft the value-based payment programs to the particular administrative systems and capabilities of the hospital or physician practice, but it also results in inconsistencies between different payment programs.

While some of the differences in quality measures result from the nature of providers' practices and other reasons described above, many companies said in interviews that some standardization of quality measurements would be desirable to make the market more efficient and to increase the possibility of multi-payer initiatives. This is particularly true from the point of view of the providers, who have difficulty administering different quality measurements imposed by different payers.

Variation in Attribution Methodologies

"Attribution" is the process of assigning a patient or patient population to a specific provider, group of providers or health care facility. This is important because patients may see more than one provider in a given period of time. Attribution clearly delineates the claims and payments related to the provider giving care to a particular patient. Used in the context of a multi-payer Patient Centered Medical Home, attribution is necessary to identify the primary care provider (PCP) responsible for coordinating patients' care and the insurance company or companies responsible for the payments related to care coordination and other services.



"Selected or Assigned" means that the member chooses the provider or, if no choice is made, the insurance company assigns a provider.

"Number of Visits" means that the member is attributed to the PCP whom the patient sees the greatest number of times.

"Performed Services" means that the member is attributed to the provider who performed the particular service. This is often used with pay-for-performance payment models.

"Most Recent Visit" means that the member is attributed to the PCP whom the patient last visited.

"Number of Claims" means that the member is attributed to the PCP who has the greatest number of claims related to that patient.

"Contractual Agreement" means that the member is attributed to a PCP by enrolling in a particular program or insurance product.

As the chart above demonstrates, insurance companies do not use common attribution methodologies. Some of the inconsistencies are due to hospital based programs (which tend to use “Performed Services” attribution methods) versus physician based programs (which tend to use “Number of Visits” or “Selected or Assigned” methods). Based on interviews, many companies agreed that standardized attribution methodologies would facilitate statewide reform and multi-payer initiatives.

4. Early Results: Evidence of Savings and Better Quality

The majority of the insurers stated that savings data were not yet available because the programs were only recently implemented.

Some companies, however, did report savings, and initial evidence is positive.

Few companies were able to measure savings, but initial results were positive.

Evidence of Savings

- Independent Health reported that for the last 6 months of 2012, its “Primary Connection” PCMH w/ shared savings model generated a total of \$3.73 per member per month (PMPM) in savings on the total cost of care for the 40,000 members in the program.
- HealthNow’s “Facility Quality Incentive Program,” an at-risk P4P model, reported that the program lowered the total cost of care for the attributed patient population, resulting in savings of over \$3 million.
- United Healthcare’s “Accountable Care Shared Savings Program,” a P4P model, reported that early results (through 9 months) indicate that the first contract under the program decreased inpatient utilization of attributed members by 23% and associated costs by \$104,000. Over the same time period, comparable savings were seen due to decreased emergency room utilization.
- Excellus’s “Rochester Medical Home Initiative,” a PCMH model, reported an impact on costs that equated to a 1.2:1 return on investment (ROI).

Quality Impact

- United Healthcare reported that early results for its “Accountable Care Programs,” an ACO model, indicate that PCPs participating in the program have successfully increased HEDIS scores overall.
- Healthnow reported that under its “Patient Centered Medical Home” program, members have fewer emergency room visits, outpatient services and prescriptions resulting in average savings of \$500 per member per year.
- Hudson Health Plan reported that a preliminary study showed a correlation between a primary care visit following a hospital discharge and a lower readmission rate.

Multi-Payer Success Story: Adirondack Medical Home Demonstration

In 2009, New York enacted legislation establishing the Adirondack Medical Home Demonstration, bringing together providers and payers to improve primary care in five counties in the Adirondack region of northern New York. This rural area has traditionally been underserved in primary care services. DOH brought together seven commercial payers, Medicaid, Medicare and a number of health care providers to establish a patient centered medical home that focused on chronic disease management, care transition to the home, care transition to post acute care and emergency diversion programs. To help fund these responsibilities, physicians are paid an extra \$7.00 PMPM.

The demonstration program has shown positive results in a number measures. From 2009 to 2012, costs (using proxy pricing³) decreased by \$45 PMPM for commercial insurance enrollees and \$31 PMPM for Medicaid managed care enrollees. Medicaid FFS costs (actual) decreased by approximately \$3 PMPM. (Costs were adjusted for patient case mix, age and gender). The number of primary care physicians increased since the demonstration began, reversing a trend of declining numbers in previous years. Quality measures for hypertension, CAD, diabetes, asthma, prevention and obesity all improved. Patient satisfaction scores have improved each year of the program.

The New York State Health Insurance Program (NYSHIP), which provides health insurance coverage for New York State and municipality employees also participates in the Adirondack Medical Home Demonstration and saw savings of approximately \$1 million per year, starting in year 2 of the demonstration. It is projected that NYSHIP will realize savings of \$4.6 million (net of investment) over the life of the demonstration.

The Adirondack Medical Home Demonstration and other pilot programs provide valuable templates for future reform efforts. Recently New York developed the State Health Innovation Plan, a five year plan to build on the successes of the Adirondack Medical Home Demonstration, Governor Cuomo's Medicaid Redesign Team and other initiatives to increase advanced primary care and value-based contracting in New York.

5. Barriers to Reform

There are a lot of moving parts when it comes to payment reform. Payers and providers must coordinate claims processing, quality metrics and payment systems. Different payers may have

3 Types of Barriers:

- **Logistical**
- **Provider Participation**
- **Patient Engagement**

different claims systems and different quality measurements. Providers responsible for coordinating patients' care must have effective, interoperable IT systems that share electronic health records. Provider practices may have to transform the way they deliver care. All of this requires up-front financial investment. And savings may not be guaranteed.

The survey asked companies if there were any barriers or obstacles to provider participation and success of the companies' value-based payment programs. Most of the responses fell in three categories:

³ Payers participating in the Adirondack Medical Home Demonstration did not release their claims data, therefore "proxy pricing" was used to estimate costs by modifying base Medicare rates using factors of known commercial insurance reimbursement rates.

Logistical Barriers. Approximately half of the barriers identified by the companies concerned logistical obstacles, including the following:

- Financial constraints
- IT constraints and health information availability
- Difficulty of providers to maintain NCQA certification
- Lack of valid data to measure performance
- Coordination between providers
- Lack of staff skill
- Too time consuming

Provider Participation. Almost one third of the barriers identified by the companies concerned provider-specific obstacles, including:

- Provider or hospital participation
- Reluctance to assume risk
- Provider unwillingness to participate
- Practices not embracing changes

Patient Engagement. Approximately 18% of the barriers identified by the companies concerned patient-specific reasons, including

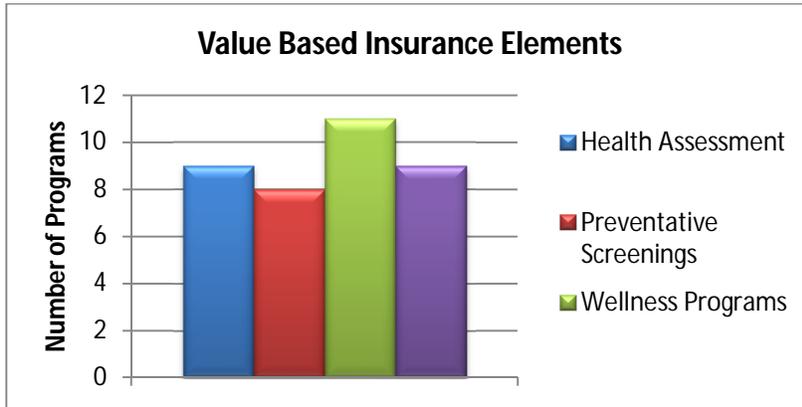
- Difficulty reaching member threshold
- Difficulty getting members to use PCPs
- Low concentration of members with a particular provider

Two New York State initiatives should help alleviate some of these barriers. DOH is developing an All Payer Database (APD), which will store claims information from all major public and private payers, such as insurance companies, Medicaid, Medicare, pharmacy benefit managers and third party administrators. The APD will provide an electronic platform for claims analysis, research and consumer transparency. The APD will enhance existing DOH databases including the Statewide Planning and Research Cooperative System (SPARCS) and the Medicaid data warehouse. SPARCS collects clinical and demographic information on all hospital discharges, emergency department visits, ambulatory care visits and hospital outpatient service visits.

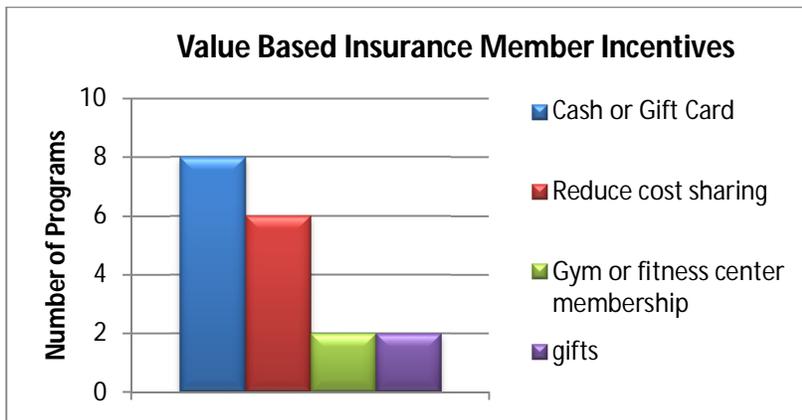
DOH is also developing the Statewide Health Information Network of New York (SHIN-NY), a secure, state-wide electronic network that allows providers to share health records and coordinate care of patients who receive services from multiple providers. The SHIN-NY will result in a foundation for the exchange of health information across diverse entities, within communities and across the state to improve patient care.

Value-Based Insurance Design and Patient Engagement

“Value-Based Insurance Design,” or VBID, refers to the use of health plan incentives to encourage enrollee use or adoption of high value health services, high performing health care providers, healthy lifestyle such as smoking cessation or increased physical activity. Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans such as a Health Savings Accounts.



The survey showed that there is a fairly even distribution of programs that encourage wellness, health assessments, preventive screenings and doctor visits.



The most common incentives were cash and reduced cost sharing.

Inventory of Value Based Insurance Designs (based on 2012 data)

Company	Program	Description of Program	Line Of Business	Program Elements				Member Incentives			
				Health Assessment	Preventative Screenings	Wellness Programs	Encourage Doctor Visits	Cash or Gift Card	Reduced Cost Sharing	Gym Membership	Gifts
Aetna	No Cost HIC Incentive Offering	Wellness program; cash incentives	Large Group and Small Group HMO	✓		✓			✓		
Aetna	Customized Buy Up Incentives	Wellness program; gift incentives	Key, Select, NA, P&L, Small Group	✓		✓		✓			✓
Amerigroup	Member Incentives	Health screenings; gift incentives	All lines of Business	✓	✓			✓			
CDPHP	CDPHP Healthy Direction	Wellness program, health assessment, annual physical; lower out of pocket cost.	EPO/offered through CDPHP Universal Benefits Inc.			✓	✓		✓		
Emblem	Several wellness programs	Preventive screenings and prenatal care. Financial rewards and gifts.	EPO/PPO	✓	✓	✓		✓			✓
Empire	Options in Group Contracts	Wellness programs	Group	✓		✓					
Excellus	Healthy/ Active Rewards program	Health screenings, routine exam and immunizations; cash incentives.	Commercial Line of Business		✓	✓	✓	✓			
HealthNow	Align Products	Best practice guidelines with Kaleida Health to coordinate care.	POS in select counties				✓				
HealthNow	The Good Life	Health screenings, and coaching	POS, PPO, EPO		✓	✓					

Company	Program	Description of Program	Line Of Business	Program Elements				Member Incentives			
				Health Assessment	Preventative Screenings	Wellness Programs	Encourage Doctor Visits	Cash or Gift Card	Reduced Cost Sharing	Gym Membership	Gifts
Independent Health	Empower	Health assessment; , lower out-of-pocket costs	Independent Health Benefit Corporation	✓			✓		✓		
Independent Health	Evolve	Holistic wellness and preventive screenings; gift card incentives	Independent Health Benefit Corporation	✓	✓	✓		✓			
MVP	Wellstyle Rewards	Health assessment, wellness programs giftcard incentives	All EPO and PPO products and option in ASO groups			✓		✓			
MVP	Silver Sneaker Program	Physical activity in older members; social events and gym memberships	All Medicare Advantage Members	✓		✓				✓	
MVP	Medicaid Member Incentives	Identify members needing preventive care using HEDIS measures; gift card incentives	Medicaid, Family Health		✓		✓	✓			
MVP	Medicaid Provider Incentives	Incentive program for dental referrals	Medicaid Manage Care, Family Health Plus, Child Health Plus				✓				
Touch-stone	Member Care Pass Program	Health screening, annual preventive measures; gift basket, zero dollar copays for PCP and dental services	All members		✓		✓		✓		
United/Oxford	Simply Engaged	Health screenings, coaching; gift card incentives	Large Group Business 100+ on UHIC 50+ OHP and OHI	✓				✓			
United/Oxford	Fitness Reimbursement	Gym membership when a member completes a minimum number of visits within a six month period	Small Group Business 2+ on OHI, OHP, UHIC	✓		✓				✓	

				Program Elements			Member Incentives				
Company	Program	Description of Program	Line Of Business	Health Assessment	Preventative Screenings	Wellness Programs	Encourage Doctor Visits	Cash or Gift Card	Reduced Cost Sharing	Gym Membership	Gifts
United/Oxford	Advantaged Tiered Benefits	Lower out of pocket costs for tier one providers; tier two providers have higher out of pocket costs	Small Group Business 2+ on UHIC				✓		✓		
WellCare	Member Incentive Program (MIP)	No cost sharing preventative care visits. Mail Pharmacy Service	MIP: Healthy Choice, Family Health Plus, Child Health Plus. Mail Pharmacy Service - HMO SNP		✓		✓		✓		

Other Payer Initiatives

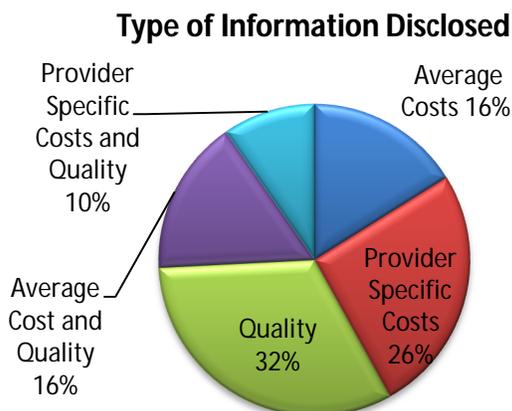
Transparency Initiatives

Value-based payment models are data driven. To link provider reimbursement to quality or care coordination, both the payers and providers need data not only on patients' diagnoses and the types of services provided but also on what processes were following in delivering those services, the quality and efficiency of the care delivery, the outcomes of the care and information on other providers who may be involved in a patient's care. Transparency of data between payers and providers is therefore a necessary foundation for successfully implementing innovative payment programs.

Also, data transparency for patients also can transform care delivery and patient engagement. Access to coordinated medical records can help patients better understand their health needs. Access to different providers' charges and payment rates can better allow patients to understand their potential liability, which is particularly important for patients with high deductible health plans or those considering out-of-network providers. And access to data on the quality of providers can help patients make informed decisions when seeking higher value services.

Transparency is key to reform, but efforts are inconsistent and confidentiality clauses in provider contracts hinder progress.

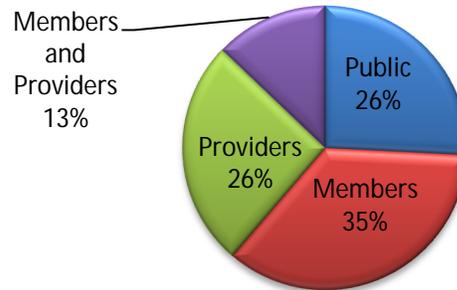
The survey therefore asked insurance companies if they had any programs to promote cost, payment or quality transparency with providers or consumers. For each such program, the survey also asked to whom the information was disclosed, the method of disclosure and the type of information disclosed. The results are summarized below.



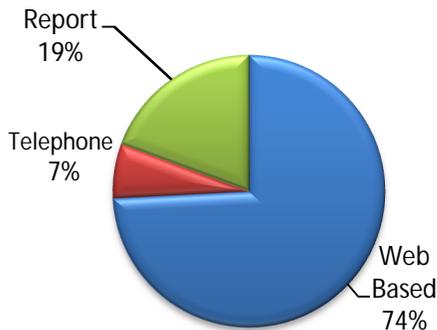
14 companies offered some type transparency initiative, but the types of data released were not consistent. Some companies released provider-specific cost data, while others released only average costs. Most of the companies released some form of quality data.

Companies most often released data to providers and members, but only 1/4 of the companies released data to the public

Information Recipients



Method of Disclosure



Most of the transparency programs use web based platforms for releasing data, while only 7% offer telephonic services.

Limits on Transparency

The survey asked if there are any limitations to making data available to public. While many companies have some type of program to make data available to the public, many of the programs have limitations. There are generally two types of limitations on data that is made available to the public: (1) limitations on types of data and (2) external limitations such as the proprietary nature of the data.

Limitations on the type of data made public. Many companies offered only limited data sets to the public. While this is somewhat difficult to quantify, examples of such limitations include the following:

- Limited number of procedures or episodes available
- Average billed charges only (not specific payment rates)
- Cost estimates based on Medicaid rates
- Not all network providers included
- Only practices with over 300 members included.

Legal or contractual limitations. Of the transparency programs listed in companies' responses, over half claimed that the information was disclosed only to providers and not to the public because the information was proprietary or subject to confidentiality clauses in the provider contracts. Data that was not considered proprietary was usually general data such as average payment rates for providers in a geographic area or disclosure of payment methodology, as compared to payment rates for specific providers.

The following chart shows the specific transparency initiatives of each of the companies providing responses to the survey.

Company Name	Program Name or Description	Method of Disclosure			Information Recipients			Information Disclosed		
		Web Based	Tele- phone	Report	Public	Member	Provider	Avg Costs	Provider Specific Costs	Quality
Aetna	Member Payment Estimator	✓				✓			✓	
Aetna	Estimate the Cost of Care	✓			✓			✓		
Aetna	Medical Procedure by Facility	✓				✓			✓	
Aetna	Hospital Comparison Tool	✓				✓				✓
Aetna	Price-A-Drug Tool	✓				✓		✓		
Aetna	Institutes of Excellence	✓			✓					✓
Aetna	Provider Payment Estimator	✓					✓		✓	
Amerigroup	None									
CDPHP	Members' satisfaction with performance of PCPs	✓			✓					✓
Emblem	Cost and Payment Transparency	✓				✓			✓	
Emblem	Quality Transparency	✓			✓					✓
Empire	Anthem Care Comparison	✓				✓		✓		✓
Empire	Blue Precision	✓			✓			✓		✓
Empire	Imaging Cost and Quality		✓			✓		✓		✓
Excellus	A cost transparency tool and Healthcare Advisor tool	✓				✓	✓	✓		✓
Freelancers	OON Pricing	✓				✓	✓		✓	
Freelancers	Pre-Treatment Estimate	✓				✓	✓		✓	
Freelancers	OON Balance Billing Initiative			✓			✓		✓	
HealthNow	Treatment Cost Advisor	✓				✓		✓		
HealthNow	Blue Cross Distinction Centers	✓			✓				✓	✓
Hudson Health	Quality and Utilization Reports			✓			✓			✓
Independent Health	Primary Connection			✓			✓		✓	✓
Independent Health	Treatment Health Estimator	✓				✓		✓		
Managed Health	Provider Portal	✓					✓			✓
Managed Health	QIP metrics			✓			✓			✓
Metro Plus	None									
MVP	Primary Care Quality	✓			✓					✓
MVP	Health Grades	✓			✓			✓		✓
Senior Whole Health	None									
Touchstone	STAR Measures			✓		✓	✓			✓
United/Oxford	My Healthcare Cost Estimator	✓				✓			✓	✓
United/Oxford	Telephone Service		✓			✓		✓		
Univera	None									
WellCare	Transparency via the IPA warehouse	✓					✓		✓	

Electronic Health Records Incentive Programs

The key to success for any type of payment reform is the use of some type of Electronic Health Records (EHR) system. EHR systems allow providers to efficiently review a patient’s claims history from other providers and from different payers, enabling the provider to deliver care in the most efficient manner possible. EHR development is also one of the biggest challenges, technologically and financially, for both payers and providers.

The survey asked companies whether they had any incentives, promotions or other programs for participating providers to develop interoperable EHR systems. Few companies reported such programs, as specified in the chart below.

ELECTRONIC HEALTH RECORD USE		
Company Name	Type of Incentive, Promotion, etc.	Description
CDPHP	As a member and funding source for Health Insurance Exchange of New York (HIXNY), CDPHP has invested over \$10 million over the last 7 years for acquiring EHRs and optimizing connectivity, meaningful use and interoperability	<ul style="list-style-type: none"> • 2004 – 2006 EMR adoption with \$15000 for a provider who meets the target • 2007 – 2008 Small Practice EMR Initiative. • 2011 – 2012 Specialist HIT Program. • 2012 – present Enhanced Primary Care (EPC) Program.
Excellus	Excellus provides participating hospitals with a capital add-on to fund certain health information technology initiatives implemented and coordinated by the regional RHIO organization on behalf of its broad base of community payer, provider and business stakeholders.	
United/Oxford	Optum Insight Product CareTracker	Web based application - Fully integrated with all operational functions of the provider's practice.
Managed Health	MHI gave grant money to improve quality of care for members, some providers invested in EMR	
Independent Health	Provided \$2 million to HEALTHeLINK a non-profit set up to establish electronic health records	

Non-Payment For Specific Services

The survey collected data on participating provider contracts that include provisions for non-payment for specific services associated with complications that were preventable or potentially preventable, or services that were wholly unnecessary (“never” events, e.g., surgery on the wrong body part). Various sources publish lists of non-payment events, including National Quality Forum (NQF), DOH and CMS, and some companies have developed their own lists. Those sources have different number of “never” events. NQF lists 27 services, DOH lists 13 services and CMS lists 20 services (see Appendix C). Adding to the inconsistency, different companies use different sources. Chart 1 below shows the source used by each company. Appendix C shows the specific non-payment events recognized by each source.

Source of Guidelines to Define Non-Payment Events							
	NQ F	DO H	CM S	Own *	None	Limited DOH**	Lines of Business
Aetna				✓			All Lines of Business
Affinity				✓			All Lines of Business
Amerigroup					✓		None
CDPHP		✓	✓				Medicaid: DOH Medicare: CMS
Emblem		✓					Medicaid: DOH Medicare: CMS
Empire						✓	All Lines of Business
Excellus		✓	✓				All Lines of Business
Freelancers					✓		None
HealthNow	✓	✓	✓				Medicaid: DOH Medicare: CMS Commercial: NQF
Hudson Health					✓		None
Independent Health			✓			✓	All Lines of Business
Managed Health					✓		None
Metro Plus					✓		None
MVP	✓	✓		✓			Medicaid: DOH Medicare: NQF Commercial: Own
Senior Whole Health			✓				CMS: Medicare
Touchstone					✓		None
United/Oxford	✓						All Lines of Business
Univera		✓	✓				Medicaid: DOH Medicare: CMS
Wellcare		✓	✓				Medicaid: DOH Medicare: CMS

* "Own" means the company uses its own standards to define non-payment events.

** "Limited DOH" refers to three measures recognized by DOH (Surgery Performed on the wrong body part, surgery performed on the wrong patient, wrong surgical procedure performed on a patient)

Conclusions and Recommendations

Almost all insurers in New York are developing programs to help contain costs and promote quality. The scale of those programs, however, remains relatively small for most payers. Few enrollees and providers are impacted. Also, few programs are moving away from the FFS payment structure, but instead are adding shared savings, P4P payments or care coordination payments on top of FFS payments.

With insurers working independently, programs are not consistent, using different payment structures, quality measures, and attribution methodologies. Many of the programs are too new to determine how much savings they will generate. But some early results are encouraging, with some insurers beginning to show savings.

New York is looking at ways to encourage and incentivize successful programs. Bringing pilot programs to scale requires substantial investments by insurers and providers. Expanding programs beyond individual payers will require standardization where possible so providers can economically administer programs from various payers. Multi-payer alignment will be a key to success. "Alignment" can take various forms, including dialogue, cooperation, collaboration, shared resources and strategic or operational agreement on principles and implementation.

Insurers cite logistical barriers to provider participation in reforms, such as high investment costs. However, many of the recommendations below may help reduce those barriers, including standardized quality and attribution standards, increased transparency and an All Payer Database (APD). If payers know that they will receive a return on their investments through better standardized measures and increased data and transparency to evaluate risk and rewards and improved health, they may be more likely to invest in value-based payment programs.

Develop Standardized Scorecard.

Most insurer reform efforts are new pilot programs that do not impact a large number of members or providers. DFS, in conjunction with DOH and other stakeholders, should develop a scorecard to measure progress with consistent metrics to allow comparison and analysis of which programs work best. In turn, this would inform expansion of the programs to larger populations.

Standardize Quality Measures.

Insurer reform initiatives use a variety of quality measures. Providers facing differing quality measures from multiple insurers may be unwilling or unable to undertake payment reforms. Greater standardization of quality measures would facilitate transformation and increase efficiency on a system-wide basis. Some of the reported variation in quality measurements may make sense, at least at first, because certain metrics are provider specific or program specific. Insurers agreed that increased standardization will help. DOH, in conjunction with DFS, other agencies and stakeholders, should continue to develop a common, core set of quality metrics. Consideration should be given to using established benchmarks, such as National Quality Foundation (NQF), Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Health Providers and Systems (CAHPS), which would allow for national benchmarking. Also, standardized measures could allow provider-, community-, or payer-specific additions to the core set appropriate to the local needs.

Standardize Attribution Methodologies.

As with quality measures, insurers use a variety of attribution methods. Some of the variation stems from the types of services delivered. Hospitals and specialists will have different attribution methodologies than PCPs because of the differences in the way they deliver care. However, greater consistency through increased standardization among providers would increase efficiencies on a system-wide basis. Insurers similarly agreed that increased standardization of attribution methodologies will be helpful. DOH, in conjunction with DFS and other state agencies, should work with stakeholders to help standardize attribution methodologies.

Increase Transparency.

Providers need meaningful data, across all payers, to efficiently serve their patient populations and to measure their own success in a value-based payment environment. Similarly, consumers need access to understandable data about their providers and insurers in order to make meaningful choices for their health care. An all payer claims database (APD) would allow development of both quality and cost information and metrics necessary for patients and consumers to actively engage in health care delivery. The APD is particularly important with the increased prevalence of high deductible health plans and the focus on actuarial value of the “metal levels” of health plans under the Affordable Care Act. DFS should work with DOH and other state agencies as well as stakeholders to increase the transparency of data for consumers and providers. DFS and DOH already have received a “Grant to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle III” from the U.S. Department of Health and Human Services to help develop a web-based platform to make available data on costs and quality of health care services.

Increase Value-Based Insurance Design.

Patients will become more engaged in their health care delivery if they have financial incentives to do so. These incentives can decrease cost sharing if patients go to higher quality providers, or simply provide financial incentives to patients to lead a healthier lifestyle. Many insurers already have such programs, but expanding them would increase savings. DFS should work with insurers, providers and consumer groups to develop standards for the DFS policy form approval process to help encourage and expand use of value based insurance design options.

Standardize “Never” Events.

Non-payment for specific services varies among the insurers surveyed. DFS, in conjunction with DOH and other state agencies as well as stakeholders, should work to standardize and expand the list of “never” events to increase savings and increase efficiencies among providers.

Incentivize Use of Electronic Health Records.

Interoperable electronic health records (EHR) are the foundation of value-based payment programs and health care transformation. They allow tracking of services provided to patients by different providers, provide insurers and providers with quality of care information and enable insurers to link provider reimbursement to the quality of care. But infrastructure development requires investment and training. The survey showed that few companies provide incentives for providers to increase development and use of electronic health records. Because capital needs are high, and all avenues of investments should be explored and shared. DFS, in conjunction with DOH and other state agencies as well as stakeholders, can develop targets for increased EHR investments and development.

Recognize Geographic Variation.

Because value-based programs are concentrated in certain geographic areas, DFS should continue to research whether particular programs are more successful in specific areas and whether there are specific conditions in those regions that lend themselves to success. Consideration should be given to expanding the successful programs State-wide or to those areas of the state where there are fewer value-based programs.

Appendix A: Definitions

Types of Payment Models

Fee for Service (FFS) Payment: Payment to a provider, group of providers and/or health care facility based on a negotiated or payer-specified payment rate for every unit of service the provider delivers, without regard to quality, outcomes or efficiency.

Pay for Performance (P4P): Payments to a provider, group of providers and/or health care facility for meeting or exceeding pre-established benchmarks for care processes and patient health outcomes, such as primary care provider rewards for patients receiving recommended immunizations or hospitals scoring well on quality measures such as readmission rates or hospital acquired infection rates.

Care Coordination/Care Management Payments: Payments to a provider, group of providers and/or health care facility for a specified time period (e.g., monthly) to pay for care coordination and the infrastructure needed to enable care coordination, including health information technologies, disease registries, etc. For the purposes of this request, we are requesting information on three categories of care coordination payments: Patient Centered Medical Homes (PMHC), Accountable Care Organizations (ACOs) and programs that integrate physical and behavioral health (IPBH).

Episode-of-Care Payment: A single payment to a provider, group of providers and/or health care facility for all services to treat a given condition or to provide a given treatment, based on the expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. (Also referred to as a Bundled Payment or Case Rate).

Shared Savings: A payment arrangement that provides an incentive for a provider, group of providers and/or health care facility to reduce unnecessary health care spending for a defined population of patients or for an episode of care by offering the provider a percentage of any realized net savings.

Shared Risk: A payment arrangement in which a provider, group of providers and/or health care facility accepts some financial liability for not meeting specified financial or quality targets. Examples include but are not limited to baseline revenue loss, loss for costs exceeding global or capitation payments, withholds that are retained, loss of bonus and adjustments to fee schedules. For the purposes of this data request Shared Risk arrangements that also include a Shared Savings component should be included in the Shared Risk category.

Global Payments: Prospective payment to a provider, group of providers and/or a health care facility for all or most of the care for an attributed group of patients over a specified period of time, such as month or year.

General

Accountable Care Organization (ACO): A group of health care providers who give coordinated care, chronic disease management, and thereby improve patients' quality of care. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Attribution: Assignment of a patient or patient population to a specific provider, group of providers or health care facility for the purposes of calculating health care costs, payments, savings or quality scores.

Integrated Physical and Behavioral Health (IPBH): A delivery system and payment model that integrates and coordinates primary care and other medical services with behavioral and mental health to provide better, higher quality care and achieve cost savings.

Line of Business: The type of health plan. For the purposes of the request, line of business includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), HMO Point of Service (HMO POS), Indemnity, Medicare Advantage, Medicaid Managed Care and Administrative Services Only (ASO) contracts.

Patient Centered Medical Home (PCMH): A model of enhanced primary care where patients are attributed to a provider who is responsible for coordinating or arranging all of the patient's care across all settings and practitioners.

Payment Reform Program: Health care payment models, other than FFS, that incentivize providers to increase quality of services, increase administrative efficiency, increase care coordination, and/or decrease costs. Payment Reform Programs would include but not be limited to care coordination programs and any program where provider reimbursement is tied to the quality of the services provided.

Quality Measurements: Standardized assessment or measure of the quality of a provider's services that is used as the basis of a Payment Reform Program that incentivizes, requires or rewards some component of the safe, timely, patient centered, efficient and/or equitable health care.

Value Based Benefit Design: The use of plan incentives to encourage enrollee use or adoption of high value health services, high performing health care providers, healthy lifestyle such as smoking cessation or increased physical activity, etc. Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans such as a Health Savings Accounts.

Total Cost of Care: The of actual payments associated with care for patients attributed to a provider, group of providers or health care facility, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments and adjustments.

Appendix B: Payment Reform Survey



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawskey
Superintendent

June 25, 2013

OFFICER NAME, TITLE
COMPANY NAME
ADDRESS 1
ADDRESS 2
CITY, STATE, ZIP

Re: Request for Information Pursuant to Section 308 of the New York Insurance Law

Dear OFFICER NAME:

The Department of Financial Services (the “Department”), in conjunction with the Department of Health, is working to improve health care costs and quality. In furtherance of this goal, the Department is reviewing information regarding health plans’ cost containment and quality improvement initiatives. This information is necessary to help promote cost containment efforts, establish baseline data and track progress. To assist the Department in compiling the necessary information, please provide the Department with responses to the following requests for information.

Please provide the information in the format requested. For the requests below, please provide written responses using the numbering and lettering indicated. For the information requested on the attached spreadsheet, please provide your answers using the attached Spreadsheet #1. Defined terms are included on Attachment A.

Your response must be received at the Department, to the attention of the undersigned, on or before July 26, 2013. Unless otherwise indicated, the relevant time period for the requested information is calendar year 2012.

Requests

1. Payment Reform Programs

a) Please provide the name or other designation of each Payment Reform Program your company is engaged in, the date the program commenced and a brief description of each program.

b) For each program, please describe the quality measurements used and a list of all of the quality measurements used.

c) For each program, please describe the attribution methodology (if applicable).

d) For each program, please indicate whether it is a pilot/demonstration program with limited provider participation or whether any qualified provider can participate.

e) For each program, has this reimbursement structure lowered the total cost of care for the attributed patient population? To the extent that such information is available, please provide details as to the amount of savings and how they are tracked and measured for each program.

f) For each program, are there any barriers or obstacles to provider participation and success of the program? Please describe separately for each program.

g) Please complete the attached spreadsheet #1 regarding your Payment Reform Programs.

2. Value based benefit design

a) Do you offer any products with value based benefit design?

b) If so, please provide the following information:

- 1) a description of each type of the benefit design;
- 2) each line of business that includes the value-based benefit design;
- 3) for each line of business, the counties where the benefit is available and the number of enrollees using the benefit design in each county;
- 4) for each benefit design, the estimated financial savings generated by the benefit design, the method of measuring the savings and the impact on premiums, to the extent such information is available.

3. Non-payment for specific services

a) Do you have any participating provider contracts that include provisions for non-payment for specific services associated with complications that were preventable or potentially preventable, or services that were unnecessary?

b) If so, please indicate the specific conditions or complications that trigger non-payment.

c) For each specific program, indicate the number of providers subject to the non-payment arrangement, the number of claims that were not paid pursuant to the program and the total billed amount of all such claims.

4. Transparency

a) Do you have any programs to promote cost, payment or quality transparency with providers or consumers? If so, please describe each program and the method by which it is made public, including any URLs for websites used to access the data.

b) For each such program, please indicate the following:

- 1) to whom the information is disclosed (e.g., general public, providers, enrollees, patients of participating providers, etc);
- 2) the method of disclosure (e.g., public website, password protected website, etc.);
- 3) the type of information disclosed (e.g. provider charge data, specific reimbursement data, average reimbursement data, utilization data, practice pattern variation data, etc.);

c) Are there any limitations (statutory, contractual, etc) to you making provider reimbursement data available to public? If so, please describe any and all such limitations. If the limitations are contractual in nature, please provide copies of each such contract.

5. Electronic Health Record (EHR) use

a) Do you have any incentives, promotions or other programs for participating providers to develop interoperable EHR systems? If so, please describe each to incentive, promotion or other program.

I look forward to your cooperation in gathering the requested information. If you have any questions, please contact me at (518) 474-4567 or John.Powell@dfs.ny.gov.

Very truly yours,

John D. Powell
Director of Rate Review,
Health Bureau

Appendix C: Non-payment standards

	NQF	NY-DOH	CMS
<i>Source: National Quality Forum</i>			
Surgical Events			
Surgery performed on the wrong body part	✓	✓	✓
Surgery performed on the wrong patient	✓	✓	✓
Wrong surgical procedure performed on a patient	✓	✓	✓
Retention of a foreign object in a patient after surgery or other procedure	✓	✓	✓
Intraoperative or immediately post-operative death in an ASA Class 1 patient (Healthy Person)	✓		✓
Product or Device Events			
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility	✓	✓	
Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended	✓	✓	✓
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility	✓	✓	✓
Patient Protection Events			
Infant discharged to the wrong person	✓		
Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	✓		
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility	✓		
Care Management Events			
Patient death or serious disability associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	✓	✓	
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	✓	✓	✓
Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility	✓		
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient	✓		✓

	NQF	NY-DOH	CMS
is being cared for in a health care facility			
Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	✓		
Stage 3 or 4 pressure ulcers (bed sores) acquired after admission to a health care facility	✓		✓
Patient death or serious disability due to spinal manipulative therapy	✓		
Environmental Events			
Patient death or serious disability associated with an electric shock while being cared for in a health care facility	✓	✓	
Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	✓	✓	
Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility	✓	✓	✓
Patient death associated with a fall while being cared for in a health care facility	✓		
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility	✓	✓	
Criminal Events			
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider	✓		
Abduction of a patient of any age	✓		
Sexual assault on a patient within or on the grounds of the health care facility	✓		
Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of the health care facility	✓		
<i>Source: CMS</i>			
Surgery Infection			
Surgical Site Infections (Mediastinitis) after coronary artery bypass graft			✓
Surgical Site Infections after certain orthopedic procedures			✓
Surgical Site Infections following bariatric surgery for obesity			✓
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures			✓

	NQF	NY-DOH	CMS
Non-Fatal Falls			
Fractures			✓
Dislocations			✓
Intracranial injuries			✓
Crushing injuries			✓
Number of Measures used to define non-payment events	27	13	20