Provider Value Based Payment Initiatives Survey

Introduction

Thank you for participating in our survey. Your feedback is important. The purpose and goals of the survey are as follows:

1. Identify and quantify the "current state" of value based reimbursement from the provider perspective. This analysis will complement the data we are gathering from major health insurers in Wisconsin.

2. Capture a baseline understanding from the provider perspective will a) allow us to get a more complete picture of the impact of the migration of Medicare and Medicaid fee for service payments to value-based. The planned payer survey will capture Medicare Advantage and Medicaid managed care as well as commercial self-funded and fully insured coverage.

3. Identify potential technical assistance opportunities for those providers who may not be tracking the overall migration of their revenue streams from volume based to value based.

4. Contribute to our understanding of the baseline percent of healthcare payments (measured in terms of dollars paid) that are currently being paid in fee for service alternatives that link payment to value.

We need to establish a baseline to be able to demonstrate the gap that needs to close between the current state and the 80% target, as well as to track progress toward that target as the Wisconsin SHIP is implemented.

CMMI's guidance to SIM grantees notes that CMS has announced an overall goal of tying 60% of all Medicare FFS payment to "alternative payment models", and 90% of all Medicare payments to quality or value, by 2018. CMMI has further noted that State Health Innovation Plans should "aim to move over 80% of payments to providers from all payers [to] fee-for-service alternatives that link payment to value, [which is defined as] the intersection of quality and cost effectiveness." (CMMI Guidance, 2/5/2015, at 20.)

Please complete the following survey.

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Section I: Organization Information

In all cases, please provide data for Calendar Year 2014.

* 1. Contact Name and Organization (required)

Name of Organization	
Contact Name	
Contact Title	
Contact Email	
Contact Phone	
Address, including zip	
County	

* 2. Total number of unduplicated patients seen in your system in Wisconsin (required)

3. If complete CY2014 data is not available, what date(s)/year(s) does the data come from?

* 4. Number of covered lives by coverage type (required):

Commercial

Commercial, outside of marketplace, if available

Commercial, through of marketplace, if available

Medicaid

Medicare

Uninsured or Self-Pay

Other, specify:

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Section II: Value Based Payment Baseline

Introduction:

CMMI's guidance to SIM grantees notes that CMS has announced an overall goal of tying 60% of all Medicare FFS payment to "alternative payment models", and 90% of all Medicare payments to quality or value, by 2018. CMMI has further noted that State Health Innovation Plans should "aim to move over 80% of payments to providers from all payers [to] fee-for-service alternatives that link payment to value, [which is defined as] the intersection of quality and cost effectiveness." (CMMI Guidance, 2/5/2015, at 20.)

As part of developing the State Health Innovation Plan, Wisconsin needs to establish a baseline of health care payments that are currently made in a value-based alternative to fee-for-service. This

will allow us to identify the gap that needs to close between the current state and CMMI's 80% target, as well as to track progress toward that target as the Wisconsin SHIP is implemented.

Value based payments are designed to improve the quality and safety of care as well as spur efficiency and reduce unnecessary spending. If a payment method only addresses efficiency, it is not considered value-oriented. It must include a quality component [for example, minimum performance as payment threshold, or additional payments for higher quality outcomes]. (Adapted from Catalyst for Payment Reform) For example, a bundled payment that does not link payment in any way to quality (e.g. trigger the payment or affect the amount of payment) would not be considered a value-based alternative to fee-for-service.

5. In all cases below, “quality component” is defined as payments that include incentives, requirements, or rewards for the provision of safe, timely, patient centered, effective, efficient, and/or equitable health care (*equitable health care refers to care of equal accessibility and quality to everyone, regardless of race, age, gender, ethnicity, income, geographic location, or any other demographic detail*).

Total gross revenue **received for Wisconsin patients** seen in CY2014 or most recent 12 months (*please specify time period if other than CY2014*).

Total gross revenue from payers that do not include any quality, satisfaction or efficiency measures in determining reimbursement in CY2014 or most recent 12 months. (FFS)

Total gross revenue received through shared-savings arrangements with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months.

Total gross revenue received through bundled or episode-based payments with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months.

Total gross revenue received through FFS plus pay for performance programs in CY2014 or most recent 12 months. Please list pay for performance gross revenue only (i.e. do not include the FFS gross revenue received here).

Total gross revenue received through fully capitated payments with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months, if available. Capitation is defined as: *a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance (quality, safety, and efficiency) and patient risk.*

Total gross revenue received through partial capitation payments with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months, if available. Capitation is defined as: *a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance (quality, safety, and efficiency) and patient risk*.

Total gross revenue received through any other program that links payment to quality that is not otherwise described above in CY2014 or most recent 12 months.

Total gross revenue received through a program that links payment to reporting of quality or efficiency measures that is not otherwise described above in CY2014 or most recent 12 months.