



Healthier People. Health Care Value.

Payment Initiative Survey

Introduction

Thank you for participating in our survey. Your feedback is important.

The purpose and goals of the survey are as follows:

1. As current initiatives that seek to improve health or healthcare for people with diabetes, hypertension, or depression are identified, we will discover areas of alignment between current approaches to payment/investment in health and healthcare transformation and attributes of a good payment model, as well as identifying gaps/opportunities to improve alignment.
2. Establish a baseline of the 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 State Health Innovation Plan (SHIP) is implemented.

The Center for Medicare and Medicaid Innovation's (CMMI's) guidance to State Innovation Model (SIM) grantees notes that CMS has announced an overall goal of tying 60% of all Medicare fee-for-service (FFS) payment to "alternative payment models", and 90% of all Medicare payments to quality or value, by 2018. CMMI has further noted that SHIPs 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.)

3. Identify baseline elements of the current Wisconsin healthcare landscape required by CMMI, including identification of those health plans with more than 5% market share across all populations (Medicaid, Medicare, and commercial [both self-funded and fully insured]). (CMMI Guidance, 2/5/2015, at 17.)

Please complete the following survey.



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Section I: Organization Demographics

*** 1. Name, Role and Organization (required)**

Name of Organization	<input type="text"/>
Contact Name	<input type="text"/>
Contact Title	<input type="text"/>
Contact Email	<input type="text"/>
Contact Phone	<input type="text"/>
Address, including zip	<input type="text"/>
County	<input type="text"/>



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In all cases, please provide data as of January 1, 2015.

2. If January 1, 2015 data is not available, what time period is covered in the data?

* 3. Total number of covered lives in Wisconsin (include commercial [fully insured and self-funded], Medicaid, Medicare Advantage, short term, etc.) (required)

* 4. Covered lives by coverage type in Wisconsin

Commercial - Fully Insured Large Group Market

Commercial - Fully Insured Small Group Market

Commercial - Self-Funded

Medicaid

Medicare Advantage

Other, specify:

5. Total premiums for CY 2014 by coverage type in Wisconsin

Commercial - Fully Insured Large Group Market

Commercial - Fully Insured Small Group Market

Commercial - Self-Funded

Medicaid

Medicare Advantage

Other (please specify)

* 6. Based on your response in question #3, please identify the number of members who were enrolled as of January 1, 2015, by coverage type, with claims identifying any combination of the following diagnoses over the past 24 months (i.e. January 1, 2013 - January 1, 2015): adults 18 - 64 as of January 1, 2015 with two visits (over the past 24 months) where diabetes and hypertension were noted as diagnoses. (required)

CPT codes, furnished in any position, are as follows:

Diabetes: 99657, 25093, 25092, 25091, 25090, 25083, 25082, 25081, 25080, 25073, 25072, 25071, 25070, 25063, 25062, 25061, 25060, 25053, 25052, 25051, 25050, 25043, 25042, 25041, 25040, 25033, 25032, 25031, 25030, 25023, 25022, 25021, 25020, 25013, 25012, 25011, 25010, 25003, 25002, 25001, 25000

Hypertension: 4010, 4011, 4019, 40200, 40201, 40210, 40211, 40290, 40291, 40300, 40301, 40310, 40311, 40390, 40391, 40400, 40401, 40402, 40403, 40410, 40411, 40412, 40413, 40490, 40491, 40492, 40493, 40501, 40509, 40511, 40519, 40591, 40599

Commercial - Fully Insured Large Group Market

Commercial - Fully Insured Small Group Market

Commercial - Self- Funded

Medicaid

Medicare

* 7. Based on your response in question #3, please identify the number of members who were enrolled as of January 1, 2015, by coverage type, with claims identifying any combination of the following diagnoses over the past 24 months (i.e. January 1, 2013 - January 1, 2015): adults 18 - 64 as of January 1, 2015 with two visits (over the past 24 months) where depression and diabetes were noted as diagnoses. (required)

CPT codes, furnished in any position, are as follows:

Diabetes: 99657, 25093, 25092, 25091, 25090, 25083, 25082, 25081, 25080, 25073, 25072, 25071, 25070, 25063, 25062, 25061, 25060, 25053, 25052, 25051, 25050, 25043, 25042, 25041, 25040, 25033, 25032, 25031, 25030, 25023, 25022, 25021, 25020, 25013, 25012, 25011, 25010, 25003, 25002, 25001, 25000

Depression: 29636, 29635, 29634, 29633, 29632, 29631, 29630, 29626, 29625, 29624, 29623, 29622, 29621, 29620, 3004, 2980, 311

Commercial - Fully Insured Large Group Market

Commercial - Fully Insured Small Group Market

Commercial - Self-Funded

Medicaid

Medicare



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Section II: Value Based Payment Baseline

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 SHIPs 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 SHIP, 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.

8. In all cases, “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 healthcare (*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*).

In all cases, “members” are those members who resided in Wisconsin in CY 2014; additionally, CY 2014 refers to dates of service in CY 2014 (i.e. NOT payments in CY 2014).

**Please note that we are asking for responses in dollar amounts instead of percentages. We will be calculating percentages overall across payers in aggregate, therefore, we are asking for dollars in order to calculate aggregate percentages.*

Total paid claim expenditures to providers on behalf of members who resided in Wisconsin (which might include out-of-Wisconsin providers) with dates of service in CY2014 or most recent 12 months, regardless of payment models or methods for commercial fully insured, Medicaid, and Medicare Advantage (*please specify time period if other than CY2014*).

Total dollars paid to providers on behalf of members who reside in Wisconsin that contain only traditional FFS payments in CY2014 or most recent 12 months.

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

Total dollars paid through bundled or episode-based payments with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months, including DRG (where applicable)

Total dollars paid through FFS plus pay for performance programs in CY2014 or most recent 12 months.

Total dollars paid through fully capitated payments (if available) with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months. 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 dollars paid through partial capitation payments (if available) with quality-related triggers, bonuses, or other components in CY2014 or most recent 12 months.

Total dollars paid through a program that links payment to quality that is not otherwise described above in CY2014 or most recent 12 months.

Total dollars paid 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.