Payer Participation: The focus of this tab is specific to payer participation in value-based purchasing and/or alternative payment models supported by SIM. Awardees must report information on payer participation and should align their reporting to the Payment Taxonomy Framework Categories to the best extent possible. Awardees should consider using this framework to establish principles for data-sharing and goal-setting among payers in the state.

Payer Participation in Value-based and Alternative Payment Model

	Category 1 Payments: Fee-for-service with no link of payment to quality			Category 2 Payments: Payment Linked to Quality			Category 3 Payment: Alternative Payment Models			Category 4 Payment: Population-based Payment		
Payer Name	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**
Medicare (FFS)	109,138	70%		-	0%	*n/a*	*51,326*	*30%*	*Medicare Shared Savings Program*	*0*	*0%*	
Medicare Advantage	15,177	100%		-	0%	*n/a*	-	*0%*	*n/a*	*0*	*0%*	
Medicaid: United HealthCare	63,445	70%		13,595	15%	*Quality Bonus Program, tying bonus payments to quality*	13,595	*15%*	*Two models: (1) Hospital ACO program with risk sharing tied to total cost of care; and (2) Accountable Shared Savings program, tied to total cost of care*	*0*	*0%*	
Medicaid: Highmark	63,445	70%		-	0%	*n/a*	27,191	*30%*	*Two models: (1) Medicaid Risk tied to total cost of care; and (2) Primary care P4V, bonus payments based on total cost of care, utilization, quality*	*0*	*0%*	
Commercial: Highmark	233,048	70%	*Individual, fully insured group, state employees, other self-insured groups*	-	0%	*n/a*	99,878	*30%*	*Two models: (1) ACO shared savings tied to total cost of care; and (2) Primary care P4V, bonus payments based on total cost of care, utilization, quality*	*0*	*0%*	
Commercial: Other Payers	129,807	100%	*Aetna, Cigna, others, with provider panels typically too small for value-based payment*	-	0%	*n/a*	-	*0%*	*n/a*	*0*	*0%*	

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value- based purchasing • Physician Value- Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes Medicaid shared savings	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and