Testimony of UnitedHealthcare Community Plan of Ohio, Inc.
Joint Medicaid Oversight Committee
November 17, 2016

Good morning Chairman Burke and members of the Committee. My name is Tim Binkley and I am the Chief Operating Officer for the UnitedHealthcare Community Plan of Ohio. On behalf of UnitedHealthcare, thank you for the opportunity to address the Committee regarding our progress in entering into value-based contracts with Medicaid providers to help us better serve Ohio's most vulnerable populations.

UnitedHealthcare is a part of UnitedHealth Group, a *Fortune 6* company. UnitedHealth Group is proud to employ over 3,200 Ohioans and honored to provide health care benefits to over 2 million individuals in Ohio.

UnitedHealthcare has been committed to payment reform initiatives for many years – beginning with capitation 30 years ago. UnitedHealthcare is projected to have $60 billion across our commercial, Medicare, and Medicaid lines of business in value-based arrangements in 2016. Our enterprise goal is 85% of our payments in value-based contracts by 2018; today we are at 51%.

Our program includes multiple payment models along the spectrum of risk and gain sharing with providers. To ensure savings are not driven by reduced access to, or quality of care, we include strong thresholds and incentives for quality in our value-based purchasing arrangements.

UnitedHealthcare Community Plan is committed to, and actively working towards, meeting the Ohio Department of Medicaid's (ODM) goal of 50% of payments in a value-based setting by 2020. Currently, we have approximately 20% of our medical spend, less pharmacy, in upside/downside risk contracts. The SIM episode and CPC initiatives will enhance that rate substantially beginning January 1, 2017. Furthermore, UnitedHealthcare Community Plan has an additional 40% of its' medical spend in non-risk bearing, value-based contracts.

We participate in several initiatives and models today:

- **Episodes of Care originating from the State Innovation Model (SIM) Grant**: We are an active and engaged partner in the SIM initiative. We are currently in Wave 2 of the program, with the financial impacts of the program going live on January 1.

- **Performance-based Contracting**: We partner with two large integrated health systems in metropolitan services areas which tie fee-for-service reimbursement to quality and efficiency metrics. Approximately 20,000 of our members are touched by this initiative.

- **Administrative Relief Program**: We partner with 112 provider groups and provide administrative relief when quality metrics are achieved. As a part of this program, 90,000 authorizations are waived annually.

- **ACO Models:** We support ACO models with particular focus on pediatrics. Since 2006 we have participated in a full-risk arrangement, supporting 35,000 of our child members, with Partnership for Kids.

- **Comprehensive Primary Care program (CPC):** We fully support this initiative and look forward to working with the 30-50 provider groups that will take part in CPC beginning on January 1**.**

- **Primary Care Provider Incentive (PCPi)**: We are working to implement a new quality-based initiative with provider practices that have 100 or more members assigned to them beginning January 1. PCPi will touch 72% of our members.

- **Ohio Quality Improvement Network**: We have engaged this group and are committed to working with them to provide an incentive-based program for member Federally Qualified Health Centers.

Since the onset of the statewide initiative for VBP, we have been offering supports to both providers and consumers to assist them with the transition from volume to value-based payments. To support providers, we have hired numerous staff solely dedicated to helping practices increase quality outcomes and interface more efficiently with our Plan. Additionally, we are heavily investing in technology and staff to promote population management and have enhanced our investments in data analytics and patient engagement resources.

To promote the best possible outcomes for consumers, we assign new members to the highest quality practices. We also provide our members with tools that help them understand the cost of their healthcare choices. UHC has an application called Health4Me, with which approximately 10% of our population have some type of meaningful engagement. Approximately half those members have used MYHCE within the application which allows consumers to compare both quality and price for hundreds of the most common procedures.

While we have seen initial success with VBP, there are challenges. Limited engagement and enthusiasm among providers for entering into value-based reimbursement designs has proven to be a barrier for our Plan to achieve greater penetration of value-based contracts within our network. In working with our providers in value-based contracting arrangements, we have witnessed some of the challenges they face that lead to their reticence.

The administrative burden facing physicians today is significant and compounded by VBP requirements. Most doctors in practice today are trying their best to provide their patients the highest quality care using the information and tools at their disposal. The administrative burden they face has become even more acute within VBP as each health plan has a specific program design, unique clinical and quality goals, reporting requirements, and reimbursement structures which providers need to understand and track. In many cases these requirements MAY even differ within a single health plan, with unique requirements for specific populations.

Many providers, particularly smaller practices, are seeking to survive in a changing marketplace as evolving state and federal payment models such as MIPs and MACRA bring uncertainty. A VBP arrangement, particularly an arrangement requiring downside risk, is not always palatable in such a climate. It is important to consider how these dynamics could play out in relation to access to care for Medicaid members. Hospitals are required to participate in VBP contracting arrangements; however other types of practices are not compelled to do so.

In working with providers and supporting them through VBP arrangements we have several learnings we would like to share with the Commission to help Plans overcome these barriers and ensure success:

1. One size does not fit all. The incentive structure that motivates one provider to engage meaningfully in a value-based arrangement will not necessarily motivate all other providers. We need to work with providers to understand their motivations, pain points, and opportunities to design reimbursement structures that drive value for the provider. There should be a minimum panel size designation to ensure the provider's capability to manage risk.

2. The levels of incentives built into value-based contracting strategies need to be commensurate with the level of work providers need to do to earn that incentive; this includes both administrative and clinical work. If the level of incentive is not commensurate, the provider is unlikely to take on the work that is required if they feel it is not worth their time.

3. Providers need to be equipped with the necessary tools to be successful in the program; this includes IT and analytics that create actionable data that assist them in meeting their quality-based incentives. We have found that most providers are not equipped with the proper tools to be successful within VBP today.

4. Once the right structure is in place, the health plan should get out of the way. In our experience as a leader with the Administrative Relief Program, we have found that when a VBP program is going well, the best thing for the health plan to do is to step away and let the providers administer care.

5. A centralized claims data base would provide a significant boon to the system. Ohio does not currently have a data warehouse or repository to aggregate Medicaid claims and encounter data across health plans, providers, and populations. A centralized repository coupled with analytic services would greatly assist Ohio in paying for value by providing a comprehensive view of health plan and provider performance on VBP metrics, informing areas for improvement at the practice level, and providing evidence with which to negotiate with plans for the purposes of paying for value.

6. We are working closely with Ohio on the pilot to support the electronic exchange of medical records – CliniSync. The launch of that program will also support the critical, meaningful exchange of data to support health plans and provider practices on achieving VBP and quality goals.

Thank you for the opportunity to testify today. I would be happy to answer any questions from the Commission.

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