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Community Plan of North Carolina

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Community Plan

Value-based Strategy

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UnitedHealth Group's Value-Based Care Spend Hits $69 Billion

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UnitedHealth Group signage stands in front of company headquarters in Minnetonka, Minnesota, March 9, 2016. (Photo: Mike Bradley/Bloomberg)

UnitedHealth Group says it's paying almost half of its annual reimbursements – or $69 billion – to doctors and hospitals via value-based care models quickly replacing fee-for-service medicine in the U.S.

UnitedHealthcare's value-based compensation models are categorized into three general areas:

1. Performance-based programs.
2. Bundled and episode-based programs.
3. Accountable care programs.

Social Determinants and VBP

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Social Determinants of Health Key to Value-Based Purchasing Success

Providers and payers are quickly transitioning away from fee-for-service, but value-based purchasing success hinges on both parties addressing social determinants of health.

- Of the soon-to-be 40 states that provide Medicaid services through risk-based managed care plans, 35 include SDOH activities related to screening and/or referrals and care coordination in their MCO contracts

Value-Based Purchasing:

A path to improve Quality and Health.

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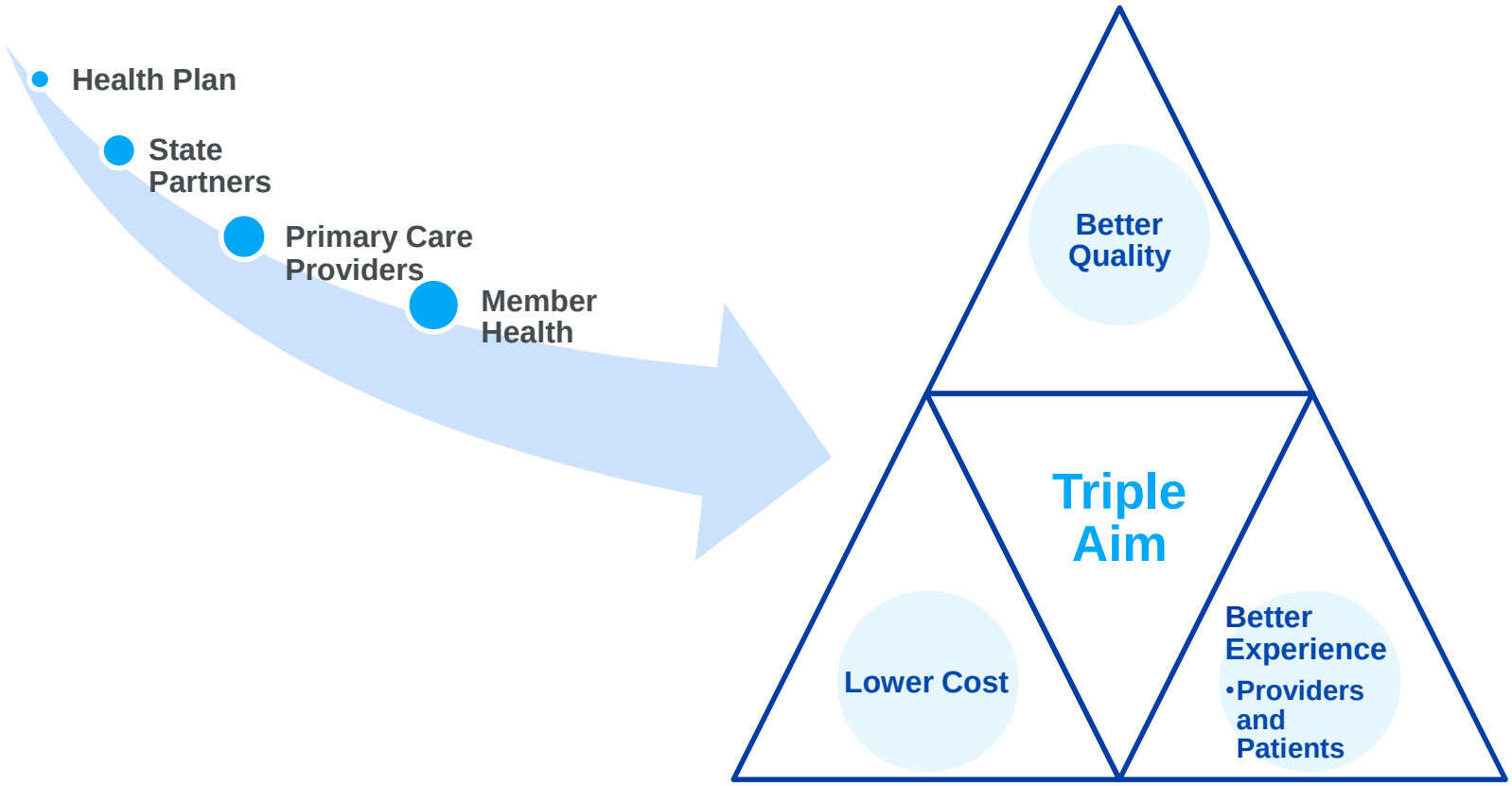
Delivering on the Triple Aim

We seek to **align incentives** across the many stakeholders that fund and deliver care to the most vulnerable populations by driving **increased adoption and effectiveness** of value based payment and care delivery.



North Carolina Medicaid

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- North Carolina Medicaid will leverage the LAN APM Framework as a guide to move away from fee-for-service and towards VBP.

- Payment arrangements between PHPs and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework,

- DHHS requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures. (RFP Scope of Services Addendum - Page 175)

Value Based Payment

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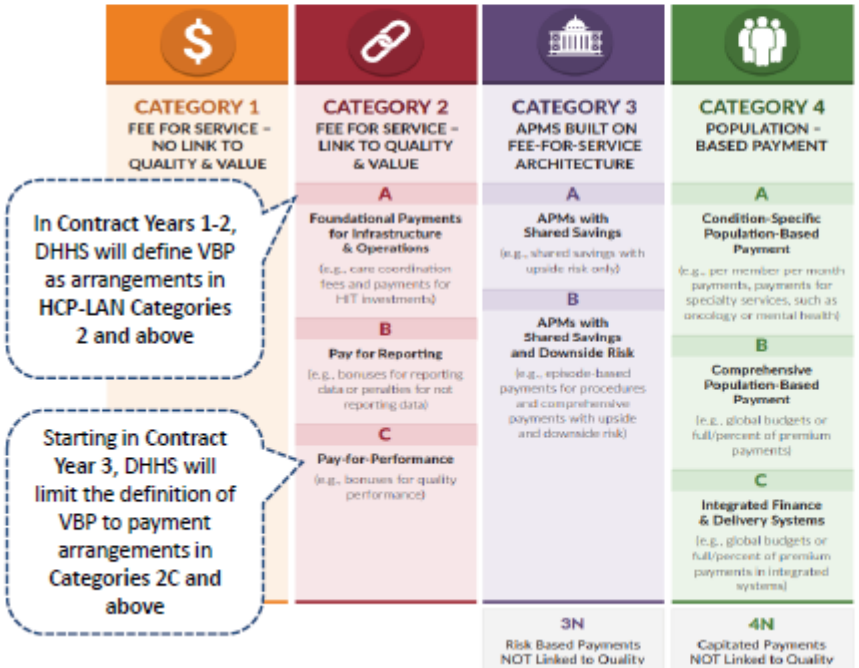
Defining and Measuring VBP Adoption

DHHS defines VBP using the Health Care Payment-Learning Action Network (HCP-LAN) Alternative Payment Models framework. Beginning in Contract Year 3, DHHS will limit the definition of VBP to only those arrangements that clearly link payment to quality or total cost of care.



VBP Targets Going Forward

- DHHS will set targets for the percentage of PHPs' medical payments that should be made through VBP arrangements in each Contract Year.
- Annual VBP targets will also include **sub-targets** for the percentage of payments in shared savings and risk-bearing arrangements (Categories 3-4).
- **Targets will increase over time so that by the end of Year 5 of managed care (summer of 2024), nearly all PHP/provider contracts will be expected to have a VBP component**

North Carolina- Improved Value

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- In-person, localized care
- Continuity of local providers
- Integrated community of health

- Depth of resources and best practices from experience
- Sophisticated support system, including data analytics and VBP

Singular focus

Benefits of Value-Based Purchasing

VBP

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VBP improves partnership with Medicaid care providers to drive better quality care and better value for our Medicaid members and state partners

- **Collaborate with care providers by:**
  - meeting practices where they are in their ability to bear risk,
  - helping them navigate VBP
  - providing a glide path for them to follow as they **change the way they deliver care** and accept increasing levels of risk.

Shift to Value-Based Payment

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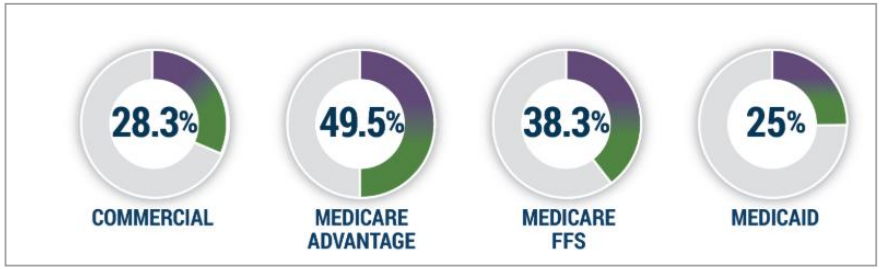
North Carolina Medicaid's increasing focus on value-based payment (VBP) is part of a broader shift in payment models across payers.

National Landscape

- **34%** of U.S. healthcare payments were "value-based" in 2017, up from **23%** in 2015, according to research conducted by the Healthcare Payment Learning and Action Network (HCP-LAN).*
- Value-based arrangements were most common in Medicare but are widespread across payers.

Percentage of Healthcare Payments in Level 3 or 4 Payment Models by Payer (2017)



*Payments categorized as level 3 (alternative payment models built on FFS architecture with upside/downside risk) or 4 (population based payment) under the Healthcare Payment Learning and Action Network (HCP-LAN) alternative payment model framework.

Source: "APM Measurement: Progress of Alternative Payment Models", HCP-LAN, 2018.

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Focus on supporting the delivery of person-centered care

Under VBP arrangements, consumers are at the center of the health care experience supported by a more coordinated care team.

VBP emphasizes high quality care that is delivered in an efficient manner and care that takes into account the preferences, needs, and values of individuals and their caregivers.

VBP Benefits

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Heightened incentive to coordinate care.

VBP supports coordination both within the health care system and among different entities and organizations.

Technology, access to data, and financial incentives support care providers in coordinating care for individuals across the health care continuum.

VBP Benefits

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Encourages proactive care.

VBP incentivizes care providers to keep consumers healthy and close gaps in care.

Approach uses research and evidence-based practices to **address proactively** the social, environmental, and medical factors that contribute to an individual's health and influence healthy outcomes rather than reactively treating an illness or disease.

VBP Benefits

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Emphasis on collaboration and transparency.

Payers and care providers share a common goal of better outcomes as opposed to a fragmented system where payment is solely based on services rendered.

VBP Benefits

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Reduction in health care waste.

Value is the new standard for payers and care providers, and reimbursement is based on quality and individual health improvements.

These outcomes positively affect both the lives of individuals and the health care system's bottom line.

State Value-Based Purchasing Experience

Arizona

- The Arizona Health Care Cost Containment System has required its contracted Managed Care Organizations (MCOs) to implement VBP reform since 2014.

- MCOs in Arizona are required to have 50% of all payments to providers tied to value; however, the state allows MCOs the flexibility to develop models that meaningfully engage providers

Hawai'i

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- Since 2013, Hawai'i Med-Quest (Medicaid) has required its contracted MCOs to incorporate VBP requirements into their provider contracts.

- Beginning in 2017, Hawai'i requires 80% of payments to care providers to be in VBP arrangements. MCO's have discretion on how to implement VBP arrangements, but all MCOs are required to use the same quality measures.

Pennsylvania

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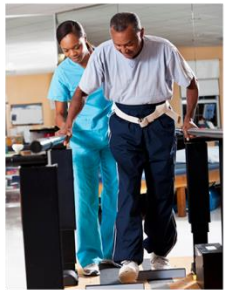
- Pennsylvania was an early leader in VBP reform, as the state has had a VBP strategy in place since 2013.

- Pennsylvania requires its contracted MCOs to have 30% of all payments to care providers subject to VBP by the end of 2019, and in 2018, the state announced requirements that Behavioral Health Managed Care Organizations must also implement VBP models that increase over the life of the contract.

Thank you.



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