3. Capitation Payments (Section 10.0 Capitation Payment Information Section 11.0 Rate Component

a. Describe proposed approaches for Physician Incentive Plans, including innovative approaches to incent provider behavior and participation.

INNOVATE

We focus our innovative provider incentive programs on ***meeting providers where they are along the continuum of arrangements that support providers at various levels of capability and readiness.*** We will partner with DMS and providers to further develop and expand our portfolio of Physician Incentive Plans and value-based payment (VBP) models to support improving enrollee and provider experiences, while improving the health of Kentucky's overall population.

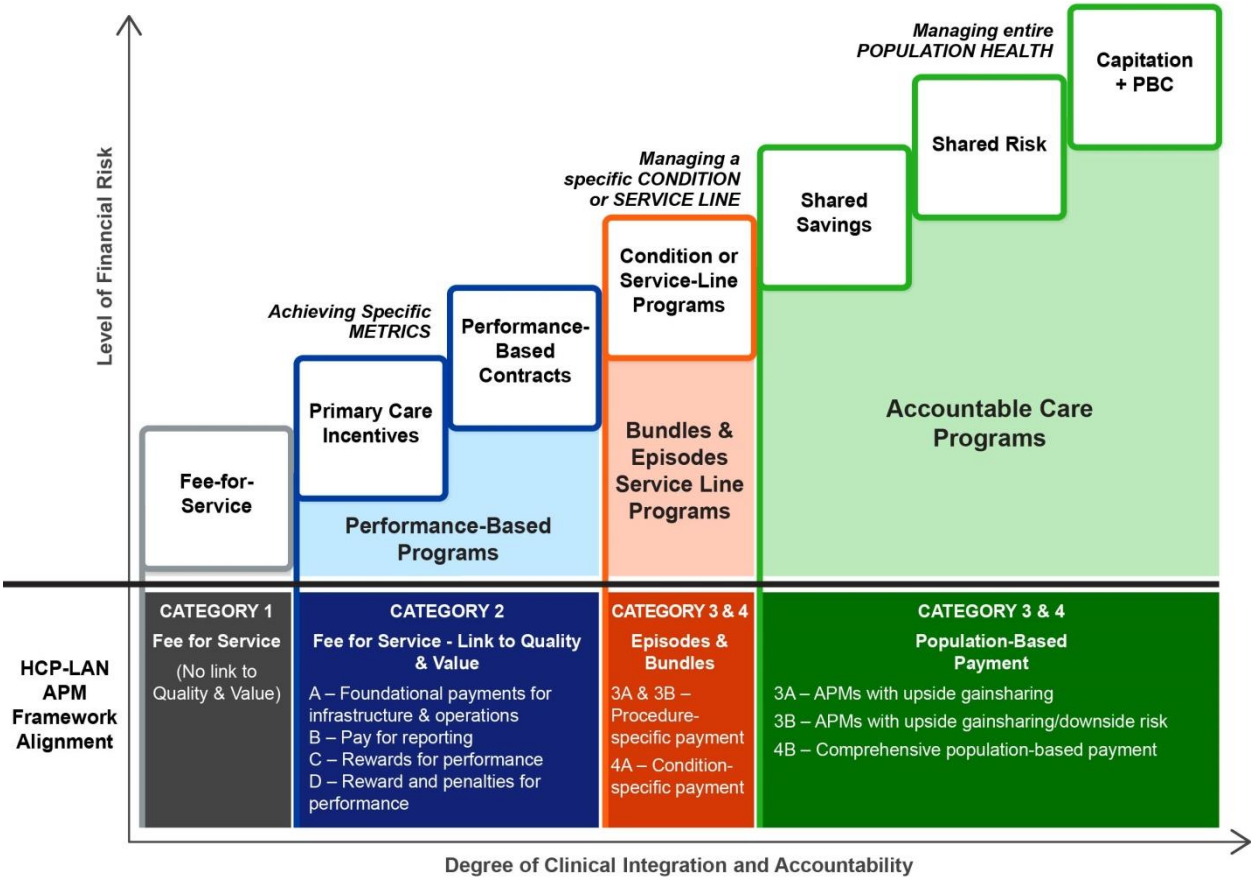

Figure 1. Our suite of Physician Incentive Plans spans the clinical integration and reimbursement risk continuum. We meet providers where they are — aligning our incentive models with their operational sophistication and readiness to accept risk.

All provider incentive plans in our continuum drive and improve provider behavior transformation through the combination of established HEDIS quality/performance goals, shared actionable data, online population health tools and our direct, regular clinical transformation support and provider outreach and training. **UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is fully compliant with the Federal Regulations as set forth in 42 C.F.R. 422.208 and 42 C.F.R. 422.210**.

We encourage providers interested in VBP models, that may be hesitant to participate in our more advanced performance-based quality VBP models (APM Category 3-4), to first participate

in our upside only quality program (APM Category 2). For many providers, this APM category serves as an entry point to a pay-for-quality environment. We see APM Category 2 models as a crucial engagement platform to build provider best practices that can mature into future VBP opportunities that entail greater risk at higher APM categories. If providers are interested in moving up the APM continuum, we would recommend they become an Accountable Care Organization (ACO) to gain experience in the upside-only "total cost of care" shared savings model before taking on risk.

If a provider is willing to move into an APM Category 3 or 4 risk-based agreements, we conduct an assessment to gain a thorough understanding of the practice's overall readiness, model of care, capacity and capabilities. This includes a review of their IT infrastructure to confirm that they are compliant with data transfer processes to report and submit encounter data in an accurate and timely fashion that complies with DMS requirements. Several methods of risk mitigation exist which are specific to the provider and the situation; these may include a security deposit, security reserve or a letter of credit. To evaluate risk readiness, we review the provider's interim and most recent audited financial statements.

The following are brief descriptions of the innovative Physician Incentive Plans we may implement with Kentucky network providers, pending final review and approval by DMS, along with the corresponding HCP-LAN Category. UnitedHealthcare will align with all DMS requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 19.9 Value-based Payment.

Risk-based Incentive Programs

Capitation (APM 4A-4B): The Capitation Model supports a comprehensive population health approach by giving providers a monthly cash payment along with timely clinical data to support proactive enrollee engagement and to manage high-risk patients optimally. We make capitation payments each month based upon the number of enrollees assigned to a practice; the practice in turn uses those funds to provide or arrange for the best possible care for each of their patients. Sub-capitated arrangements like this are only successful with providers who have demonstrated strong population health management and quality improvement capabilities. As previously stated, we conduct an assessment to gain a thorough understanding of providers' overall readiness, model of care, capacity and capabilities before implementing a delegated arrangement. The assessment reviews criteria such as financial solvency, platform optimization and medical management clinical operations, including data sharing and performance. Once a provider participates in all upside quality programs and a comprehensive evaluation of readiness, data exchange, and capacity to ensure success, this model is available to them.

Bundles (Episodes of Care) (APM 3A-3B): For specialty physicians or providers not yet ready for total population health arrangements, we can support and advance them from performance-based programs to the episode-based payment program. This program is built upon the fee-for-service (FFS) reimbursement foundation with retrospective shared savings opportunities based upon the cost of care of all services related to conditions or procedures that are critical to our state partners. This approach gives the primary accountable provider for a given condition or procedure the opportunity to be rewarded for quality and savings relative to market average benchmarks for the cost per episode on a retrospective basis. We are currently piloting this model in partnership with state Medicaid programs on a limited scale, focusing on a list that aligns with each state's primary cost-reduction goals. Programs typically focus on critical, high-cost conditions and procedures such as perinatal care, asthma, COPD, joint replacement and cardiac procedures. We assess the efficacy of these programs before making strategic decisions to expand them more broadly.

Behavioral Health Provider Shared Savings Model (APM 3A): This model for outpatient behavioral health providers will focus on reducing the PMPM inpatient behavioral health cost over a 12-month measurement period and meeting defined quality metrics. For each metric achieved, a certain amount of shared savings will be available for the provider.

Behavioral Health Facility Shared Savings (Clinical Excellence) (APM 3A): This model for facility providers (inpatient, residential and partial hospitalization programs) focuses on a reducing the 30-day episode cost of care over a 12 month measurement period and meeting defined quality metrics. For each metric achieved, a portion of shared savings will be available to the provider.

Integrated Behavioral and Physical Health Home VBP Model (APM 3A): To support organizations in providing comprehensive integrated primary and behavioral health care that will result in the best outcomes for our enrollees with serious mental illness (SMI) and substance use disorder (SUD), we will implement our innovative Integrated Behavioral and Physical Health Home VBP shared savings model. The goal of this integrated model is to improve performance and reduce the overall behavioral and medical total cost of care (TCOC). If a behavioral health provider is able to reduce the TCOC and meet defined quality metrics, they will be eligible to receive a percentage of the shared savings amount. Metrics will focus on medical and behavioral health measures including medication adherence measures and align with the Commonwealth's priorities including the 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness measures.

Accountable Care Programs (APM 3A-3B): Our ACO models have upside/downside shared savings provisions based upon performance against total cost of care and quality metrics. We base bonus opportunities on savings accrued against TCOC or clinical efficiency metrics. The distribution of shared savings providers can earn will be determined by performance against a suite of quality measures aligned with DMS-selected metrics.

Non-risk-based Incentive Programs

Primary Care Physician Incentive (APM 2C): Our primary care incentive model, PCPi, focuses on closing care opportunities and improving quality outcomes that are critical to DMS. Participating providers receive FFS reimbursement plus the opportunity to earn incentives for closing care opportunities. In 2019, over 2.8 million UnitedHealthcare Medicaid enrollees are included under this program.

Opioid/medication-assisted treatment (MAT) VBP Program (APM 2C): We propose developing three opioid-related VBP programs within the Commonwealth:

- The OUD Quality MAT VBP for PCPs includes incentives payments for care management service and infrastructure enhancements related to MAT
- The ED MAT Induction & Referral VBP supports and enhances the Kentucky "bridge clinics," designed to provide MAT treatment on-demand, by incenting EDs to establish protocols for patients identified as needing MAT services (e.g., referral to bridge clinics)
- The Maternal and Infant Opioid Health Home VBP focuses on the holistic needs of pregnant women with OUD, neonatal abstinence syndrome and mom/baby support

Obstetrics (OB) PCPi Incentive (APM 2C): This program rewards qualifying OB specialist practices for performance relating to closing patient care opportunities for certain HEDIS prenatal and postpartum measures and improving birth outcomes.

Dental VBP Incentive (APM 2C): Dental providers participating in this model will receive a bonus reimbursement for achieving improved outcomes on selected quality metrics: annual

dental visits (ages 2-20); oral evaluation (ages 0-21); cleanings (ages 0-21); topical fluoride application (ages 1-21 who are elevated risk); and caries risk assessment (ages 2-20 years).

Hospital Performance-Based Contract (HPBC) Incentive Model (APM 2C): This program rewards hospitals for improving the quality of care provided to our enrollees and improving efficiency and performance. For each provider, we will incorporate customized, hospital-specific improvement targets that align to DMS's performance metrics and priority areas. Hospitals have the opportunity to earn all or a pro-rated portion of an incentive based upon their performance against these measures.

b. Provide examples of successful Physician Incentive Plans the Vendor has implemented, including information about their structure, measurable outcomes, challenges and lessons learned.

Examples of Successful Implemented Programs and Structure

Using national Medicaid and Kentucky Commercial and Medicare VBP experience, as well as discussions with local Medicaid providers, we have learned that our incentive plans need to be true partnerships with network providers. Together we establish achievable joint goals and objectives to drive practice transformation that are based upon the individual provider's readiness and mutually shared information. We evolve our suite of VBP solutions by building upon our continuous efforts, incorporating feedback from providers and DMS, noting common challenges, reflecting emerging industry best practices and applying lessons learned in other markets.

For our ACO model, we target providers who are clinically and financially ready to transition from our primary care performance-based model to a more advanced VBP model. These models target multispecialty groups, PCPs and patient-centered medical homes (PCMHs) with over 1,000 assigned UnitedHealthcare enrollees committed to collaborating to achieve clinical integration and comprehensive population management. As previously noted, we base bonus opportunities for participating ACOs on savings accrued during performance against metrics such as TCOC or utilization metrics such as non-emergent ED use or avoidable admissions. Nationally, our ACOs show 9% lower admission rates and 2% fewer ED visits compared to non-ACOs.

Accountable Care Program Success Example: El Rio FQHC Partnership in Arizona

For ACOs in Arizona, we have offered TCOC VBP incentive models since 2012 (APM Cat. 3) with shared savings (upside/downside) and quality incentives. Our partnership with the El Rio ACO has resulted in the following successes, specifically for individuals with developmental and intellectual disabilities (DID):

- Inpatient/1,000 was ***reduced by 11%*** comparing April 2016 through March 2017 versus January 2017 through December 2017
- Comparing April 2016 to September 2017, BCR for individuals with DID was ***reduced by 2.7%***.
- ED/1,000 was ***reduced 10%*** and PCP visits ***increased 7%***.

These results are more meaningful when we consider that, on average, our predictive modeling indicates ACOs have membership whose overall health risk is 8.92% higher than non-ACO practices.

Our **Maternity Episode Program** has influenced the use of elective interventions (e.g., C-sections) and the use of appropriate support during labor and delivery, thereby driving a reduction in the likelihood of avoidable complications and readmissions — ultimately improving the total cost of perinatal care.

Maternity Episode Program Success Example from Tennessee

We have 171 obstetrics providers participating in a maternity episode of care program in our Tennessee market and we have seen risk-adjusted costs for the maternity episode decrease year-over-year since its inception in 2014. Additionally, quality outcomes such as C-section rates have decreased by 4%.

As previously noted the Capitation Model supports a comprehensive population health approach and, like many of our VBP models, is not a one-size-fits-all model. When UnitedHealthcare begins discussing a **capitation arrangement** with a provider, we first conduct a thorough review to validate the provider is able to take on risk and effectively manage their population. This normally occurs 6 to 12 months before implementing a capitation arrangement. During the review period, we confirm we are contracting the correct type of capitation agreement and, when applicable, that we are including provider-appropriate delegation of financial responsibility (DOFRs) the practice can efficiently manage. With four different types of capitation programs (global, shared, ancillary and split) and multiple areas of delegation (e.g., claims administration, medical management, credentialing), we have learned to take our time and customize the program to meet the unique needs and capabilities of the specific provider's practice.

Challenges and Lessons Learned (APM Categories 3 and 4)

A significant barrier we encountered with APM Category 3 and 4 models is provider readiness and bandwidth to engage in practice transformation and act upon clinical engagement opportunities, which is especially needed for providers within our ACO models to reach their highest success potential. This is mainly due to the lack of experienced ACO providers with population health and performance improvement expertise; for example, we currently have only one ACO in our Medicare and Commercial lines of business in Kentucky. Another challenge we face in many states is provider unwillingness to move to downside risk models unless mandated by the Commonwealth, preferring instead to stay in upside only VBP programs. In Tennessee, the State requires that providers take downside risk and had the MCOs, including UnitedHealthcare, implement an Episodes of Care (bundled) program. This approach and collaboration has led to a significant savings; from 2015 to 2017, the risk-adjusted savings of these programs totaled $53.9 million for all three Tennessee MCOs. Of note, CMS has also seen the national financial impact when providers agree to participate in downside risk agreements. According to CMS, of the 44 organizations that took on downside risk as part of the Next Generation Medicare ACOs, CMS saw $164 million in savings for 2017. CMS also recently updated the Medicare Pathways to Success, with one change reducing the time that new ACOs can remain in upside-only agreements, from 6 years to 2 years. Because of their changes, CMS is projecting a savings to Medicare of $2.9 billion over the next 10 years.

Time and experience have shown a Benefit Cost Ratio (BCR) shared savings approach to measuring TCOC to be challenging for many ACOs for various reasons (e.g., lack of ACO direct effect on revenue, inability to generate frequent BCR tracking reports). Thus, UnitedHealthcare is moving to deploy the **Accountable Care Shared Savings (ACSS) PMPM Model** as the primary option for ACOs managing TCOC. With a TCOC ACO model, we target providers who are clinically and financially ready to transition from our primary care performance-based model to a more advanced VBP model. These models target multispecialty groups, PCPs and PCMHs with over 1,000 assigned UnitedHealthcare enrollees committed to collaborating to achieve clinical integration and comprehensive population management. As previously noted, bonus opportunities for participating ACOs are based upon savings accrued during performance against a suite of quality measures or clinical efficiency metrics. Nationally, our ACOs show 9% lower admission rates and 2% fewer ED visits compared to non-ACOs.

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