UnitedHealth Premium® Program Version 14 methodology

Program introduction

The UnitedHealth Premium program provides physician designations based on quality and cost efficiency criteria to help members make more informed choices about their medical care. Physicians may also use these designations when referring patients to other physicians and to support their efforts to provide quality and cost-efficient care to their patients. In markets where tiered benefit plans are available, employers may offer employees a tiered benefit plan with a lower member cost share for using Premium Care Physicians.

The UnitedHealth Premium program evaluates physicians annually, using updated quality and cost efficiency methodologies and data. Physicians receive one of the following **designations** based on a comparison of current version and previous version evaluation results:

Premium Care Physician
The physician meets the UnitedHealth Premium program quality and cost-efficient care criteria.

Quality Care Physician
The physician meets the UnitedHealth Premium program quality care criteria but does not meet the program's cost-efficient care criteria or is not evaluated for cost-efficient care.

Does Not Meet Premium Quality Criteria
The physician does not meet the UnitedHealth Premium program quality criteria so the physician is not eligible for a Premium designation.

Not Evaluated For Premium Care
The physician's specialty is not evaluated in the UnitedHealth Premium program or the physician's program's evaluation is in process. Or, the physician does not have enough claims data to be evaluated for UnitedHealth Premium program quality, so the physician is not eligible for the Premium Care Physician designation.

Physicians can review their Premium designation details by signing into **UnitedHealthPremium.UHC.com** after they receive their evaluation notifications.

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United Healthcare

Eligibility requirements

Physicians are evaluated by the Premium program when they meet all 3 of the following requirements:

- Have an active UnitedHealthcare commercial fee-for-service contract
- Practice in one of the **primary credentialed specialties** evaluated by the program
- Practice in a **state and county** included in the program

Quality and cost-efficiency methodology—Overview

Quality is the primary program measurement and is evaluated using national standardized measures. Attribution methods based on health plan claims data determine which physicians are responsible for care given to patients. When there are a sufficient number of quality measures attributed, the Premium program compares the physician's quality performance to the target benchmark. The physician meets the Premium program quality care criteria when the physician's quality performance is not statistically less than the target benchmark.

Cost efficiency uses 2 measurements for the evaluation: patient total cost measurement and patient episode cost measurement. The physician's Premium specialty determines which measurement is applied. Attribution methods based on health plan claims data determine which physicians are responsible for care given to patients. When there are a sufficient number of patients or episodes attributed, the Premium program compares the physician's cost efficiency performance to the target benchmark. The physician meets the Premium program cost-efficient care criteria when the physician meets the Premium program quality care criteria and the physician's cost efficiency performance is statistically less than the target benchmark.

Physicians who do not have a sufficient number of measures, patients or episodes attributed to be evaluated may meet the Premium program quality and/or cost-efficient care criteria, based on an affiliated medical group result for their Premium specialty within the same geographic area. Medical group results are determined using a similar methodology applied to physicians.

We reserve the right to exclude physicians, as appropriate, including, but not limited to, situations when there may be a sanction against a physician's license or a physician has lost their license.

Quality evaluation

The Premium program first uses clinical quality measures from the National Quality Forum (NQF)-endorsed measures when available for the specialties being evaluated. Those measures are supplemented with others as necessary to evaluate clinically important conditions and specialties.

Additional measures are selected from or developed using published literature and information from organizations such as:

- The National Committee for Quality Assurance (NCQA)
- American Medical Association Physician Consortium for Performance Improvement® (PCPI)
- Specialty societies relevant to a specific disease and clinical condition
- Government agencies
- Other national expert panels

From these sources, the Premium program uses measures relevant to the specialties evaluated by the Premium program that can be evaluated using health plan claims data and that are useful in determining differences in physician performance.

The Premium program also counts NCQA Diabetes and Heart/Stroke **Recognition Programs** in the quality evaluation. The Premium program adds the greater of 25 measures or 10% of the physician's total measures (whichever is larger) as compliant to the quality evaluation for physicians who have achieved recognition in one or more of these programs applicable to their Premium specialty.

Data used

To evaluate quality, the Premium program uses health plan claims data based on services provided to patients enrolled in UnitedHealthcare commercial fee-for-service, UnitedHealthcare Medicare Advantage, and UnitedHealthcare Community Plan health plans. The quality evaluation uses claims submitted and processed for dates of service between Jan. 1, 2017, and Feb. 29, 2020. These dates of service are prior to the President's proclamation declaring the COVID-19 national emergency. Claims for patients receiving hospice care or who had benefits administered under a coordination of benefits process are not used in the evaluation.

Attribution methods

Attribution methods based on health plan claims data determine which physicians are responsible for care given to patients. Quality measures are attributed to physicians with significant involvement in the care of the patient. The determination of significant involvement varies by the physician's role and the attribution method applicable to the quality measure. Multiple physicians may be attributed to a single measure when appropriate.

Performance evaluation

When there are a sufficient number of quality measures attributed, the Premium program compares the physician's quality performance to the target benchmark. The quality evaluation requires a minimum of 20 attributed quality measures among at least five patients across all patient populations, conditions and procedures. NCQA recognition programs, if applicable, satisfy the measure and patient minimum requirements. The physician's quality performance is the sum of all attributed measures where the patient meets the quality measure criteria. To establish the target benchmark, the Premium program determines the number of measures expected to be compliant at the 50th percentile compliance level. This is accomplished by first calculating the national compliance rate for each measure by unique combinations of:

- **Premium specialty**
- Patient population (commercial, Medicare, Medicaid)
- **Condition or procedure**
- **Severity level** (when applicable)

A minimum of 50 instances of each unique measure combination are required to calculate the national compliance rate. For the NCQA all-cause readmission measure, rather than calculating the national compliance rate, the Premium program uses the NCQA-specified method to calculate the risk-adjusted expected rate of readmission based on prior and current health of the patient among other factors.

Once the national compliance (or expected) rate for each measure is calculated, the rate is multiplied by the number of applicable measures attributed to the physician. This adjusts for the physician's **case-mix**.

The chi-square goodness of fit test (for statistical significance) and the phi coefficient (for effect size, or absolute difference) are used to determine if the physician's performance is not statistically less than the target benchmark with 98% confidence. The physician meets the Premium program quality care criteria when the physician's performance is not statistically less than the target benchmark.

Physicians who are attributed surgical complication and redo measures are evaluated in two steps:

1. The physician's quality performance is compared to the target benchmark using only these two outcome measures. If the physician's performance for these quality measures is statistically less than the target benchmark, the physician does not meet the Premium program quality care criteria.
2. If the physician's performance for these quality measures is not statistically less than the target benchmark, then all attributed measures are used to determine if the physician's quality performance is not statistically less than the target benchmark.

View the Quality Performance Evaluation Example

Cost efficiency methodology

There are two measurements applied for the evaluation of cost efficiency: patient total cost measurement and patient episode cost measurement. The Premium program uses the cost measurement applicable to the physician's **Premium specialty**. For specialties measured using patient total cost, when the physician does not have a sufficient number of patients attributed, the Premium program uses the patient episode cost measurement. The cost efficiency evaluation requires a minimum of 10 attributed patients attributed patients for patient total cost measurement or 10 attributed episodes for patient episode cost measurement.

We include episodes for conditions and procedures relevant to the specialties evaluated by the Premium program and that are useful in determining differences in physician performance. Costs from health plan claims data related to these episodes are used.

Data used

The Premium program uses actual allowed costs from health plan claims data for patients enrolled in UnitedHealthcare's commercial fee-for-service, UnitedHealthcare Medicare Advantage fee-for-service or UnitedHealthcare Community plans (excluding members enrolled in a long-term care plan). We exclude patients that are dual eligible for Medicare and Medicaid.

Actual allowed costs are the amounts paid by the health plan and the patient to the provider. Patient total cost measurement uses claims submitted and processed for two distinct calendar years: 2018 and 2019. Patient episode cost measurement uses claims submitted and processed for complete episodes that start in 2018 or 2019. These dates of service are prior to the President's proclamation declaring the COVID-19 national emergency. Only the most recent year is used when there are a sufficient number of patients or episodes attributed for evaluation. When there are not a sufficient number of patients or episodes attributed for the most recent year alone, both years are used. Claims for patients receiving hospice care or who had benefits administered under a coordination of benefits process are not used in the evaluation. The Premium program excludes patient and episode low cost outliers from the cost efficiency evaluation. **High cost outliers** are addressed by the use of percentile ranks to evaluate cost efficiency.

Attribution methods

Attribution methods based on health plan claims data determine which physicians are responsible for care given to patients. For patient **total cost measurement**, patients are attributed to the physician with the most significant involvement in the care of the patient for the conditions relevant to the physician's **Premium specialty** for each calendar year measured. Multiple physicians in different specialties may be attributed a single patient for the same calendar year, when appropriate.

For **patient episode cost measurement**, episodes are attributed to the one physician with the most significant involvement with the patient for the specific condition or procedure. The determination of significant involvement varies by the physician's Premium specialty and the applicable attribution method.

Performance evaluation

For **patient total cost measurement**, the physician's cost efficiency performance is the sum of patient total cost ranks. Patient total cost is the risk-adjusted total cost per month for a patient which includes services from episodes for conditions relevant to the scope of practice for the physician's Premium specialty. Relevant services include those provided by other healthcare professionals as well as facility, pharmacy and ancillary services (e.g., diagnostic tests). Patient total cost is **risk adjusted** by dividing the patient's total cost per month by the patient's risk score, which is based on the patient's conditions and demographic characteristics. Only patients with at least 7 months of eligibility during the year(s) used are included.

For **patient episode cost** measurement, the physician's cost efficiency performance is the sum of patient episode cost ranks. Patient episode cost reflects a combination of resource utilization, resource mix and unit cost. Episodes include services delivered to a patient related to a specific procedure or treatment of a condition. Services may include those provided by other healthcare professionals as well as facility, pharmacy and ancillary services (e.g., diagnostic tests).

To establish the target benchmark, determine the physician's performance and adjust for the physician's case-mix, patient total costs and patient episode costs are first put into ''treatment sets'' by unique combinations of:

- **Premium specialty**
- **Condition or procedure** (patient episode cost only)[1]
- Care Setting (inpatient or outpatient for applicable patient episode cost only)
- Patient population (commercial, Medicare, Medicaid)
- Product/network
- **Geographic area**
- Inclusion of pharmacy cost
- **Severity level** (patient episode cost only)
- **Risk level** (patient total cost only)

A minimum of 20 patients or episodes is required across at least two physicians in the same specialty and same geographic area for each treatment set to create a benchmark for comparison.

To determine the physician's performance a **proportional weight** is given to each patient total cost and episode cost treatment set based on expected cost to treat. Weighting is achieved through the duplication of each patient or episode cost in a treatment set. The number of times each cost is duplicated is determined by comparing the expected cost of the treatment set to the expected cost of the lowest cost treatment set for the same Premium specialty and geographic area. Patients and

episode costs in treatment sets with higher expected costs are duplicated a greater number of times than those in treatment sets with lower expected costs. Medicare and Medicaid treatment sets are used only to determine the proportional weight given to each treatment set. Physician performance is evaluated using only the commercial treatment sets.

For each physician, the cost percentiles from each weighted treatment set that includes costs attributed to the physician are combined. The combined weighted treatment set contains the cost percentiles for the physician as well as his/her peers. Within each combined weighted treatment set, the cost percentiles are ordered from low to high and assigned a rank from one (lowest) to N (highest). The physician's cost percentile ranks from the combined weighted treatment set are added together to determine the sum of cost ranks. An adjustment is made to account for the effect of duplicating costs on sample size.

To establish the target benchmark, the Premium program multiplies the physician's number of attributed patients (for patient total cost) or episodes (for patient episode cost) by the median of the total patients or episodes (including those attributed to the physician) in the related treatment sets and adjusts the result to the 75th percentile cost level (i.e., the boundary of the highest quartile of costs).

The **Wilcoxon rank-sum test** is used to determine if the physician's performance is statistically less than the target benchmark with 90% confidence. The physician meets the Premium program cost-efficient care criteria when the physician meets the Premium program quality care criteria and the physician's cost efficiency performance is statistically less than the target benchmark.

Physicians are also assigned a cost efficiency rating. A cost efficiency rating is a classification of physicians based on a comparative assessment of their cost efficiency performance. **Cost efficiency ratings** range from A-G, with A being the most cost efficient and G being the least cost efficient.

View the Cost Efficiency Evaluation and Rating Example

Group Evaluation

Physicians who do not have a sufficient number of **attributed measures** for quality and/or do not have a sufficient number of attributed patients or episodes for cost efficiency, may meet the Premium program quality and/or cost-efficient care criteria based on an affiliated medical group evaluation result for their **Premium specialty** within the same **geographic area**. Medical group evaluation benefits physicians within an affiliated medical group who share similar practice patterns and care protocols. The Premium program considers physicians to be affiliated with a medical group when they are included under a medical group agreement(s) with UnitedHealthcare at the time of evaluation.

Groups are defined by tax identification number(s) (TINs) that operate as a single health care organization. A group can range from a single TIN to a multiple-TIN health system. Attribution methods, based on health plan claims data, determine which groups are responsible for care given to patients.

Medical group evaluation results are determined using a similar methodology as applied to physicians. For medical groups, the quality and cost efficiency methodologies are applied to the aggregate set of quality measures, patient total costs and patient episode costs for all affiliated physicians with the same Premium specialty within the same geographic area. Group evaluation results are not publicly displayed, nor are they used for tiered benefit plans.

Medical groups receive one of the following evaluation results for each Premium specialty within the same geographic area:

Evaluation Result	
Quality:	Meets Criteria
Cost Efficiency:	Meets Criteria
Quality:	Meets Criteria
Cost Efficiency:	Not Evaluated
Quality:	Meets Criteria
Cost Efficiency:	Does Not Meet Criteria
Quality:	Not Evaluated
Cost Efficiency:	Does Not Meet Criteria
Quality:	Does Not Meet Criteria
Cost Efficiency:	Does Not Meet Criteria

Important notes about the UnitedHealth Premium Program

The information from the UnitedHealth Premium program is not an endorsement of a particular physician or health care professional's suitability for the health care needs of any particular member. UnitedHealthcare does not practice medicine nor provide health care services. Physicians are solely responsible for medical judgments and treatments supplied. A Premium Care Physician or Quality Care Physician designation does not guarantee the quality of health care services members will receive from a physician and does not guarantee the outcome of any health care services members will receive.

Likewise, the fact that a physician has a Not Evaluated for Premium Care or a Does Not Meet Premium Quality Criteria designation does not mean that the physician does not provide quality health care services. All physicians in the UnitedHealthcare network have met certain minimum credentialing requirements. Regardless of whether a physician has received a Premium Care Physician designation, members have access to all physicians in the UnitedHealthcare network, as further described under the member's benefit plan.

The designation of "Not Evaluated for Premium Care" is given when a physician does not practice in a specialty that is evaluated by the Premium program, or when a physician's evaluation is in process. It is also given when a physician does not have enough health plan claims data to be evaluated, but it is not an indicator of the total number of patients treated by the physician or the number of procedures performed by the physician. Rather, it reflects the statistical requirements of the Premium program, which includes only health plan claims associated with specific Premium program measures and relevant to the physician's specialty. In some cases, there may not be enough data to complete the analytic process from a statistical standpoint.

UnitedHealthcare informs members that designations are intended only as a guide when choosing a physician and should not be the sole factor in selecting a physician. As with all programs that evaluate performance based on analysis of a sample, there is a risk of error. There is a risk of error in the claims data used in the evaluation, the calculations used in the evaluation, and the way the Premium program determined that an individual physician was responsible for the treatment of the patient's condition. **Physicians have the opportunity to review this data and submit a reconsideration request.** UnitedHealthcare uses statistical testing to compare a physician's results to expected or normative results. There is a risk of error in statistical tests when applied to the data and a result based on statistical testing is not a guarantee of correct inference or classification. We inform members that it is important that they consider many factors and information when selecting a physician. **We also inform our members that they may wish to discuss designations with a physician before choosing him or her, or confer with their current physician for advice on selecting other physicians.**

The information contained in this Premium Program Methodology V14 document is subject to change.

Learn more

UnitedHealthPremium.UHC.com

UnitedHealth Premium Program, 9700 Health Care Lane, MN017-W700, Minnetonka, MN 55343

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