UnitedHealthcare has been on the leading edge of innovative payment models. We were one of the first to recognize top-performing medical centers that practice evidence-based medicine. More than 20 years ago, we launched our Centers of Excellence program to direct our members to facilities that excel at treating complex medical conditions like cancer and congenital heart disease.

Over time, our partnerships with physicians, hospitals, and provider organizations expanded to build performance-based payment models, Patient-centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).

In 2010, the Affordable Care Act (ACA) brought these payment models to the forefront by promoting a close partnership between patient and physician and the importance of an integrated care team. The ACA created multiple programs for ACOs and PCMHs with Medicare, Medicaid and the Center for Medicare & Medicaid Services.

Today, UnitedHealthcare has the deepest, most integrated value-based incentive platform in the industry.

We meet providers where they are, not where we expect them to be. Each arrangement is unique and based on the provider’s ability and desire to manage care and risk. These partnerships bring value to our customers, and continue to deliver a positive, affordable health care experience for your employees.

**What is meant by “value?”**

By “value,” we mean a balance of quality, efficiency and lower costs. We place metrics around the value, and use these metrics to determine how we pay providers. We pay based on how well providers meet or exceed the metrics, not for the number of services they perform.
So, does it work? The numbers behind these value-based programs tell the story. **UnitedHealthcare targets an overall return on investment of at least 2:1 for its value-based programs.** The 2:1 ratio is based on:

- Providers *earning* bonuses, fee schedule increases and payment inflators, and
- Improved outcomes when providers reduce unnecessary utilization of services including prescriptions, hospitalizations, emergency room visits, out-of-network referrals, specialist use, etc.

The truth is that the fee-for-service model hasn’t worked. Fee-for-services incorporates automatic payment increases and rewards for volume - the more services that are delivered, the more fees are paid. We believe that paying for value encourages the best patient care.

**Defining value-based incentive models**

While definitions may vary across the industry, here is how we describe the most common ways we pay for value.

**Performance-based Programs**
Performance-based programs today include primary care incentives as well as hospital and physician performance-based contracts. Under these programs physicians earn bonuses when they demonstrate improvements in quality care and cost outcomes. The metrics include some Healthcare Effectiveness Data and Information Set (HEDIS) measures, as well as hospital readmissions, hospital-acquired conditions, potentially avoidable hospitalization rates and non-network provider use.

Primary care incentives work well in smaller physician practices that may not have the tools to cover the cost of adding hours, staff or technology to support the additional services for members. While providers continue to be paid on a fee-for-service basis, providers are also paid a bonus when they achieve a goal for measures such as prescribing Tier 1 drugs and referring within the network.

**Patient-centered Medical Homes**
In a PCMH, each member is attributed to a personal primary care physician, or “medical home.” The physician coordinates all aspects of patient care both inside and outside of the clinic from specialty care, hospital stays, home health care, community services and other resources as needed to provide comprehensive care.

Primary care physicians are compensated for improving quality in two ways: a PMPM payment and a shared savings bonus. The PMPM payment is for the extra patient management and care coordination. These payments are on top of office visit payments. Providers may earn bonuses by reducing discretionary or unnecessary hospitalizations, emergency room visits, specialty referrals and diagnostic tests. Bonuses of up to 50 percent are paid from the amount of savings generated by reducing unnecessary treatments.
Payments are only made on behalf of those members who receive care from a primary care physician participating in our program and only made to those physicians entitled to receive them.

We are also pleased to mention UnitedHealthcare was selected for the CMS Comprehensive Primary Care Initiative (CPCI) program in Ohio, Colorado and New Jersey.

**Accountable Care Organizations**

An ACO is an organized group of care providers – physicians and a variety of health care professionals, specialists and sometimes hospitals. Together, they care for a defined group of more than 5,000 UnitedHealthcare members. By closely coordinating patient care, providers not only limit unnecessary medical care, they reduce costs and improve patient satisfaction. The health insurance company works with the providers to set cost and quality goals for this group of patients. When the goals are met or exceeded, the providers receive a bonus.

Providers in an ACO are encouraged to invest in technology, care coordinators and infrastructure to help track and monitor patient care.

Unlike a PCMH, which generally focuses on a single practice with multiple doctors, an ACO may include multiple physician practices as well as hospitals or other entities.

**UnitedHealthcare’s approach**

We believe the transition to value-based incentive programs provides the best path to better health, better care and lower costs – for everyone.

Value-based incentive programs are no longer the wave of the future. Value-based incentive programs are the way we do business today. In fact, our 8 million fully insured members participate in value-based incentive arrangements in the markets where the opportunity exists.

Our clinical team works with providers to explain the arrangement and ensure we have a mutually agreed-upon approach. We assist providers with incorporating new capabilities such as population health management, with using technology and data and with improving primary care access.

Currently, more than $27 billion, or over 25 percent, of our network health care spend is tied to performance-based payments, where provider incentives and annual inflators must be earned, not automatically given. We expect this to grow to more than $65 billion by 2018.

Here are some important facts:

- We have implemented performance- and value-based programs in all 50 states across our commercial and government program business.
• UnitedHealthcare has **15 ACOs contracted** that support commercial business. We anticipate entering into 10 or more new ACOs per year in the foreseeable future.

• We are advancing a program that also includes incentives for referrals to UnitedHealth Premium® Designated specialists. On average, specialists who have achieved Premium Designation status are **20 percent more cost-effective**. To the extent that primary care physicians encourage referrals to these specialists, overall costs can be reduced.

• We **track and monitor how well providers are doing** through the year by setting milestones and checkpoints.

• Value-based payment models are **a few of the multiple tools** we use to manage your medical costs.

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**Over $27 billion of network spend is tied to our accountable care platform**

- **Performance-based Programs**
- **Achieving specific METRICS**
- **Primary care incentives, performance-based contracts**
- **Centers of Excellence**
- **Managing a specific CONDITION**
- **Bundle/episode payments**
- **Accountable Care Programs**
- **Managing ENTIRE POPULATION HEALTH**
- **Shared savings, shared risk, capitation (including ACO, PCMH)**

- 32,000+ physicians
- 900+ medical groups
- 575+ hospitals
- 160+ Centers of Excellence
- 65,000+ physicians
- 550+ medical groups
- 65+ hospitals

**Increasing level of integration, financial risk and accountability**

We have **value-based engagement with more than 600 hospitals, 1,150 medical groups and 80,000 physicians participating in our Accountable Care Platform**

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**Your responsibility**

We have the presence, membership base and momentum to confidently invite our self-funded customers to be part of this success. UnitedHealthcare is pursuing a variety of value-based incentive programs, and self-funded customers will recognize the benefits in bottom-line savings and healthier employees.
Your investment in these programs is your share of the bonus payments paid to providers. Currently, we are showing a return on this investment for PCMH is greater than 3:1, and for our ACO programs and our primary care incentive programs is greater than 2:1.

There are different types of payments depending on the type of funding arrangement:

- **Performance-based payment** includes incentive fees for certain services identified at the beginning of the program. A primary care incentive program, for example, may pay primary care physicians for prescribing Tier 1 prescriptions and using network laboratories.

- **PCMHs** include both clinical integration payments, paid to providers or taking on additional services or for investing in staff and technology to monitor patient care. PCMHs may also receive a bonus based on a share of savings if they exceed the trend target.

- **ACO arrangements** pay a bonus based on managing medical cost within a budget and achieving quality targets. Then, the provider receives a share of the actual savings, generally 50 percent.

It works like this:

- Any **PMPM amounts** paid to participating providers are deducted from the customer’s claim bank account. A self-funded customer sees these payments reflected in their banking report when the group has members attributed to a participating primary care provider receiving incentive payments.

- **Bonus payments** are calculated and paid annually, at the end of the provider’s measurement period, based on performance below the target. Because each program ends on a different date, the customer’s allocation is spread throughout the year. Once the cost targets are achieved, a quality factor is added. This quality performance influences whether the provider receives the full payout or a reduced percentage of the total payout.

- Self-funded customers are charged for bonus payments and PMPM amounts only when they have members attributed to providers who are participating.

- **Customer reports show** member-level detail and incentive-type detail (e.g., bonus payments, PMPM clinical integration) supporting invoices for any clinical incentive or bonus payments. Banking statements will show summary transactions of the total incentive. A summary and detailed level report of the payment allocation is available to you each quarter.

- **Claims costs** for the health care services provided to members will continue to be paid and deducted from the self-funded customer’s claim bank account as they are today.
We encourage you to continue employee incentive programs that reward workers for making wise choices about their health and health care.

**The benefit to you and your employees**

Value-based incentive programs offer several benefits to you and your employees. The patient-physician relationship strengthens, the overall cost decreases, quality of care improves, access to care increases, and long-term chronic care costs may be reduced.

**Better health**
A direct benefit of improved quality of care means healthier employees. Healthier employees mean a more productive workforce.

**Better care**
Our members – your employees – will experience greater satisfaction with their care and the quality of care.

**Lower costs**
- You will see reductions in health care claims costs in real time as providers begin to achieve cost and efficiency targets.
- The return on investment for our PCMHs is an impressive 3:1, and for our ACO programs and our Primary Care Incentives is greater than 2:1.
- You will recognize savings as they occur throughout the year based on improved performance and quality initiatives.
- UnitedHealthcare assumes the administrative cost associated with value-based payment model innovations. There is no cost to you to participate in these programs.

Members do not need to do anything differently when they are part of a value-based incentive program. Members without a primary care physician will simply be attributed to a medical practice based on the one they most frequently visit or recently visited as reflected in our claims data.

Most importantly, you do not pay bonuses if the providers that your employees are attributed to do not perform. With value-based payment models, there is little risk and much to gain.
Here is a sample quarterly report of the Savings and Incentive Payment Summary. A detailed version of the report that shows member participation by practice is also available quarterly.

**Savings and Incentive Payment Summary Report**

**Savings and Incentive Payment Summary**

**Value-Based Programs**

YTD March 2014

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**Average Members**  
1,143

**Customer Members**  
51,000

**Participation Rate**  
2.2%

**ROI:**  
2.30

**The bottom line**

We believe value-based payment programs can transform how health care is reimbursed and delivered. As the industry embraces paying for value, and more providers and payers participate, we are optimistic that you will see the financial value, and your employees will experience higher quality, more affordable care.

But we’re not stopping here. Value-based payment programs are just one of the ways we manage the network and curb the medical trend. We continue to refine our current payment programs and research new ways to achieve better health, better care and lower costs for all.