The evolution of paying for health care

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 collaboration with physicians, hospitals, and provider organizations expanded to build performance-based payment models, bundled payments for episodes of care and accountable care models that pay provider groups, such as Accountable Care Organizations (ACOs), for assuming more risk and responsibility in achieving specific medical cost targets and quality goals.

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 Patient-centered Medical Homes (PCMHs) with Medicare, Medicaid and the Centers for Medicare & Medicaid Services.

Today, UnitedHealthcare has some of the deepest, most integrated value-based incentive programs in the industry.

More than $41 billion of our health care spend is tied to performance-based payments.

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 alliances 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 1 – 6% lower medical costs as a result of its value-based payment programs. Over the long term, our goal is to deliver 10-15% lower total medical costs through our accountable care programs.
The savings 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.

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 Per-member per month (PMPM) payment and a shared savings bonus. The PMPM payment is for the extra patient management and care coordination.

Accountable Care Organizations

An ACO is an organized group of care providers – physicians and a variety of health care professionals, specialists and sometimes hospitals. 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, over 11 million of our 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 $41 billion 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 over 40 ACOs contracted that support commercial business. We anticipate that number to exceed 75 by the end of 2016.
- We have a variety of innovative plan and network design solutions that encourage the use of high performing providers, such as narrow networks, PCP Centered plan designs and Tiered Benefit plan designs.
- High performing providers include UnitedHealth Premium designated specialists, who are up to 20 percent more cost-effective¹, as well as ACOs, which deliver on average, 1-6% lower medical costs. We are in the process of developing ACO-based products and expect even greater savings.
- 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.

Your responsibility

We have the presence, membership base and momentum to confidently involve our self-funded customers in this success. UnitedHealthcare is pursuing a variety of value-based incentive programs that will help customers 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. UnitedHealthcare targets 1 – 6% lower medical costs as a result of its value-based payment programs.

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 will be 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.
UnitedHealthcare targets 1–6% lower medical costs as a result of its value-based payment programs.

Over the long term, our goal is to deliver 10–15% lower total medical costs through our accountable care programs. 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.

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.

1 Savings estimates based on UnitedHealthcare’s 2012 analysis for 25 specialties and 147 markets. Figures are based on book-of-business results and represent the national average expected cost differential between Tier 1 and non-Tier 1 providers for entire episodes of care. Actual savings achieved will vary by customer depending on geographic availability and customer-specific service mix. All figures and estimated savings represent historical performance and are not a guarantee of future savings.

2 Hospital PBC results

The United-Health Premium® designation program is an information resource to help our members choose a physician. It may be used as one of many factors members consider when choosing a physician. As with any performance assessment program, physician evaluations have a risk of error. Please visit myuhc.com® for detailed program information and methodologies.

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