Table of Contents

Transitioning to Value-based Incentive Programs

Value-based Program Overview

1. What is a value-based program?
2. What is UnitedHealthcare’s Approach?
3. What are the different types of value-based programs and how do they perform?
4. What is UnitedHealthcare’s commitment to payment reform?
5. What experience does UnitedHealthcare have with value-based contracting?
6. Where are your programs located?
7. In addition to modernizing payment models, what is UnitedHealthcare doing to improve the health care system?
8. If new payment models emerge, will you end your current medical home programs and ACOs?

Benefits to Employers and Members

9. Why are value-based programs important for self-funded customers and their employees?
10. What are the most important network initiatives impacting self-funded customers?
11. How can employers support this effort?
12. How do value-based programs affect employees?
13. What if an employee does not have a primary care doctor, can they still be part of these programs?
14. How can you help employees take an active role in their health care?

Financial Responsibility for Self-funded Customers

15. How do self-funded customers pay for these programs?
16. Will self-funded customers know where their money is going?
17. Can a customer opt out later if they find that the payments increase their claims cost?
18. Does an employer have to do anything to participate?
19. How will a self-funded customer know the provider group produced savings?

How Value-Based Programs Work

20. What are the different types of value-based payments?
21. What is your participation in the Comprehensive Primary Care Initiative program run by CMS?
22. How do I know I saved more money than I am funding?
23. How do value-based program work compared to fee-for-service agreements?
24. Do self-funded customers pay more for these programs?
25. How does attribution work?
26. Does a self-funded customer pay if they do not have any employees participating in these programs?
27. How are pharmacy carve-outs handled?
28. Do programs pay twice for services when there is a care management carve-out?
29. What happens if medical costs go up rather than down?
30. Are stop-loss premiums potentially impacted?
31. What are the benefits to providers that participate in value-based programs?

Payment Processes

32. How are value-based contracts set up?
33. How do you calculate provider medical cost targets?
34. How are cost savings from value-based contracting shared with self-funded employer groups?

Employer Reporting and Support

35. What kind of financial reporting will be available for value-based contracting payments?
36. Can you create a report that shows the impact specifically to my employees?
37. How can your account teams help?
38. Can you project cost savings for a specific employer group? Can the savings be guaranteed?
39. What audit rights will a customer have relative to these payments?
40. Is there an ROI and cost analysis for each customer?
41. What criteria will be used to improve or maintain the quality of care delivered by participating network providers?

Appendix – Detailed Criteria
Transitioning to Value-Based Programs

Affordable health care is possible when the entire delivery system, which includes payers, employers, care providers, and consumers, is more accountable for cost, quality and experience. Our goal is to work collaboratively to achieve the triple aim of better health, better care and lower costs.

One of the ways we approach this is through value-based programs. We identify and reward the best-performing providers that manage the use of the health care system and reduce inappropriate and unnecessary care. These programs are different from limited efforts to negotiate price discounts, which historically reduced costs but did little to improve the quality of care.

Our involvement with value-based payments began over 30 years ago initially with capitated arrangements followed by Centers of Excellence programs. Over time, we have shifted to increased collaboration, outcomes-based payment and new benefit designs to drive innovation in how we pay for health care and how it is delivered. We expanded our partnerships with physicians, hospitals, and provider organizations to support performance-based programs including the new Comprehensive Primary Care Incentive models (CPCI), Patient-Centered Medical Homes (PCMHs), and Accountable Care Organizations (ACOs). By forging these relationships, we bring value to you, our customer, and continue to deliver a positive, affordable health care experience for your employees.

UnitedHealthcare commitment is demonstrated by the 8 million fully insured members we under this new model already. What’s more, many self-funded customers have already committed their employees to value-based models as well. In 2014, the value-based model is the way we will approach contracting with most hospital and providers. By 2015, all fully insured and self-funded customers will participate.

This document outlines our value-based payment approach and answers some frequently asked questions you may have about our programs. We hope that this will simplify the programs for you so you can see how UnitedHealthcare can help you and your employees experience better health, better care, and lower costs.

Value–Based Program Overview

1. What is a value-based program?
A value-based program is a partnership with health care providers in which we pay for value, not volume.

Value-based programs can take many forms but all are rooted in the principle that payment is not based on quantity but on health outcomes per dollar spent. Unlike fee-for-service where payment was based on the number of services delivered, value-based programs determine specific services delivered to a defined population at a predetermined price and according to agreed-upon quality standards and outcomes.

2. What is UnitedHealthcare’s approach?
We have a four-pronged coordinated approach to our value-based programs.

1. Payment models that reward for value. Our network contract team, working with our actuaries, designs an outcomes-based reimbursement model that gives providers a financial incentive to reduce waste, medical cost spend and improve quality of care.

2. Provider support. Our clinical team engages with providers to 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.

3. Customer partnership. UnitedHealthcare works with our customers to help engage them in the process. Not only do we believe that value-based arrangements lead to lower cost, but a direct benefit of improved quality of care means healthier employees and a more productive workforce.

4. Employee advantages. Our members – your employees – will experience greater satisfaction with their care and the quality of care. And, medical cost savings will translate into lower premiums.

3. What are the different types of value-based programs and how do they perform?

In addition to an array of pay-for-erformance and condition specific payment programs, UnitedHealthcare has
several approaches to drive affordability and quality improvements.

**ACO** – organized groups of providers, which may include hospitals that provide care to a defined group of patients. In the ACO, providers are accountable for overall cost and quality and population health management is provided across all levels of care. Providers exceeding their goals earn a bonus based on a percent of savings.

**PCMH** – In a PCMH, each member is attributed to a personal primary care physician practice, or “medical home,” who knows medical and family history and coordinates all patient care. Care is coordinated across all aspects of the health care system including specialty care, hospitals, home health care, and community services and support. Primary care physicians are compensated regularly for improving quality, focusing on preventive care, coordinating care for patients and improving the health care experience. These payments are PMPM fees for the additional services. Then, they share in the savings generated when unnecessary hospitalizations, emergency room visits, specialty referrals and diagnostic tests are reduced.

**CPCi** – Medical Home run by CMS that is multi-carrier. Providers are paid similar to PCMH, with a prospective PMPM fee based on number of attributed patients and a bonus, if earned, at the end of the program year.

**PCPi** – Incent primary care physicians to support cost effective and evidence-based medicine. Examples of metrics include: prescribing Tier 1 prescriptions and referring patients to participating reference labs. Bonus is based on 50 percent of savings attributable to the metrics outlined at the beginning of the program. Our pilot demonstrated positive results and ideas to improve the program for the broader enhanced market launch in Q1 2014.

### 4. What is UnitedHealthcare’s commitment to payment reform?

Currently, more than **$27 billion, or over 25 percent, of our total 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.

Today, all fully insured and most self-funded customers already participate in value-based payments. To maximize the customer benefits, all customers will participate in value-based contracting arrangements as of January 2015.

### 5. What experience does UnitedHealthcare have with value-based contracting?

We have been using value-based programs for years to support our commercial, Medicare, and Medicaid lines of business. We have deep experience and knowledge of performance-based compensation, including Primary Care Incentives (PCPi); condition-based compensation, including Centers of Excellence, bundled and episodic payments; and value-based compensation, including bonuses based on a share of savings and risk-sharing models for ACOs and PCMHs.
We already pay hundreds of hospitals and physician groups and thousands of individual physicians based on performance-based compensation, with incentive applied to fee schedule increases based on achieving quality and cost-efficiency measures. The more advanced value-based contracting models are designed to reward providers with bonuses for managing total medical cost and quality.

6. Where are your programs located?
We have implemented performance- and value-based programs in all 50 states across our commercial and government program business. Our ACO platform represents over 600 hospitals, over 80,000 physicians and over 1,150 medical groups. We are bringing on substantially more markets and states in the near future, at least 12 per year. The map below shows some of the locations different programs.

7. In addition to modernizing payment models, what is UnitedHealthcare doing to improve the health care system?
We are working to solve the big problems by focusing on these three areas — accountability, health and engagement — because we know how important they are to the health of your employees and your bottom line. Some key areas include promoting evidence-based medicine, reducing system inefficiencies, improving patient safety, leveraging our broad national network to drive affordability in new and existing markets, working collaboratively with government, providers and customers to support health information and better informing and engaging members through transparency and tools.

8. If new payment models emerge, will you end your current medical home programs and ACOs?
No. Our payment models have and will continue to evolve and as we learn more and replicate best practices. We accomplish this through an initiative that is scalable across all of our markets and flexible enough to integrate with provider entities of different capabilities and organizational structures, from small primary care practices to large accountable care organizations.

Benefits to Employers and Members

9. Why are value-based programs important for self-funded customers and their employees?
Increased performance through reduced claim costs is based on alignment of the entire system working toward the best outcomes. The investment our customers make is based on their share of the provider incentive payments and bonus without any allocation for administrative costs, which are assumed by UnitedHealthcare.

- **Solid predictable performance** — UnitedHealthcare targets an overall return on investment (ROI) of 2:1 or greater for value-based programs. Currently, UnitedHealthcare’s ROI for our ACO programs and our Primary Care Incentives exceeds that goal and PCMH has an ROI of 3:1 or greater. Our ROI is for comprehensive care and not for a slice of the services provided.
- **Medical cost savings** — Savings are estimated based on the performance of each provider arrangement.
Customer reports – We provide several types of reports about the value-based programs.
- Customer Expense Reports support the Banking Detail Report, which breaks down PMPM or bonus to attributed members. These reports are produced at the time they are charged.
- Summary Savings Reports show program level performance and bonus dollars for each type of program (e.g., ACO, PCMH, CPCi).
- Savings Detail Report shows the employer share of payment for attributed members during the program year.
- Customer Specific Reports are only available if the customer has at least 5,000 attributed UnitedHealthcare members in a particular program in a market to ensure that the date is credible.

Real-time employer savings – Employers recognize savings through reduced claim costs as they occur throughout the year.

Positive impact to members – The program is seamless to members. Ultimately, the goal is for members to have a simple and personal health care experience.

10. What are the most important network initiatives impacting self-funded customers?
1. Accountable care delivery – management of Accountable Care and PCMH agreements, and ongoing program development to incent providers who are not ready to undertake these deeper initiatives.
2. Reinforce network use and benefit steerage
3. Performance-based contracting – ongoing pursuit of performance-based contract arrangements with both hospitals and physicians that offer incentives for quality and cost-efficient care
4. Narrow or targeted networks and benefit programs that promote the use of UnitedHealth Premium® Designated providers

11. How can employers support this effort?
Employers are important catalysts for driving new payment models, including more complex financial arrangements that allow physicians and hospitals to share in the savings produced by these models so they have incentives to generate savings in the first place. Employers also need to continue exploring value-based benefit designs and deploying new employee incentive programs that reward workers for making wise choices about their health and health care.

12. How do value-based programs affect employees?
There is nothing employees need to do differently. The program should be seamless to them. However, if a patient is actively seeking a participating provider, we can direct the member to an appropriate provider.

Value-based contracts help increase collaboration among providers and hold them more accountable for the care they give. This means a better patient experience and higher-quality health care. Because most value-based contracts ensure that providers meet quality metrics before they share in cost savings, this helps them to encourage patients’ use of preventive screenings and earlier detection of diseases. This increased accountability helps providers support patients taking more responsibility for their health decisions resulting in lower cost of care, improved outcomes, and increased satisfaction with the health care experience.

13. What if an employee does not have a primary care doctor? Can they still be part of these programs?
If a member does not have a primary care provider, a provider may be assigned based on their actual use reflected in our claims data. However, we encourage members to develop a relationship with a primary care physician. This ensures that members have someone responsible for them across the continuum of care.

14. How can you help employees take an active role in their health care?
We are working on simplifying and personalizing the health care experience for all of our members – ensuring that communications are clear and easy to understand, getting them to the right person in the service process who can answer their questions and engage them in their health if they are interested, making sure that our communication channels are based on their preferences, delivering a robust set of consumer tools to help them make better decisions about their health care and much more.
Financial Responsibility for Self-Funded Customers

15. How do self-funded customers pay for these programs?
There is no administrative cost to customers for participation in these programs. 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.

PMPM prospective payments
Any prospective PMPM amounts paid to participating providers to compensate them for the additional services are deducted from the customer’s bank account. A self-funded customer sees these payments reflected in their Banking Report only when the employer has members attributed to a participating primary care provider.

Shared savings bonus
Bonus payments are retrospective payments calculated and paid at the end of the measurement period for the program. Providers earn bonuses based on a share of savings, generally 50 percent, if their performance exceeds the target for the previous year. Once the cost targets are achieved, a quality factor is added. Performance quality influences whether the provider receives the full payout or a reduced percentage of the total payout. While the experience for a specific customer will vary, customers will benefit from overall reduced medical trends and improved quality.

16. Will self-funded customers know where their money is going?
Yes. The value-based customer reports show member-level detail and incentive-type detail (e.g., bonus based on share of savings, primary care incentives) supporting invoices for any PMPM incentive or bonus payments. Banking statements will show summary transaction of total incentive.

PMPM fee incentives are made at the time we make the allocations. Bonuses will be paid out to providers at the end of the measurement period. However, savings occur to employers throughout the year.

17. Can a customer opt out later if they find that the payments increase their claims cost?
No. All customers will participate where they have membership allocated to a participating provider.

Value-based contracts are now the standard way in which we operate our network, and are core to how we do business. We expect these value-based programs to continue to have an overall favorable impact on total costs as providers meet cost and efficiency targets. In addition, some value-based contracts may be multi-year. Because the continuity of providers in our network is important, the continuity of value-based program funding arrangements is also essential for our providers.

18. Does an employer have to do anything to participate?
No. This is the new standard payment model for all UnitedHealthcare clients.

19. How will a self-funded customer know the provider group produced savings?
These value-based programs are the same programs that UnitedHealthcare is employing on its fully insured business, so we are completely aligned with our self-funded customers.

A provider group cannot earn a bonus without generating savings for our customers. In most instances, providers are only eligible to earn a portion of the savings that exceed a specified threshold. When calculating a provider’s share of savings, the level of payment is impacted by the provider’s performance against cost and quality measures.

Our process includes a sophisticated attribution methodology, excluding high-cost claims (e.g., transplants), and incorporating both quality and other metrics into the calculation of the provider’s bonus amount. Our approach ensures that we reward providers for truly providing high-quality, cost-effective care.
We have a scorecard to measure performance toward specific goals. We work with providers as they take on increased accountability for managing the cost and quality of the care provided to their patients. We use a matrix approach to support success including teams from health care economics, network, clinical and more to support and help the providers succeed.

For each measurement period, a new set of criteria and targets are established to support continuous improvement.

Reports provide population market detail for costs and savings for self-funded customers to help them assess their financial impact.

**How Value-Based Programs Work**

**20. What are the different types of value-based payments?**

Value-based payments take the form of primary care incentive payments and bonus payments.

Primary care incentives are PMPM fees for taking on additional services and care support such as expanded hours, increased outreach, support for appointments, and follow up on specialist care. These fees are paid throughout the measurement period, generally the plan year, and are designed to help the providers pay for increased services they provide.

Bonus payments are retrospective payments, generally paid annually, based on exceeding specific medical cost targets and measurable quality factors. In some instances the ACO payment may incorporate both up and downside risk.

As payment programs evolve and provider groups become more sophisticated in data and measurement, UnitedHealthcare will use more bonus arrangements rather than fees. This will occur as providers sign new contracts over the next few years.

**21. What is your participation in the Comprehensive Primary Care Initiative program run by CMS?**

We were selected to participate in the Centers for Medicare & Medicaid Services (CMS) Comprehensive Primary Care Initiative (CPCI) program. The CMS initiative is unique because it is a multi-payer project available in select geographies only and targets advanced provider practices with electronic health records and the ability to provide comprehensive care management activities.

CMS offers bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.

Currently, we participate in three states Ohio, Colorado and New Jersey.

**22. How do I know I saved more money than I am funding?**

Employers will only contribute toward a bonus payment if the provider exceeds the trend target established for them. If the employer and the population involved do not see demonstrable value, then no payment is made. It is clear at the beginning of the year, what criteria are expected.

This trend target is at least 2 points below the medical trend. If the provider does not exceed the goal, then no payment is made.

**23. How do value-based programs work compared to fee-for-service agreements?**

For larger provider arrangements, our programs align providers with total cost of care management. For smaller providers, our programs incent providers on specific targets that will lead to lower overall costs.
The following chart summarizes a recent incentive payment calculation for one of our ACOs. The ACO was able to reduce medical costs by approximately 1 percent for members attributed to the ACO. Because the ACO was able to deliver medical care for less than the PMPM target, we shared 50 percent of savings, below this target. Even with the bonus payment, medical trend was about zero percent, well below the market average. While not all ACOs will perform at this level, we clearly have some opportunity to improve medical costs with these programs.

**Sample ACO Bonus Payment**

24. **Do self-funded customers pay more for these programs?**
No. There are no additional administrative fees to participate in these programs. We treat self-funded customers the same as we treat fully insured customers.

25. **How does attribution work?**
For products requiring a primary care provider (PCP), the member is assigned to the provider they select. For open access products, we assign a member to a PCP once they have a qualifying claim. We continue to monitor claim activity and change the assignment if the member changes primary care physicians or if they notify us of a provider they want to use for primary care. Correct attribution is important for calculating PMPM incentive fees and bonus payments.

26. **Does a self-funded customer pay if they do not have any employees participating in these programs?**
No. If a self-funded customer does not have any members attributed to providers who are participating, they will not be charged for bonus payments.

27. **How are pharmacy carve-outs handled?**
Medical cost target and medical cost performance metrics will be adjusted. In this situation, bonus payments will be for medical-only expenses.

28. **Do programs pay twice for services when there is a care management carve-out?**
No, customers are not paying twice for the same service. These incentive fee payments represent compensation
for a broad range of population health management services and clinical interventions beyond what is traditionally done with care management programs. This payment also covers activities that participating providers engage in to support care management and to improve both member engagement and the overall effectiveness of our care and disease management programs.

29. What happens if medical costs go up rather than down?
We expect these programs will reduce, not increase, overall medical expense trends relative to a fee-for-service reimbursement methodology.

Practices participating in our PCMH demonstrated 2 percent to 5 percent lower medical and pharmaceutical costs compared to control practices. Our ACO programs also show positive results, with a return on investment of greater than 2:1.

Based on these factors, we project that providers will generate savings for attributed members of 1 percent to 2 percent lower than projected costs in their first year of participation. Each year, new targets are set to encourage ongoing savings and improved quality. As new providers are continuously being added, we expect the net customer savings for attributed members to be in the range of 2 percent to 5 percent annually.

– When the costs targets are not achieved, there is no bonus to the provider. The provider only gets a share of the actual savings, generally 50 percent.
– Will medical costs continue to increase over time?

Yes. We expect that they will, but we believe these programs will significantly slow the rate of increase.

30. Are stop-loss premiums potentially impacted?
Stop-loss premiums may be moderately impacted over time by changes in medical cost trend. We do exclude high-cost claims and transplants claims from the bonus payment calculations to mitigate the impact of statistical fluctuation.

Bonus payments reimbursed by self-funded customers will not accumulate to individual or aggregate stop-loss thresholds for self-funded customers with integrated stop loss.

31. What are the benefits to providers that participate in value-based programs?
Our partners are accountable for managing patients across the care continuum – these are not simply pay-for-performance programs. Providers in these programs experience increased market share and financial incentives to control overall cost.

To help providers reach success, UnitedHealthcare provides:
• Infrastructure support for delivering evidence-based high quality care
• Practice pattern transformation to improve accountability readiness
• Comprehensive performance measurement and reporting
• Member empowerment strategies
• Clinical consultation, and
• A robust suite of tools offered by Optum

UnitedHealthcare works with providers to reduce practice variation, decrease duplications in care and promote the proper setting for care, thus reaching quality objectives while reducing overall costs. On an ongoing basis UnitedHealthcare provides physicians with detailed health intelligence and updated reports to enable physicians to collaborate across specialties and to help them make informed medical care decisions based on a complete picture of each patient's situation.
Payment Processes

32. How are value-based contracts set up?
Value-based contracts establish that we will pay for value. There are a few ways the contracts are set up.

1. **Meeting performance and quality metrics.** In a performance- or value-based model, some or all of the provider’s total potential payment is tied to the provider’s performance on cost-efficiency and quality performance measures. The bonus is not paid unless the provider meets those targets.

2. **Adopting technology and process improvement.** Fees are sometimes paid to providers who engage in practice transformation. Payments are made to providers who adopt technology, institute care management capabilities to provide additional services to members, and improve access to primary care. Our PCMH model brings this to life. We have PCMH models in several states covering over 300,000 individuals.

3. **Advancing population health.** Accountable Care Organizations are geared toward advancing population health and using population-based metrics to drive greater value. When successful, providers in ACOs receive a bonus based on cost and quality measures. Compensation is calculated by meeting a combination of specific cost and quality targets.

Most importantly, we meet providers where they are today, not where we expect them to be. We seek to understand where and how they can assume more financial risk both on a clinical and financial basis.

33. How do you calculate provider medical cost targets?
UnitedHealthcare begins with a baseline of historical cost and then trends it forward for the applicable measurement period using an actuarial cost projection. This trend factor is calculated using available information on projected rate changes and market performance. The trend implicit in these targets is generally lower than the expected trends in the market. The resulting medical cost target is designed to be reasonably achievable for providers while creating value for our customers through savings against projected trends.

Providers earn a portion of any savings, up to a maximum level, generally 50 percent of the amount saved adjust for quality.

34. How are cost savings from value-based contracting shared with self-funded employer groups?
Self-funded employers will see reductions in health care claims costs in real time as providers begin to achieve cost and efficiency targets.

When the provider exceeds the performance target, we pay bonuses to providers based on improvement and on attainment of medical cost-savings targets. For self-funded customers, bonus payments are paid from a self-funded customer’s bank account and a report is produced. Although bonuses and PMPM incentive fees are paid in addition to fee-for-service health care claims, these programs continue to have an overall favorable effect on total costs, generally 2:1 or greater.
Employer Reporting and Support

35. What kind of financial reporting will be available for value-based contracting payments?
Employers will receive reports for both payments and savings as a result of value-based programs. For additional payments not included in traditional claims payments, employer groups will receive regular reports on payments made to providers.

36. Can you create a report that shows the impact specifically to my employees?
Each program is evaluated as part of our reporting and settlement processes with the provider. From this information, estimated PMPM savings and payments are calculated. This information will give the customer information on estimated program savings, payments, and ROI for each program and in total.

37. How can your account teams help?
Our account team will assist the self-funded customer in budgeting for potential provider bonuses based on aggressive medical cost targets and anticipated performance relative to targets, creating budget predictability for our customers.

UnitedHealthcare pays providers any earned bonus at the end of the measurement period or plan year. Customers will see provider payments on their Banking Detail Report as a single line item based on payment model (e.g., ACO, PCMH). The reporting identifies each provider arrangement, the number of members attributed to each arrangement, and the incentive paid for these members.

---

### Sample Summary Report for ABC Corporation

<table>
<thead>
<tr>
<th>Program</th>
<th>Attributed Member Months</th>
<th>PMPM</th>
<th>Account Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Mary’s ACO</td>
<td>600</td>
<td>6.21</td>
<td>3,726.00</td>
</tr>
<tr>
<td>NE PCMH</td>
<td>120</td>
<td>5.11</td>
<td>613.20</td>
</tr>
<tr>
<td>Tampa PCPi</td>
<td>12</td>
<td>2.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Houston PCPi</td>
<td>38</td>
<td>4.00</td>
<td>152.00</td>
</tr>
<tr>
<td>Memorial ACO</td>
<td>300</td>
<td>18.00</td>
<td>5,400.00</td>
</tr>
<tr>
<td>SE PCMH</td>
<td>1,000</td>
<td>6.45</td>
<td>6,450.00</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,430</td>
<td>29,965.20</td>
<td>13,008.00</td>
</tr>
</tbody>
</table>

Average Members: 1,143
Customer Members: 51,000
Participation Rate: 2.2%
ROI: 2.30
38. Can you project cost savings for a specific employer group? Can the savings be guaranteed?

Your account team can provide a projected financial impact report for a group. Please discuss savings with your account executive.

39. What audit rights will a customer have relative to these payments?

The customer would have the same audit rights as they have outlined in their Administrative Service Agreement relative to payments being made as a result of value-based contracting.

40. Is there an ROI and cost analysis for each customer?

Our customer report, as illustrated above, provides a summary of PMPM and total savings, payments for each program, and a summary of customer members attributed to each program. This allows for the calculation of an estimated ROI.

41. What criteria will be used to improve or maintain the quality of care delivered by participating network providers?

Quality has always been a central tenet to UnitedHealthcare’s contracting strategies. From our Centers of Excellence programs, first report cards to the UnitedHealthcare Premium Designation program, our payment programs have evolved to one that pays for performance. We continually design and refine our robust approach to ensuring that quality care is rewarded.

For performance-based programs, key performance metrics include: HEDIS Quality Measures, as well as hospital readmissions, hospital-acquired conditions, potentially avoidable hospitalization rates, non-network provider use, intermediate outcomes (HAC/HAI), optimal Tier 1 prescription drug use, efficient lab use, and appropriate emergency room use.
Shared savings payments require providers to meet a quality performance target based on evidence-based medicine and nationally endorsed clinical quality measures. Once the quality criteria are met, the bonus the provider receives will vary depending on performance against these clinical quality measures and patient engagement. A larger bonus may be earned by the provider based on exceeding key metrics.

Appendix

42. Do you have examples of quality program performance for ACOs?
In addition to providing an ROI greater than 2:1 on most programs, our Accountable Care Programs demonstrate improved health outcomes including:

- 4% – 5% reduction in medical cost reduction
- 17% reduction in inpatient days per 1,000
- 16% reduction in emergency room visits per 1,000
- 13% reduction in inpatient admissions per 1,000

Utilization dropped in services such as non-generic prescriptions and non-network laboratory use. We frequently saw reduced emergency room visits and inpatient utilization.

In addition, programs focused on Medicare Advantage members achieved at least a 4 Star HEDIS level on screenings for diabetes, cardiovascular care, colorectal cancer and rheumatoid arthritis.

43. What requirements do you use to select accountable care program partnerships?
This list reflects the major criteria we use to determine qualified accountable care programs, including ACOs:

- Physician leadership with clear governance
- Robust end-to-end clinical programs
- Ability to coordinate care across all care settings
- Effective Health Information Technology
- Disciplined financial accounting and systems
- Mechanisms to appropriately distribute funds
- Ability to manage and willingness to accept risk
- Tools for patient activation and engagement

44. How do you measure the success of a value-based program?
Quality and efficiency measures drive behavior changes when incentives focus not only on traditional quality measures, but also emphasize clinical outcomes and appropriate utilization of services. Achieving quality and efficiency means improved quality and reduced medical cost. Some of the metrics we review include:

- HEDIS quality measures
- Quality defects
- Intermediate outcomes – HAC/HAI
- Optimal Tier 1 prescription drugs
- Efficient lab use
- Appropriate emergency and specialist use
- Readmission rates/average lengths of stay
- Potentially avoidable hospitalizations
- Total cost of care targets

45. How do you measure the performance of your value-based contracting programs?
We measure performance based on the type of contract.

Hospital performance-based contracts may include measures such as:

- All-Cause readmission rate
- Risk-adjusted average length of stay
- Hospital-Acquired Conditions/Infections
- Emergency to observation/inpatient escalation rate
• Radiology service utilization
• National Patient Safety and National Quality Improvement goals
• Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS)
• Mortality rate for three conditions
• Present on admission Indicators
• Admission notifications within 24 hours
• Hospital-Based network percentage

**Physician performance-based contracts may include measures such as:**

- Inpatient admits/1,000
- Inpatient days/1,000
- ER visits/1,000
- All-cause readmission rate
- Risk-adjusted total cost of care
- Risk-adjusted average length of stay
- Tier 1 prescription percentage
- Lab cost per accession
- Non-network lab provider referrals percentage
- Non-network ambulatory surgery utilization percentage
- Certain HEDIS measures (diabetes, cholesterol management, preventive screening, pediatric testing/treatment, patient safety)
- Quality metrics may include the percentage of eligible patients who received breast cancer screenings and the percentage of eligible patients who received cervical cancer screenings

**Our primary care physician incentive program may include measures such as:**

- Comprehensive diabetes care – HbA1c testing
- Comprehensive diabetes care – LDL-C screening
- Breast cancer screening
- Cholesterol management for patients with cardiovascular conditions LDL–C screening
- Cervical cancer screening
- Appropriate treatment for children with upper respiratory infection
- Appropriate testing for children with pharyngitis
- Annual monitoring for patients on persistent medication