UnitedHealth Premium program

Version 16 methodology

Program introduction

The **UnitedHealth Premium® program** designates physicians based on safe, timely, effective and efficient quality care criteria. This designation may be used by members to help make more informed choices for their medical care and by physicians to make referrals. Physicians may also use evaluation details to support their efforts to provide quality 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 select Premium Care Physicians.

The UnitedHealth Premium program evaluates physicians annually using updated methodologies and data. Premium Care Physicians are those who:

- Meet safe, timely, effective and efficient quality care criteria; or
- Meet safe, timely and effective quality care criteria but do not have enough data to evaluate efficient care quality criteria

Premium Care Physicians are featured in our medical care directories with the following icon and description. All other physicians have no designation display.

Premium Care Physician ❤❤

This physician meets the UnitedHealth Premium quality care criteria which includes safe, timely, effective and efficient care.

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

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 1 of the **credentialed specialties** evaluated by the program
- Practice in a **state and county** included in the program

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Methodology overview

Physicians are first evaluated for safe, timely and effective care using national standardized measures. They are then evaluated for efficient care using 2 measures: patient total cost and/or patient episode cost. The physician's Premium specialty determines which efficient care measure is applied.

Attribution methods based on health plan claims data determine which physicians are responsible for patient care. When a sufficient number of measures, patients or episodes are attributed, the Premium program compares the physician's performance to a target benchmark.

The physician meets the Premium program designation criteria when:

- The physician's safe, timely and effective care performance is not statistically lower than the target benchmark; and
- The physician's efficient care performance is not statistically higher than the target benchmark; or
- The physician does not have enough data to evaluate efficient care performance

Physicians who do not have a sufficient number of measures, patients or episodes attributed for evaluation may meet the Premium program 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 as 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.

Safe, timely and effective quality care

Methodology

The Premium program first uses clinical quality measures from the National Quality Forum (NQF) – endorsed measures when available for the specialties being evaluated.

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 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 safe, timely and effective quality care 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 evaluation for physicians who have achieved recognition in 1 or more of these programs applicable to their Premium specialty.

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Data used

The Premium program uses health plan claims data based on services provided for patients enrolled in UnitedHealthcare commercial fee-for-service, UnitedHealthcare® Medicare Advantage and UnitedHealthcare Community Plan health plans (excluding members enrolled in a long-term care plan). We exclude patients who are dual-eligible for Medicare and Medicaid. The evaluation uses claims submitted and processed for dates of service between Jan. 1, 2020, and Feb. 28, 2023. Claims for patients who had benefits administered under a coordination of benefits process, had been diagnosed with COVID-19 and/or were receiving hospice care are not used in the evaluation.

Attribution methods

Attribution methods based on health plan claims data determine which physicians are responsible for patient care. 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 measure. Multiple physicians may be attributed to a single measure when appropriate.

Performance evaluation

When there are a sufficient number of safe, timely and effective quality care measures attributed, the Premium program compares the physician's performance to a target benchmark. The evaluation requires a minimum of 20 attributed measures among at least 5 patients across all patient populations, conditions and procedures. NCQA recognition programs, if applicable, satisfy the measure and patient minimum requirements. The physician's performance is the sum of all attributed measures where the patient meets the 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.

Once the national compliance (or expected) rate for each measure is calculated, that rate is then 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 compare the physician's performance to the target benchmark with 98% confidence. The physician meets the Premium program safe, timely and effective quality care criteria when the physician's performance is not statistically lower than the target benchmark.

Physicians who are attributed surgical complications and redo measures are evaluated in 2 steps:

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

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Efficient quality care

Methodology

There are 2 measures applied for the evaluation of efficient care:

1. Patient total cost
2. Patient episode cost

The Premium program uses the efficient quality care measure 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 patient episode cost.

We include conditions and procedures that can be evaluated using health plan claims data, that are useful in determining differences in physician performance and are relevant to the specialties evaluated.

Data used

The Premium program uses actual allowed costs from health plan claims data for patients enrolled in the UnitedHealthcare commercial fee-for-service, UnitedHealthcare® Medicare Advantage and UnitedHealthcare Community plans (excluding members enrolled in a long-term care plan). We exclude patients who are dual eligible for Medicare and Medicaid. Claims for patients who had benefits administered under a coordination of benefits process, had been diagnosed with COVID-19 and/or were receiving hospice care are not used in the evaluation.

Actual allowed costs are the amounts paid by the health plan and the patient to the health care professional. The patient total cost measure uses claims submitted and processed for 2 distinct calendar years: 2021 and 2022. The patient episode cost measure uses claims submitted and processed for complete episodes that start in 2021 or 2022. Only the most recent year is used for evaluation when there are a sufficient number of patients or episodes attributed. When there are not a sufficient number of patients or episodes attributed for the most recent year alone, both years are used. The Premium program excludes patient and episode low-cost outliers from the efficient care evaluation. **High-cost outliers** are addressed using percentile ranks to evaluate efficient care.

Attribution methods

Attribution methods based on health plan claims data determine which physicians are responsible for patient care. For **patient total cost**, 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. When appropriate, physicians in different specialties may be attributed the same patient for the same calendar year.

For **patient episode cost,** episodes are attributed to the 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

When there are a sufficient number of patients or episodes attributed, the Premium program compares the physician's performance to a target benchmark. The efficient care evaluation requires a minimum of 10 attributed patients for patient total cost, or 10 attributed episodes for patient episode cost.

For **patient total cost,** the physician's efficient care performance is the sum of the 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 program specialty. Relevant services include those provided by other health care 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,** the physician's efficient care 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 health care professionals as well as facility, pharmacy and ancillary services (e.g., diagnostic tests).

To 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)
- Care setting (inpatient or outpatient – 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 2 physicians for each treatment set.

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. 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.

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Performance evaluation (cont.)

Within each combined weighted treatment set, the cost percentiles are ordered from low to high and assigned a rank from 1 (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. This is the physician's efficient quality care performance. 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 compare the physician's performance to the target benchmark with 90% confidence. The physician meets the Premium program efficient quality care criteria when the physician's performance is not statistically higher 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 to G, with A being the most cost efficient and G being the least cost efficient.

Group evaluation

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 ID number(s) (TINs) that operate as a single health care organization. A group can be composed of a single TIN or a multiple-TIN health system.

Physicians who do not have a sufficient number of attributed measures for safe, timely and effective care may be designated Premium Care based on an affiliated medical group evaluation result for their Premium specialty within the same geographic area. Physicians with a sufficient number of attributed patients or episodes for efficient care who do not meet the Premium program criteria are not eligible for this group benefit.

Physicians who do not have a sufficient number of attributed patients and episodes for efficient care may be assigned a cost efficiency rating based on an affiliated medical group evaluation result for their Premium specialty within the same geographic area.

Medical group evaluation results are determined using a similar methodology as applied to physicians. For medical groups, the methodologies are applied to the aggregate set of quality care 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.

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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 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.

The fact that a physician doesn't have a Premium Care Physician designation doesn't mean the physician doesn't 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.

There are various reasons why a physician may not be designated as a Premium Care Physician. A physician may not receive a Premium Care designation because that physician has not been evaluated for a Premium Care designation. This occurs 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 also occurs 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 document is subject to change.

Learn more

For more information, go to **UnitedHealthPremium.uhc.com.** You can also reach us at:

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