

## **Appendix A: UnitedHealthcare's (UHC) Premium Designation Program (PDP) Measured Against AMA's Principles for Pay for Performance (PFP) Programs**

The following chart contains an AMA staff description and analysis of UHC's "Premium Designation" program. In this chart, the "Premium Designation" program is broken horizontally into five sections that correspond to the AMA's five Principles for Pay-for-Performance Programs. There are also four vertical columns, the first of which contains each of the five AMA Principles. The second column contains descriptions of aspects of the program, as derived from the UHC Web site or other UHC generated documents, that pertain to each particular AMA Principle. The third column contains information about the implementation of the "Premium Designation" program that AMA derived from sources other than UHC including discussions with participating physicians and practice managers. The last column is an AMA analysis of the program when compared to the AMA Principles.

It is apparent that the "Premium Designation" program is not a true pay-for-performance program, but rather a physician profiling/reporting program, as evidenced by the absence of physician incentives as noted opposite the fifth AMA Principle. However, the "Premium Designation" program becomes part of a true pay-for-performance program when it is linked to UHC's new "Practice Rewards" program. The "Practice Rewards" program was piloted in Chicago and Cleveland and is being rolled out nationwide beginning third quarter 2007. UHC insists that the "Practice Rewards" program is a separate program from the "Premium Designation" program, but the "Premium Designation" program is used to qualify physicians for participation in the "Practice Rewards" program. AMA's limited knowledge of the "Practice Rewards" program is based on a UHC document that was provided by a participating physician from Milwaukee where the program is just now being implemented and from a somewhat obscure Web site ([www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)) that UHC maintains in addition to its primary corporate site. A summary of the "Practice Rewards" program, as well as additional AMA comments about this incentive program, are contained in Attachment 1 to the "Premium Designation" program chart.

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<p><i>1. Ensure quality of care</i></p> <p>Fair and ethical PFP programs are committed to improved patient care as their most important mission.</p>	<p>UHC’s PDP is a two-stage process. Physicians who meet or exceed quality criteria are designated by a quality star and proceed to an efficiency of care analysis.</p> <p>In the second stage, episodes and procedures are analyzed for efficiency of care. Physicians who meet or exceed both the quality and efficiency criteria are given two stars. Approximately 38% of proceduralists and 48% of the primary care specialists receive two stars.</p> <p>Physicians who perform surgical procedures are also reviewed for treatment complication rates.</p>	<p>Anecdotal reports indicate that most physicians meet the quality criteria; however, fewer physicians also meet the efficiency criteria. UHC reports that of the physicians for whom it has enough data to assign a rating, 81% pass the quality screen and of those physicians, 77% pass the efficiency screen.</p> <p>UHC does try to risk adjust for physicians’ case-mix and patient severity of illness and co-morbidities; however, the accuracy of these processes is questionable.</p>	<p>UHC claims that the PDP is designed to measure physician quality and encourage physician improvement. PDP requires physicians to pass the quality screen first before they are put through the efficiency (cost-of-care) screen.</p> <p>The efficiency ratings are the only criteria used to exclude physicians from receiving the second star. The program cannot be considered quality based and primarily committed to improving quality of care because of this efficiency rating component; instead, it ultimately becomes more of a “cost” based program.</p> <p>The effectiveness of measuring quality of care using this parameter has not been scientifically verified especially without a sophisticated mechanism to adjust for patient risk factors and patient</p>

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<p><i>Ensure quality of care (cont.)</i></p> <p>Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs.</p> <p>Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.</p>	<p>Utilizing science-based, industry-standard criteria, along with guidance from medical specialty societies and expert physicians, the PDP evaluates care delivery by physicians across 19 medical specialties including several internal medicine disciplines.</p> <p>Primary care physicians and endocrinologists with recognition through the NCQA Diabetes Recognition program and primary care physicians with recognition through the NCQA Heart/Stroke program will meet the PDP quality criteria.</p>	<p>Some of the measures that are used in PDP were evidence-based measures created by The Consortium and adopted by AQA; however, the majority of the measures in PDP are based on HEDIS measures, some of which may not be evidence-based.</p> <p>Physicians, who first pass the PDP quality screen, but perform every procedure, order every test and prescribe every medication that relevant clinical guidelines indicate, may have high short-term</p>	<p>compliance with physician recommended regimens.</p> <p>To the extent that measures are not truly evidence-based, resulting physician ratings may not judge true quality of care. Expert physicians across numerous specialties consulted on this program, but few medical societies and their practicing physicians appear to have been involved in the overall design of this program.</p> <p>These NCQA programs use chart data provided by physicians to evaluate quality and may be successful in identifying physicians who are effective in treating these conditions.</p> <p>These physicians would receive designation for quality but may fail to pass the PDP efficiency screen because of these short-term costs.</p>

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<i>Ensure quality of care (cont.)</i>		costs.  PDP does not make allowances for individual patient care regimens based on physicians’ sound clinical judgment.	Physicians could be penalized for providing appropriate, quality care that differs from recommended quality protocols.
<p><b><i>2. Foster the patient/physician relationship</i></b></p> <p>Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.</p>	UHC identifies all designated PDP physicians in online and printed physician directories.	<p>UHC does not provide differing patient copays for zero, one and two star physicians, but this feature (tiering) does exist in a few small pilot programs with individual employers.</p> <p>The risk adjustment methodology used in the program controls for a limited number of factors (i.e., age, sex and primary diagnosis). In addition, UHC uses ERG’s and APR-DRGs that supposedly perform further risk adjustment.</p>	<p>Patients can review these directories and be led to believe that they should only seek care from two star physicians, potentially severing long-term patient/physician relationships and threatening continuity and quality of care. This problem will be magnified if the tiering in the pilots is widely adopted.</p> <p>Risk adjustment should control for differences among patients in severity, comorbidities and demographics. Demographic differences often correlate to patient compliance with therapeutic regimens. If indicators are not properly adjusted to control for such differences, the</p>

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<p><i>Foster the patient/physician relationship (cont.)</i></p>		<p>Only a limited number of physicians attain PDP status.</p>	<p>PDP program can create perverse incentives for physicians to stop treating certain types of patients. UHC uses these risk adjustment methodologies in an attempt to mitigate these factors but expert opinions are divided on their effectiveness.</p> <p>Patient access to UHC’s two star physicians may be limited in rural areas and for certain specialties.</p>
<p><b>3. Offer voluntary physician participation</b></p> <p>Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices.</p>	<p>Eligible physicians are automatically assessed for designation consideration and will receive written communication from UHC as to the results.</p>	<p>Physicians can request that no quality and efficiency designations be assigned to their names in the directories.</p>	<p>Participation is mandatory for all UHC contracted physicians in specialties covered by the program.</p> <p>Although these physicians are still rated by UHC, patients cannot access their results and are free to draw their own conclusions about such physicians</p>

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<p><i>Offer voluntary physician participation (cont.)</i></p> <p>These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.</p>		<p>UHC is now sending directories of two star physicians in certain specialties to primary care physicians encouraging them to refer to those two star physicians.</p> <p>Physicians in some specialties are excluded from the program because they do not treat enough patients with conditions that are being measured while UHC also lacks enough data to rate a great many other physicians.</p>	<p>This could seriously impact the financial viability of practices that receive fewer physician referrals as well as damage some patient/physician relationships.</p> <p>Patients may consider changing physicians who lack stars in the UHC directory although their decision to change physicians may not relate in any way to physician competency or cost of care.</p>
<p><i>4. Use accurate data and fair reporting</i></p> <p>Fair and ethical PFP programs use accurate data and scientifically valid analytical methods.</p>	<p>PDP evaluates claims data for your practice using UHC enrollee claims. Using your actual data, statistical confidence intervals are constructed based on your sample size to determine, with 95% confidence, the probable range of your quality and/or efficiency scores.</p>	<p>PDP also employs a number of methodologies to its handling of the claims data that are designed to moderate the results to be more inclusive in designating physicians for quality and efficiency (i.e., truncating the actual costs of outlier cases so they do not inordinately affect efficiency ratings).</p>	<p>Claims data do not capture all information associated with a patient encounter; therefore, errors are inevitable. The claim of 95% confidence in accuracy of the ratings seems highly questionable. William Thomas’ modeling of cost efficiency ratings would suggest that confidence in these ratings is likely to be considerably lower when UHC uses as few as ten to twenty episodes to determine so-called efficiency.</p>

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<p><i>Use accurate data and fair reporting (cont.)</i></p>	<p>PDP Rates physicians as follows:            Quality and Efficiency - <i>2 Stars</i>            Quality only – <i>1 Star</i>            No Designation – <i>No Stars</i>            Lack of data – <i>Insufficient Data</i></p>	<p>Some physicians have reported that data used for designation ratings have been found to be up to two to three years old. Others reported that the data on their practice was just plain wrong such as referring to non-patients or procedures not performed.</p> <p>Sample sizes of as small as ten (primary care specialists) to twenty (procedural specialists) can be used to deny physicians’ quality and efficiency designations. PDP will use sample sizes as small as five to give physicians a quality or efficiency designation. Therefore, physicians with a small sample size, such as eight cases, can receive one or two stars, but they will not be designated as receiving <i>No Stars</i>. Instead, they will be listed in the directory as having <i>Insufficient Data</i>.</p>	<p>Old data does not reflect the current quality or efficiency of a physician practice. Bad data can only generate incorrect results.</p> <p>One unusual result can drastically affect a rating based on very small sample sizes of ten to twenty. According to Thomas, the potential accuracy of efficiency rating improves dramatically when higher numbers of episodes are used as the basis for a rating. PDP’s use of a sample size as small as five to give physicians a quality or efficiency designation results in greater number of physicians receiving stars. Using such small sample sizes will also increase the likelihood that the number of stars that physicians receive will change from year to year.</p>

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<p><i>Use accurate data and fair reporting (cont.)</i></p> <p>Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.</p>	<p>Requests for reconsideration of ratings will be considered when a physician can demonstrate that UHC claims data do not accurately represent care provided to the enrollee or if the physician can demonstrate claims data inconsistency that impact the designation analysis.</p>	<p>UHC provides physicians with a report that indicates the number of cases in the profile, individual physician rankings and market average comparison rankings, and individual clinical and cost scores. A Web site is available to physicians to obtain information on how their individual scores were compiled.</p> <p>Cost-of-care data is often not provided without repeated requests from physicians</p> <p>Many aspects of the implementation of PDP are still based on “black box” methodologies.</p>	<p>Only minimal, non-actionable data is provided to physicians without accessing the UHC Web site. Physician reports have indicated multiple problems accessing and understanding the information on the Web site. Once the information is accessed, physicians report numerous data errors.</p> <p>Physicians report difficulty in getting UHC to comply with requests for reviews.</p> <p>UHC has failed to reveal adequate information on its profiling and ranking methodologies that give physicians the ability to easily review and comment on the data and analysis used to construct their ratings.</p>

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<i>Use accurate data and fair reporting (cont.)</i>		UHC often gives insufficient warning to physicians that they have been profiled and insufficient explanations on how their specific profile was analyzed and compiled.	Physicians must be allowed adequate time, and provided with adequate tools, to understand and review all of their data and the analysis that is used in the profiling and ranking processes prior to any public reporting or programmatic use.
<p><b>5. Provide fair and equitable program incentives</b></p> <p>Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.</p>	<p>Eligible designated physicians performing at the highest levels may participate in “Practice Rewards,” a UHC program that may provide physicians with enhanced reimbursement as part of the PDP.</p>		<p>There are no direct physician bonuses for participants in PDP. See Attachment 1 (follows immediately) for details on the “Practice Rewards” program, which may provide physicians with fee schedule updates. Many aspects of “Practice Rewards” are in conflict with aspects of this fifth AMA Principle.</p>

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### **Attachment 1: UnitedHealthcare's Practice Rewards Program**

**Program Qualifications:** The Practice Rewards Program (PRP) can provide financial incentives to qualifying physicians and physician groups who have both a standard contract and fee schedule with UnitedHealthcare. Only solo practitioners who receive two stars or physician groups with at least one member of the group receiving two stars under the Premium Designation Program (PDP) are eligible for the PRP.

**AMA Comments:** UHC insists that PRP is a distinct program from PDP, but since the PDP is used to qualify physicians and groups for participation in PRP, it is logical to view these programs as two distinct parts of a PFP program. We believe that less than half of the UHC solo practice members qualify for the PRP program by obtaining two stars under PDP. Group eligibility for PRP may be greater since only one member of a physician group has to be designated with two stars. Solo practitioners/groups that are able to negotiate special terms, conditions or fees with UHC will also be excluded from participating in the PRP.

**Program Ratings:** Solo physicians/groups who are eligible to receive incentives under this program are rated using the same type of data and analytic systems used in the PDP. Solo physicians/groups are ranked in deciles for quality, efficiency (cost of care) and administrative practices (IT systems, advanced processes, interconnectivity, etc.). These rankings are weighted at 51% for quality, 30% for efficiency and 19% for administrative practices to determine an overall decile ranking.

**AMA Comments:** It is our understanding that the same data and type of systematic analysis of the data are being used in both the PDP and PRP programs. The only differences are the additional consideration of administrative practices in the PRP and the weighting and rating criteria that are being used to confer stars for the PDP and financial updates for the PRP. Therefore, the same data and analytic system concerns noted for the PDP also apply to the PRP. Because the PRP bases its ratings on 51% quality scores, UHC can conclude that this is a quality-based program; however, many physicians would dispute this notion. Using administrative practices, which includes the use of IT systems, as 19% of the physician rating, may be viewed as conforming somewhat to the AMA Guideline that supports payments to physicians for IT system development. Group practices are rated as a group, which is highly preferable to individual ratings.

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**Program Incentives:** Solo physicians/groups receiving an overall rating of 80% or more and not ranked lower than 50% in any single category (Quality, Efficiency or Administrative Practices) are eligible for a five percent increase for many services covered by their standard fee schedule. In 2008, solo physicians/groups that are not in the 80<sup>th</sup> decile or higher, but improve their ranking by two deciles or more to at least the 60<sup>th</sup> decile, are eligible for a three percent increase. These fee schedule increases apply to every physician practicing within a qualifying physician group.

**AMA Comments:** The five and three percent fee updates appear to be “new” money in conformity with AMA Principle Five, but the limited number of physicians that will likely qualify (only solo physicians/groups in the 80<sup>th</sup> decile and above from among those that even qualify for participation in the PRP) should limit the number of physicians receiving the fee update. AMA remains a strong advocate that, in order to improve the entire healthcare system, all physician participants in PFP programs should be compensated for their programmatic involvement in improving their quality of care. So-called tournament models such as this, that rate physician vs. physician, are counterproductive to this concept. It is encouraging to see that PRP will offer the three percent fee update for improvement; however, only those in the 60<sup>th</sup> decile and above will be eligible. This program is not designed to “raise all boats.” Finally, as one group practice administrator told a UHC representative at a recent meeting, “So if we do all this work to demonstrate improved quality and efficiency in our practice we may qualify for a five percent update – Right? That will still make UHC the lowest private payer to our practice.”