Healthcare Economics Professionals Council

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Attribution Models Panel

February 18, 2015

Susan E. Pantely, Principal & Consulting Actuary, Milliman
Molly McCarthy, Associate Vice President of Provider Network Performance, Priority Health
Todd Osbeck, Director of Provider Improvement intelligence, Priority Health

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Agenda

- Introductions
- Susan E. Pantely, Principal & Consulting Actuary, Milliman
- Molly McCarthy, Associate Vice President of Provider Network Performance, Priority Health &Todd Osbeck, Director of Provider Improvement intelligence, Priority Health
- Open Discussion

Save the Date

Tuesday, June 23rd
HFMA Annual National Institute (ANI)
Orlando, FL

RSVP with Celina Kurani at ckurani@hfma.org

Successful Matchmaking: Patient Attribution

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February 18, 2014

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Milliman

Whose Patient is It? And Why Do We Care?

- Goal is to have credible, measurable results
  - Beneficial to both finance and providers
- Trade-offs between methods
- Adaptable to industry trends such as e-mail visits, telehealth
- Patient, provider, and finance/actuarial should converge to same answer

Three Basic Methods

- Patient Choice
  - Oldest, Simplest Method
  - May be validated with data
  - Hard to enforce => low cost members skewed to not choosing
  - High attribution
- Geographic
  - Narrow-network
  - Use zip or county of residence
- Visit Based
  - Algorithm-based

Visit Based

- *Typically has a hierarchy of criteria for assigning members, with algorithms and tie breakers.*

Example:

1. PCP used during a recent time period, maybe for a defined subset of E&M codes

2. If no PCP, go next to medical specialists used (e.g., cardiologist, GI, oncologist, …)

3. If still no assignment, go to surgical specialist used - may only account for 2-3% of population

Balance are not attributed – may be 25% in many populations.

If you only use the PCP criteria, you may end up with 35% or so unattributed.

Visit Based

- Challenges
  - Administratively complex
  - Data Quality
    - *Health systems use the Tax ID # to identify providers, but those #s might change if the provider is acquired by or merged into another entity.*

- Advantages
  - No member selection
  - Algorithm-based
  - Conceptually simple

Visit Based: Retrospective vs. Prospective

- *Prospective approach: Run the attribution at the beginning of the measuring period, then typically add no new members. The list of attributed members can be given to the Health System at the BOY. Some members will drop off during the year, but providers know who they are managing.*
- *Retrospective approach: May start with the same attribution run at the BOY as does the Prospective approach. And there may be subsequent attributions done each quarter. But the only attribution that really counts for the contract measurement period is the one done 4-5 months after the end of the period. That may create challenges for the providers.*

Tie-Breakers and Exclusions

- Tie-Breakers
  - Greatest Number of Visits
  - RVUs
  - Most Recent Visit
  - Highest Allowed Dollars

- Exclusions
  - ESRD
  - Transplant
  - Members with annual claims over $500K

Churn Rates and Trends

- Churn rates
  - 40% - 60% annual re-attribute (members assigned to same provider)

- Trends
  - Attributed population have higher costs
  - No significant variation in risk-adjusted cost trends between attributed and non-attributed members

Provider Issues

- For providers paid on PMPM basis, may prefer consistency in payment over accuracy of assignment
- Should providers be allowed to “de-select” members for non-adherence, etc.

Next Generation

- Connect patient to the right organization / people
- Ultimate goals
  - –Connect member to the individual most likely to create improvement (physician, nurse, behavioral change, or “someone like me”)
  - –Give a single strong individual the responsibility and authority for management (including delegating to others for complex cases)
- These are often two different people

Next generation may also evolve to include high risk and/or emergency patients (now “out-of-network”)

Best Practices:
Method are still evolving but some lessons learned

- More is not necessarily better
- Plurality – Better at capturing high cost members
- Visits/services preferred (commercial) as dollars can skew results
- IP, ER, urgent care settings do not reflect patient choice

Milliman

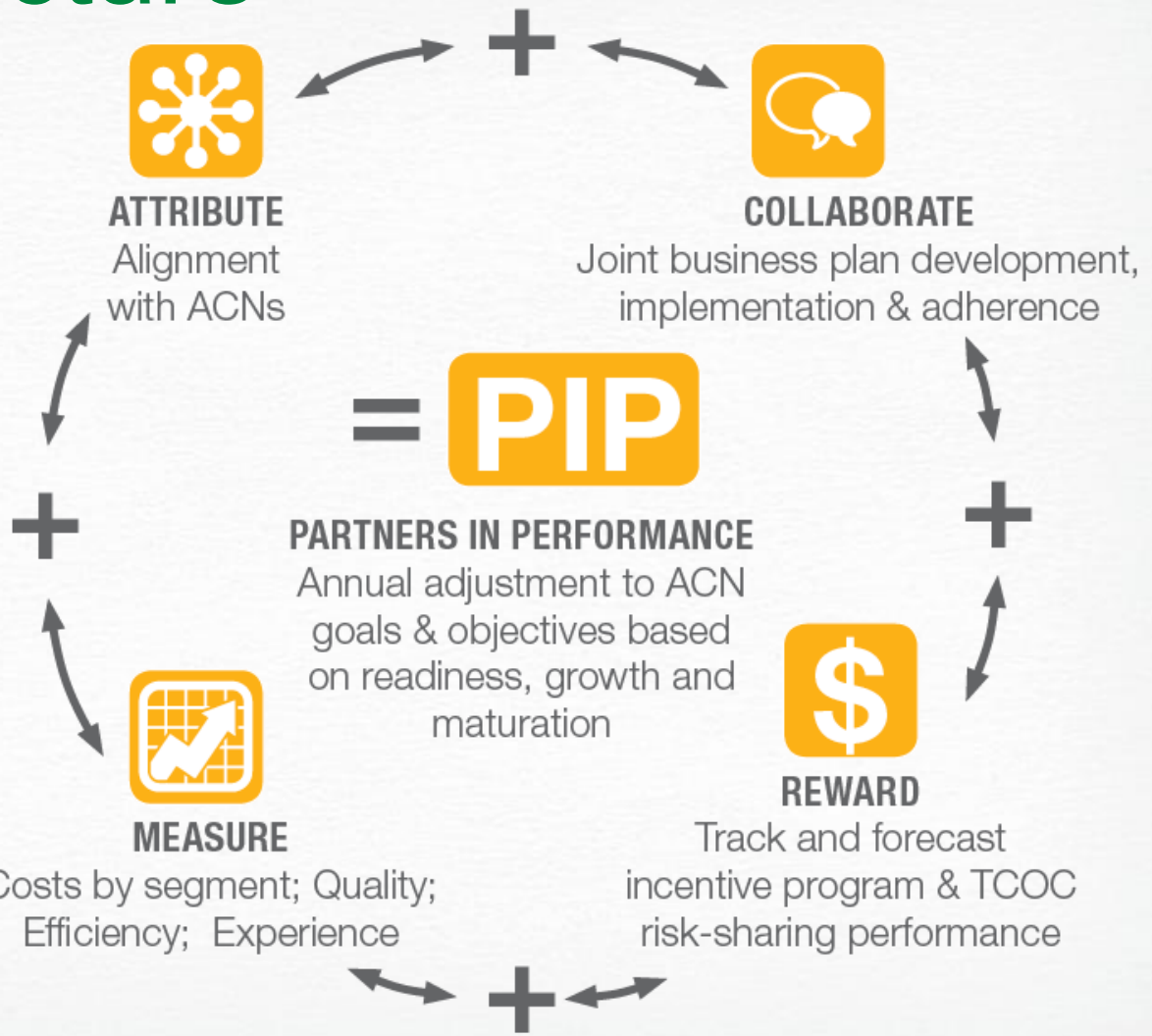
The role of attribution

Molly McCarthy, Associate Vice President
Provider Network Performance

Todd Osbeck, Director
Provider Improvement Intelligence

PriorityHealth

The big picture



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Our approach

Members

PCP
(Practice)

ACN
(Multiple practices in one network)

Business category percent of members assigned/attributed

HMO/POS	100%
ASO/PPO	73%
Medicare	99%
Medicaid	100%
Health Plan	**95%**

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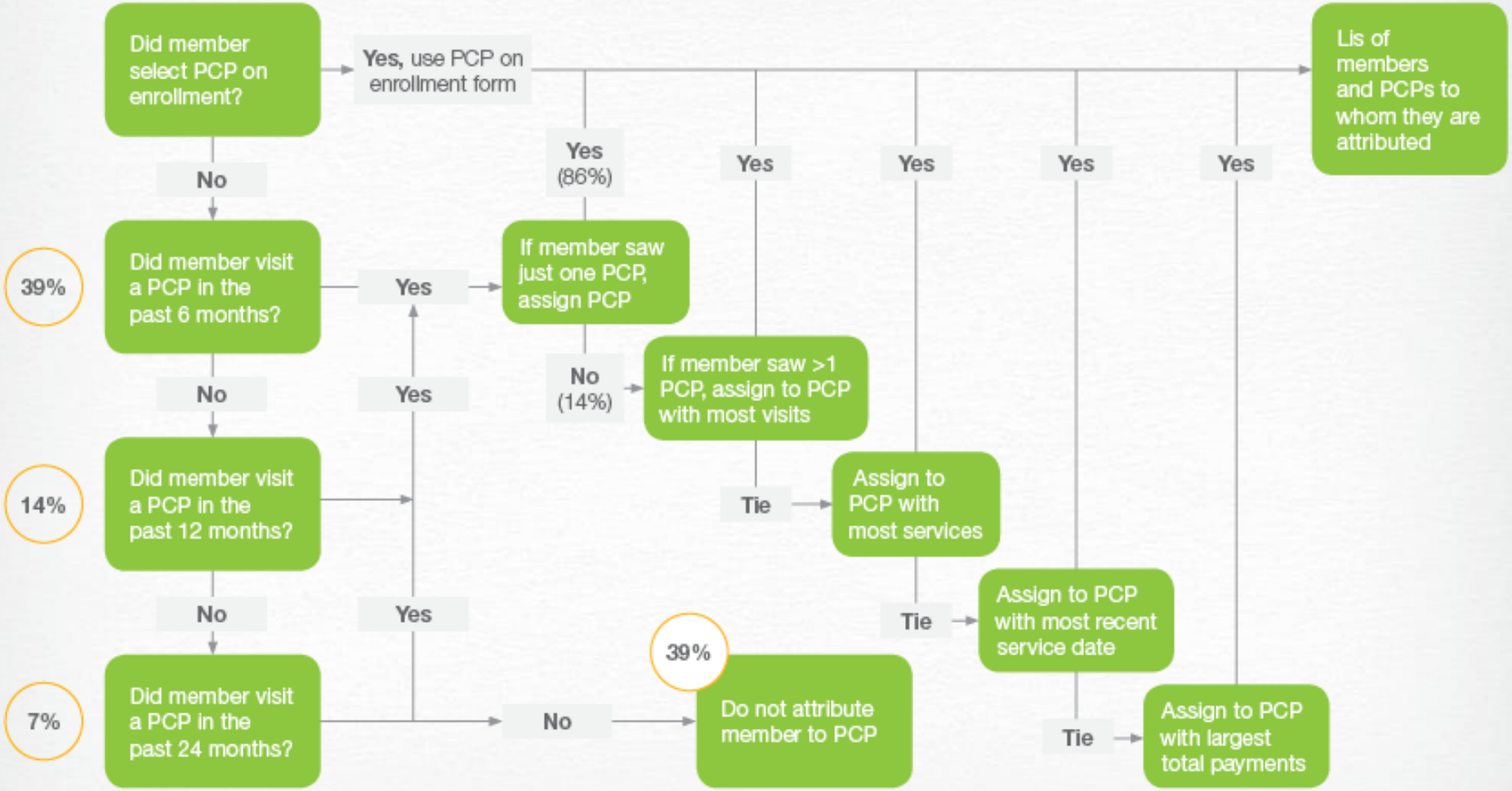
Our attribution model



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Consideration of other methods

Of members not attributed to a network PCP:

- 8% saw a network physician with a typical PCP specialty
- 14% saw a network specialist physician
- 18% saw an out-of-network physician
- 60% did not see a physician in past 24 months

Attribution and key initiatives

Attribution is necessary to pursue:

- Prevention and disease management
- Patient-centered medical home
- Care management and coordination
- Medication therapy management
- Home-based care
- Medicare risk assessments
- Post acute transformation

Performance measurement

- Population segmentation / care management target lists
- Illness burden
- Total cost of care (facility, professional, pharmacy)
- Utilization measures (readmission, IP admission, ED use rates)
- Quality measures / PCP incentive program performance

Discussion

Could we have members self-identify their PCP today and avoid the tendency to associate PCP assignment with the traditional gatekeeper HMO model of the 80s and 90s?

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