Milliman **MedInsight**

Milliman Commercial Physician Attribution Research

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Most commercial provider shared savings or shared risk arrangements include some form of physician attribution. The attribution method can have a significant impact on the financial performance of the contract. Milliman recently completed an attribution research project using approximately 9 million commercial lives and three years of data. We researched many of the questions that our payer and provider clients have been asking, such as:

- What percentage of members get attributed if I include only primary care physicians (PCPs) versus adding certain specialties?
- How does the experience of an attributed population compare to a standard commercial population?

The research shows some interesting results.

Research Key Findings: Percentage Attributed

The key findings are:

- On a concurrent attribution basis, about 60% of patients attribute to a provider with a one minimum visit criteria. This percentage is cut almost half (35%) if the minimum visit criteria increases to two visits.
- On a prospective attribution basis, about 50% of patients attribute to a provider with a one minimum visit criteria. This percentage is cut almost half (26%) if the minimum visit criteria increases to two visits.

The table in Figure 1 shows the percentage of members that attribute out of the total population for each run and calendar year of eligibility on a concurrent attribution basis:

Figure 1: Percent (%) of Attributed Patients (Concurrent)

	% ATTRIBUTED OF TOTAL POPULATION YEAR				
RUN #	**2013**	**2014**	**2015**	**AVERAGE**	**NOTES:**
Run 0	68%	67%	65%	67%	Base Criteria
Run 1	37%	35%	34%	35%	Increase minimum number of visits from one to two
Run 2	63%	61%	60%	61%	Change current enrollment criteria from "no" to "yes"
Run 3	67%	65%	64%	65%	Add six-month minimum enrollment requirement
Run 4	68%	67%	65%	67%	Include ESRD and Transplant Members
Run 5	63%	61%	60%	61%	Change provider specialties from PCP/specialist (SPC) to PCP only
Run 6	58%	56%	55%	56%	Add 12-month minimum enrollment requirement

The table in Figure 2 shows these results on a prospective attribution basis:

Figure 2: Percent (%) of Attributed Patients (Prospective)

	% ATTRIBUTED OF TOTAL POPULATION YEAR				
RUN #	**2013**	**2014**	**2015**	**AVERAGE**	**NOTES:**
Run 0	n/a	51%	47%	49%	Base Criteria
Run 1	n/a	28%	25%	26%	Increase minimum number of visits from one to two
Run 2	n/a	46%	42%	44%	Change current enrollment criteria from "no" to "yes"
Run 3	n/a	50%	45%	48%	Add six-month minimum enrollment requirement
Run 4	n/a	51%	47%	49%	Include ESRD and Transplant Members
Run 5	n/a	47%	43%	45%	Change provider specialties from PCP/SPC to PCP only
Run 6	n/a	45%	41%	43%	Add 12-month minimum enrollment requirement

Research Key Findings: Utilization for Attributed Population

As expected, an attributed population has higher utilization versus a standard population. The ratios are consistent across all states and service categories. The table in Figure 3 shows the range of the utilization ratio by major service categories for all contributors for 2015 on a concurrent and prospective basis.

Figure 3: Utilization Ratio of Attributed Patients vs. Standard Patients

	CY 2015 ATTRIBUTED/TOTAL POPULATION ANNUAL UTILIZATION PER 1,000 RATIO RANGES	
SERVICE CATEGORY	**CONCURRENT**	**PROSPECTIVE**
Inpatient*	1.15 – 1.56	0.81 – 1.50
Outpatient	1.09 – 1.60	0.70 – 1.47
Professional	1.21 – 1.67	0.86 – 1.54
Prescription Drugs	1.23 – 1.62	1.23 – 1.68
Total	**1.22 – 1.65**	**1.16 – 1.58**

These results suggest that adjusting for age and sex is not adequate when benchmarking attributed experience. Our research further looks into methodologies to adjust utilization for an attributed population.

Research Key Findings: Costs for Attributed Population

An attributed population has higher costs versus a standard population. High-level findings are:

- On a concurrent attribution basis, the allowed per member per month (PMPM) for the attributed population is about 30% to 35% higher than for a standard population
- On a prospective attribution basis, the allowed PMPM for the attributed population is about 20% to 25% higher than for a standard population

Our research further looks into cost trends and methodologies to mitigate variability.

Final Thoughts

This paper is a high-level summary of our key findings. We also analyzed and tested key drivers of these differences, quantified the volatility of an attributed population, and tested the effectiveness of risk scores in standardizing costs. For more information, please contact Milliman.

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