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How to optimize partner providers' performance using claims analytics

Dane Hansen, FSA, MAAA
Noah Champagne, FSA, MAAA

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When it comes to payer-provider partnerships, claims-based analytics is a valuable tool to encourage provider engagement.

As the prevalence of partnerships between payers and providers increases, it is critical for payers to monitor and track emerging experience and communicate these results to partner providers.

Data-driven insights through claims-based monitoring and analytics can help identify areas of action and allow payers and providers to efficiently allocate resources, increasing the likelihood of successful, long-term partnerships.

Many partnerships have found that engaging a neutral third party to assist in negotiating and monitoring contractual provisions is helpful in building trust and identifying potential improvement opportunities.

Data and analytics

Analysis of the raw claims data for members attributed to a specific provider can provide valuable insight into the provider's performance relative to the payer's full population. In general, the differential between the claims experience for the provider's attributed population and the payer's full population can be broken down into three key drivers of performance:

1. Risk (morbidity) of the underlying population
2. Cost of services
3. Volume of services (i.e., utilization)

The morbidity of the underlying population can be measured using the average risk score of the provider's attributed population. Then the average per member per month (PMPM) claims cost of the members attributed to the targeted provider can be normalized to the average risk score of the payer's full population, ensuring a consistent risk profile between the provider's attributed population and the full population for comparison purposes.

Next, the cost of services is compared between the targeted provider's attributed population and the full population, by repricing the average cost of the attributed population to the payment rates observed in the full population for each service category. The resulting repriced, risk-normalized PMPM claims cost of the members attributed to the targeted provider is then compared to the risk-normalized PMPM claims cost of the full population to derive the percentage difference in performance between the targeted population and the full population that is due to differences in costs.

Finally, the difference in performance between the provider's attributed population and the full population due to differences in utilization can be derived by removing the morbidity differences (item 1) and the cost differences (item 2).

FIGURE 1: DEVELOPMENT OF COMPARISON METRICS IN CASE STUDY

		HEALTH PLAN POPULATION (HP)	PROVIDER GROUP (PG) ATTRIBUTED POPULATION	NOTES
(1)	Allowed PMPM* Claims Cost	$400.00	$450.00	
(2)	Average Risk Score	1.150	1.200	
(3)	Risk-Adjusted† Allowed PMPM	$400.00	$431.25	(3) = $(1)_{PG}$ / $(2)_{PG}$ * $(2)_{HP}$
(4)	Risk-Adjusted† Repriced Allowed PMPM	$400.00	$425.00	Calculated by the unit price differences between HP and PG

* Allowed PMPM is the sum of the negotiated rates reimbursed to providers for healthcare services (i.e., "paid" amounts) and member cost sharing. Allowed PMPM is used instead of paid to minimize for differences in member cost sharing between the provider's attributed population and the payer's full population. Additional adjustments can be made to further normalize for differences in allowed PMPM due to induced utilization differences between the two populations.

† Normalized to the risk score of the payer's full population.

Case study

In Figure 1, we provide an illustrative case study where the methodology outlined above is used to isolate and compare a provider group's performance to a health plan's full population.

After developing the necessary metrics for comparison in Figure 1, the provider's performance can be compared against the health plan's full network and isolated into key components (see Figure 2).

In this example, the performance drivers are derived in Figure 2 based on the comparison metrics from Figure 1. The costs of the provider group's attributed population are 12.5% greater than the health plan's full population. However, a higher risk score for the provider group's attributed population accounts for 7.8% of this difference. After calculating the unit price differences using GlobalRVUs,[1] we can also derive that 6.3% of the cost difference is due to the higher average reimbursement for the provider's attributed lives than the rest of the health plan's network. Finally, we can back out the difference in performance due to "efficiency" as -1.8%, implying that the provider's attributed population uses less services, on average, than the health plan's full network. Note that any differences in mix of services or intensity of services between the provider's attributed population and the health plan's full population would be captured in the utilization differences measure.

Insights from data

Using the results of the data-driven comparative analysis described above, both the provider and the payer can draw several conclusions regarding the performance of the provider. While this is a beneficial step to understanding a provider's performance, further analysis can provide valuable additional insights to assist in maximizing the targeted provider's performance. Examples of these analyses are provided below.

COMPARISON OF EXPERIENCE AGAINST SIMILAR PROVIDER GROUPS

A comparison of performance drivers among similar provider groups can be useful in order to educate providers regarding current performance and help them understand potential, but realistic, steps to improve.

SITE OF SERVICE AND REFERRALS

Provider performance is also affected by hospitals' usage rates and specialists' referral patterns. Unit price and efficiency differences between providers and sites of service can be quantified using tools such as GlobalRVUs and episode groupers. Understanding the relative price of different sites of service (e.g., hospital versus ambulatory surgical center) and efficiency differences among specialists enables providers to understand the impact of referral choices.

A breakdown of claims experience for attributed lives into services provided at or by the providers' owned and affiliated facilities and physicians will identify opportunities to redirect care to the targeted provider's network and quantify when it makes sense for a provider to outsource (i.e., build versus buy).

FIGURE 2: DEVELOPMENT OF PERFORMANCE DRIVERS

	PERFORMANCE METRIC	NOTES*
Total Performance Difference	12.5%	=($450.00 / $400.00) – 1
Difference Due to Risk and Morbidity	7.8%	=($431.25 / $400.00) – 1
Difference Due to Unit Price Variations	6.3%	=($425.00 / $400.00) – 1
Difference Due to Utilization	-1.8%	=(1 + 12.5%) / ((1 + 7.8%) * (1 + 6.3%))

* Numbers are from Figure 1.

[1] Further information on GlobalRVUs can be accessed at https://www.milliman.com/GlobalRVUs/.

DEVELOP PERFORMANCE TARGETS AND MONITOR RESULTS

The experience of the targeted provider's attributed population can be grouped into relevant service categories and compared against external benchmarks or similar provider groups in the payer's network. The provider and the payer can use this analysis to identify and establish performance goals, such as targeted admissions, visits, or average cost.

The provider and payer can then monitor the relevant performance metrics and make the appropriate adjustments.

INDIVIDUAL PROVIDERS OR PHYSICIANS THAT ARE DRIVING INEFFICIENCIES OR HIGH COSTS OF CARE

A data-driven analysis at the provider level can be performed to identify individual providers or physicians that are high-cost or high-utilizing when compared to peer providers. For example, a surgeon may not realize that the anesthesiologist he has partnered with has costs significantly above the market average.

Third-party partners

Within many arrangements, a mistrust that one party is using the partnership to gain a financial or competitive advantage often exists. In particular, providers are often suspicious of data analyses provided by payers. Because of this dynamic, partnerships have found it useful to jointly engage a third party—typically a healthcare or actuarial consultant—to perform this claims-based analysis.

The third party can present claims data and insights through unbiased analyses and ensure that all analysis is complete and accurate. It is critical that the third-party consultant works to ensure that all parties involved in the arrangement thoroughly understand and are comfortable with the methodologies used in the analysis. This process is key to building trust between the payer and the provider.

Conclusion

As providers continue to face pressure from payers to reduce inefficiencies, lower the cost of care, and maintain high quality, payer-provider partnerships will continue to expand. In order to maximize the potential of these arrangements (and facilitate a transition to more financial risk sharing), data-driven insights through claims-based analytics can help identify provider inefficiencies in utilization and cost and improve provider performance.

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CONTACT

Dane Hansen
dane.hansen@milliman.com

Noah Champagne
noah.champagne@milliman.com