MOBE

A randomized controlled trial proves attribution.

Why conduct a randomized controlled trial (RCT)? To demonstrate that savings can be clearly attributed to MOBE® intervention. And to eliminate any questions about what's actually improving outcomes for the selected population.

How It Works

We segment a portion of the total population into two groups of at least 20,000 members. For 12 months, both groups have access to all benefits, programming, and interventions offered by the plan, and they're both affected by the same system changes. The difference between the groups is MOBE, which allows the study to show the value MOBE delivers.

Control Group	MOBE Performance Group
Value-based care	Value-based care
Care and disease management	Care and disease management
Changes to the plan design	Changes to the plan design
Changes to the provider network	Changes to the provider network
Medical policy	Medical policy
Wellness programs	Wellness programs
—	**The MOBE program**

How We Determine Your RCT Groups

Our proprietary algorithm looks at your whole population and identifies members with rising risks, who are continually seeking solutions in the health care system year-over-year. These members are mid-tier claimants, most with multiple chronic conditions. They represent strong cost saving potential and aren't engaging in other existing programs. This segment of your population is then divided into two groups.

Building Statistically Equal Groups

We pick, sort, and classify the population. We segment algorithm-identified members into relevant covariates known to affect cost. Examples include:

- Line of business: Individual, small group, or large group
- Comorbidity index/measure of chronic conditions: Low, medium, or high
- Access to care/population density: Urban or rural
- Age: 50 or younger, over 50 years old
- Gender: Female or male
- Predictive cost risk score: Low, medium, or high

We ensure equal randomization. After classifying the population across multiple dimensions, we randomize each covariate combination at the member level. For example, the six covariates bulleted above would be further randomized using 216 member features. Since randomization doesn't control for a member's starting place cost-wise, we use matching to trim any existing cohort variability.

- We generate member-level propensity scores using baseline per-member-per-month cost and predictive risk index.
- With the propensity scores, we create nearest-neighbor pairs between performance and control group members so they start from roughly similar places cost-wise.

Outlier pooling neutralizes the impact of high-cost claimants, ensuring the results don't swing in favor of one group. For example, it makes sure someone didn't just eliminate or start a very costly medication, thus swinging the results in favor of or against the MOBE performance group.

Keeping Groups in Balance

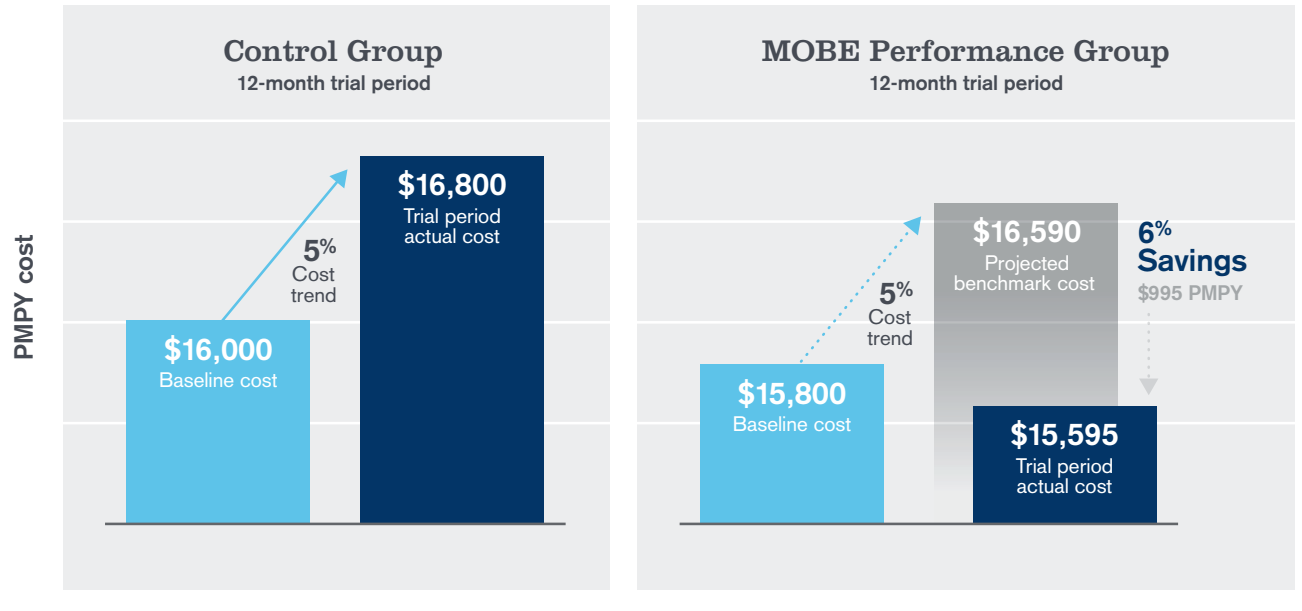
In a completely randomized process, groups can get out of balance. That's why we use Block Randomization to assign members to performance or control groups. This makes certain that important predictors of health outcomes are evenly distributed.

The Ability to Audit Each Group

Our randomization process includes a predetermined methodology for assigning people to performance or control groups. With this ceding schedule, you can review exactly how each member was assigned to their group—and even re-run the assignments yourself. This protects you by preventing members from being intentionally or inadvertently cherry-picked to sway the results.

Measuring MOBE's Impact

We create a cost benchmark by applying the control group's cost trend (the change in per-member-per-year (PMPY) cost during the trial period) to the performance group's baseline. This lets us see what the performance group's PMPY cost would have been without MOBE intervention. When we compare that benchmark to the actual trial period cost for the performance group, we see the savings attributable to MOBE.



Example savings illustration

Baseline cost: PMPY cost in the 12 months before the trial.

Trial period actual cost: PMPY cost at the end of the trial.

Cost trend: The change in PMPY cost during the trial period (We have estimated 5.0%).

Projected benchmark cost: Baseline cost with the cost trend applied (shows what PMPY cost would be without MOBE).

RCT Substantiation

We generate savings by reducing claims costs, and our use of RCTs definitively proves that the savings do come from our whole-person, cross-condition program. Top actuarial firm Milliman reviewed two different MOBE RCTs and vetted and validated our data-driven approach. Our methodology for measuring claims-cost savings is objective and aligned with industry standards. This methodology also accounts for the potential use of other programs, including CM/DM services, although overlap analyses show minimal engagement in those programs.

Milliman

MOBE®

Get the whole-person, cross-condition solution proven to reduce total cost of care.

MOBEforlife.com/health-plans | inquiries@MOBEforlife.com |