

Evaluating healthcare provider performance

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Some healthcare provider organizations are beginning to tackle the challenges of evaluating and managing provider performance to improve financial and other results under narrow network products, shared risk/savings agreements, and other value-based payment arrangements. This paper explores considerations for selecting metrics to use when evaluating provider performance, adjustments to performance metrics that help address limitations in available data, and how provider performance metrics may be used to help improve financial and other results.

CONSIDERATIONS FOR SELECTING PROVIDER PERFORMANCE METRICS

There are many types of providers involved in the delivery of healthcare—tertiary hospitals, primary care and specialty physicians, skilled nursing facilities, and home health providers, to name a few—and each plays a unique role. Though there are commonalities, a unique set of metrics is often useful to evaluate the performance of different provider types.

The specific metrics selected should depend upon the quality and robustness of available data, the ability of providers to control or influence the metric, and the ability to compare the metric across providers in an objective manner. Ideally, metrics address each component of the triple aim (cost, quality, and access) and are aligned with the organization's financial and other goals. It is important to ensure metrics are appropriate for the particular value-based payment arrangement, the organization's circumstances, and the population that care is being provided to. For example, skilled nursing facility utilization is an important metric for an aged Medicare population but not for a pediatric Medicaid population. It is helpful to use metrics that can be compared over time so changes can be monitored. Comparison of metrics across peer groups and to targets or benchmarks can potentially be helpful to motivate and drive performance improvements.

Population-based metrics, such as average per capita expenditures, utilization per 1,000 for select services, and percentage receiving specific preventive care services, are commonly used to measure provider performance when patients can be associated with a specific provider group. For example, emergency room visits per 1,000 patients may be used with primary care physician groups in situations when patients select or are assigned to a primary care physician.

An episode view, whereby a series of patient claims related to the diagnosis and treatment of a condition are grouped together, is another common approach used to measure provider performance. An osteoarthritis episode, for example, may include many services: a physician office visit and radiology services to diagnose/confirm

the condition, treatment with medication, further radiology services, a joint replacement procedure at a hospital, post-acute care in a skilled nursing facility, physical therapy once discharged from the skilled nursing facility, and follow-up visits with the physician. Multiple providers are involved in such an episode and each can be evaluated on different metrics related to the episode. The orthopedic surgeon managing the episode may be evaluated on the total cost of the episode, while it may be more appropriate to evaluate other providers on specific components of the episode. For example, the readmission rate may be used to help evaluate the hospital, and the cost of the skilled nursing facility stay (inclusive of the cost of transfers back to an acute inpatient setting) may be used to help evaluate the skilled nursing facility.

PROVIDER PERFORMANCE METRIC ADJUSTMENTS

Evaluating provider performance is often a sensitive topic. It is natural to explain or question performance results that differ from expectations. For example, some providers might feel their patients have high acuity or that they do not have enough patients to produce fully credible performance results. Concerns such as these are valid issues that need to be addressed for a metric to be used in performance evaluation. There are several adjustments that can often help address these challenges. Depending on the metric, adjustments may need to be made for issues such as:

- Differences in patient demographic, risk, and severity profiles
- The influence of large, high-cost claim expenditures
- Differences in the mix of services across providers
- Differences in reimbursement methodologies and fee schedules across providers
- The time period used to measure performance
- Low credibility of results due to few observations and the inconsistency of the available observations

High volatility, low credibility, and other influences make it critical to use adjusted performance metrics when comparing performance among providers, to benchmarks or targets, and over time. A professional with expertise in both healthcare data and advanced statistical methods can provide guidance regarding limitations that might still remain and the appropriateness of conclusions using adjusted performance metrics. For example, the robustness of the available data may not be adequate to use an adjusted performance metric to rank results from highest to lowest, but it may be adequate to statistically differentiate outlier results. Such insight is invaluable when provider performance metrics are used to help make business decisions.

USING PROVIDER PERFORMANCE METRICS TO IMPROVE RESULTS

To achieve financial and other goals, some organizations are using performance metrics when selecting preferred providers to partner with and driving performance improvements across the organization. More specifically, adjusted performance metrics can be useful as part of:

- Evaluating physician groups and other providers for participation in a narrow network, accountable care organization (ACO), or other affiliation of providers
- Identifying post-acute care and other providers with whom to develop preferred relationships
- Identifying preferred specialty physicians to whom primary care physician can refer patients
- Rewarding participating providers via incentive compensation programs
- Driving performance improvement across hospitals, primary care physicians, specialty physicians, and other providers

CONCLUSION

Careful consideration is required to select the best performance metrics to measure and evaluate the performance of healthcare providers. Adjustments to the performance metrics can be made to help address limitations in available data. Organizations that overcome these challenges and utilize provider performance metrics to increase the overall performance of the organization are better positioned for long-term success as provider reimbursement continues to transition from pay-for-volume to pay-for-value.

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