Health care is shifting from volume-based reimbursement to value-based payment. Along with this shift, the industry is developing new performance measures based on quality and costs.

The challenge for medical groups is that payment is currently stuck in the middle between the old and the new. Fee for service (FFS) still represents the bulk of collections for most groups. At the same time, quality incentives and value-based contracts are growing drivers of practice revenue. While payment models continue to be based largely on service volume, payers increasingly want physicians to focus on quality and cost control.

Many practice leaders are unsure which performance metrics to track as they try to manage the transition.

How do you lead a medical group when reimbursement is based on patient volume, yet quality of care and cost management are (or may be soon) driving additional reimbursement streams? Many practice leaders are unsure which performance metrics to track as they try to manage the transition.

The solution is to create a strategic performance measurement program that blends old and new metrics. Maintain your focus on traditional key performance indicators (KPIs) while selectively adopting new KPIs that help you manage the emerging payment environment.

Track Next-Gen KPIs

Traditional KPIs focus on the flow of money. Revenue cycle measures, for example, track the various points in the collections process—days in receivable, accounts receivable (AR) aging, denial rates, gross and net collections, and other measures of AR management.

High-level financial measures focus on profitability—monthly gross and net revenue, operating expenses, and profit margin. Even physician metrics concentrate mainly on production—schedule occupancy rates, number of visits, work relative value units (RVUs), and other productivity indicators.

Today, the shift from volume to value is creating a range of nonfinancial objectives. Government and healthcare industry leaders have set goals for reducing care fragmentation, improving care quality and patient outcomes, and controlling overall spending.

Payment models, in turn, are evolving from FFS to value-based contracts that include quality incentives, shared savings, value-based payment, and capitation. Revenue and profit metrics are still important to running your group, but you must now begin tracking a new generation of KPIs that are critical to the success of value-based care and translate well into actionable results. These new KPIs focus on care quality, clinical outcomes, patient experience, and cost of care.

Monitor Cost of Care

Cost control is an important element of several new contracting models, from shared savings contracts and bundled payment arrangements to accountable
care organizations (ACOs). To succeed under these models, physician groups need KPIs to monitor the cost of care.

Many medical groups that have entered cost-sensitive payment contracts have begun tracking per-member per-month (PMPM) cost. A traditional health maintenance organization (HMO) metric, PMPM cost allows group leaders to pinpoint and monitor the total cost of caring for contracted patients within their defined membership pool.

To calculate PMPM cost, obtain at least two years of historical claims data from the plan’s third-party administrator. Calculate average PMPM cost for all members, and analyze total spending by relevant categories. For example, break down total PMPM costs by medical spend and pharmacy spend. In addition, determine PMPM costs for high-risk cohorts such as patients with certain chronic diseases or a recent history of frequent hospital stays. Another technique is to analyze aggregate PMPM spending by random and planned events and avoidable costs.

Understanding avoidable costs allows you to identify cost reduction targets and better manage care. For example, if the hospital spend is high, focus on reducing admissions and improving management of care gaps in the outpatient environment. If spending is high on ancillary testing, take steps to reduce duplicate and unnecessary tests. If the generic drug rate is low, implement a program to increase generic drug prescribing.

**Measure Quality**

Quality measures are a key part of most new payment models. Government has tied Meaningful Use (MU) and Physician Quality Report System (PQRS) incentives and penalties to reporting on clinical quality measures. Quality performance thresholds are also a part of the Medicare Shared Savings Program (MSSP). In addition, many commercial carriers have begun to track quality measures based on claims data and clinical outcomes.

Thousands of quality measures are now available from a myriad of government agencies, specialty societies, and national quality organizations. So, which measures should your group track? The fundamental question is, What measures enable you to demonstrate you are providing quality care?

Begin with the value-based quality programs your group is already participating in, such as government or private pay-for-performance programs or any local organization such as an independent practice association (IPA), physician-hospital organization (PHO), or clinically-integrated network (CIN). All medical groups should be working to qualify for MU incentive payments, so your measurement program should include the appropriate core, menu, and clinical quality measures for your stage of adoption.

In addition, investigate voluntary opportunities for using quality metrics to improve clinical and financial performance. What measures are payers rewarding in your market? Some groups that have adopted the Patient Centered Medical Home (PCMH) model of care have secured higher payment. Under the National Committee for Quality Assurance (NCQA) medical home designation, practices track care metrics in areas such as care management, care coordination, and other quality domains.

Another approach to developing an effective quality measurement strategy is to analyze your patient population and identify its improvement priorities. What are the top five conditions your providers treat? Medical groups that serve an older population, for example, may want to focus on quality measures surrounding diabetic care or hypertension. For other groups, it may make sense to emphasize preventive measures such as weight management and smoking cessation counseling.

When selecting quality measures, keep in mind that many metrics overlap across several payment programs. For example, multiple measure sets (see Table 1) incorporate certain diabetic care measures.

Once your group agrees on a quality measurement strategy, staff must determine how your electronic medical record (EMR) will capture appropriate measures. Two considerations are important. First, ensure that the measure captures reportable structured data, not free text. Second, help providers incorporate quality data capture within their clinical workflow. For example, say a physician counsels a patient on smoking cessation. For this information to be reportable as data, enter it in a discrete field in the EMR instead of as a general note.

**Gauge Patient Access and Engagement**

One core goal of payment reform is improved patient access to care. Some practices measure access in terms of the next available appointment, but a more effective measure is “third-next-available appointment.” This KPI measures not just random appointment availability due to chance cancellations, but the true ability of patients to access your group on short notice.

To measure third-next-available appointment:

- Use your practice management system to query appointment availability for a physician.
- Count the number of days to the third available
appointment (include weekends and days off, but exclude any time blocked off for urgent appointments).

- Repeat the process for all physicians in your group, and then average the values.1

One strategy for improving patient access is to extend office hours to evenings and weekends. Surveying your patient population or just trying out a new schedule may help you determine what is convenient for your patients. Second, based on your patient population, socioeconomic factors may be preventing access. For example, patients in a rural area may need transportation for appointments. Social or community agencies may be available to provide this service.

Another key healthcare reform goal is increased patient engagement. Research shows that patients who are actively involved in their care experience better outcomes.2 Measuring patient engagement is difficult, but one good KPI to begin with is patient use of an online portal.

Under MU, you must provide portal access to more than half your patients. The challenge is that patients must demonstrate engagement with the portal. More than five percent of patients must use the portal to view, download, or transmit their personal health information, and over five percent must also send an electronic message to a care provider.

Following MU rules, portal engagement KPIs to track include the percentage of patients seen during the

<table>
<thead>
<tr>
<th>Metric</th>
<th>PQRS</th>
<th>ACO</th>
<th>MU</th>
<th>HEDIS</th>
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<td>Hemoglobin A1c control (&lt;8%)</td>
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</table>

* PQRS = Physician Quality Reporting System, ACO = Accountable Care organization, MU = Meaningful Use, HEDIS = Healthcare Effectiveness Data and Information Set.

Source: Health Directions, LLC.
A dashboard report that includes cost-of-care measures, utilization metrics, and other key performance indicators enables medical groups to successfully manage value-based contracts.

Evaluate Patient Satisfaction

Improving patient satisfaction is an element of the Institute for Healthcare Improvement (IHI) Triple Aim for improving the healthcare delivery system. In recent years, physician grading web sites and other social media channels have begun shining light on the patient experience. In addition, the Centers for Medicare and Medicaid Services (CMS) will begin posting Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Clinician & Group (CG-CAHPS) survey scores on the Physician Compare web site in 2014. The goal is to provide consumers with information to make informed healthcare decisions; this, in turn, will incentivize physicians to monitor and improve their quality scores.

Increasingly, patient satisfaction affects payment. Medical groups that include 25 or more eligible professionals can now elect to include CG-CAHPS patient experience-of-care measures in their Medicare value-based payment modifier.

To successfully administer a CAHPS survey, you must commit adequate resources, carefully plan the survey project, analyze the results, and use survey feedback to strategize improvement in the patient experience. For example, survey scores may reveal low performance on patient communication. Group leaders can work with physicians and nurses to provide patients with clear explanations of their health conditions and recommended care.
Medical groups that participate in an organized system of care need to track all the metrics discussed above plus KPIs that measure and support coordination of care and management of patient populations. The care gap report is the key data tool.

Care gap reports use clinical and claims data compared against care standards to identify patients who have not received recommended services for their health status and conditions. Care gap reports not only measure current performance, staff can use them as a practical tool to drive better patient care.

For example, your defined care pathways for diabetics might include quarterly A1c testing, annual foot and eye exams, annual nutrition counseling, and other defined services. The care gap report compares recommended care to actual utilization for each diabetic member. This allows you to gauge your effectiveness in providing recommended care to your diabetic population to prevent complications and avoidable readmissions.

Even more important, the care gap report generates clinical care alerts that identify patients who are falling short of their care protocols. Clinical staff can then use these alerts to better coordinate care—for example, by reaching out to patients to schedule needed appointments, lab tests, and other services. Alerts can also prompt physicians and staff to remind patients during appointments of any outstanding orders, including preventive care.

Medical groups that take part in an organized system of care can also use care gap reports to proactively manage high-utilization patient cohorts. Group leaders can then create care programs focused on providing great care for these patients while controlling costs.

One major priority for an organized system of care is to minimize “leakage” of patients to other provider systems. Keeping patients in the system is critical to managing the cost of care and influencing quality. This may be more difficult in urban areas, where consumers have greater access and choice. When patients leak out of your system, however, your ability to control costs and optimize care is weakened.

In addition to tracking leakage rates, monitor referral rates and network utilization rates. Pinpointing domestic versus nondomestic utilization by disease category allows you to minimize leakage through care management. All these metrics enable leaders to develop interventions to provide patients with the full spectrum of care within the network.

**How to Use New KPIs**

Next-generation KPIs enable you to guide your medical group as you enter the era of value-based payment. Five strategies are key:

1. **Communicate KPIs to physicians.** If you are going to make progress on quality, cost, and other goals, physicians need to understand the new KPIs that measure performance in these areas. Involve physicians in the KPI development process, provide all physicians with performance reports that include both old and new KPIs, and review performance measures at monthly medical staff meetings.

2. **Align compensation with KPIs.** Traditionally, RVU-based compensation plans focus on increasing patient visits. Now, physicians need to take time to provide quality care (as defined), communicate clearly, ensure a positive patient experience, and capture performance data. It’s important that compensation rewards achievement in these areas. For example, a physician compensation plan might base from 10 percent to 30 percent of pay on a physician’s quality measures, MU measures, patient satisfaction scores, etc.

3. **Incorporate KPIs into a dashboard report.** A well-designed value-based dashboard enables you to monitor patient population cost of care, determine how much high-cost patients contribute to the cost of care, identify savings opportunities, and strategize improvements. (See Figure 1 for a sample Value-Based Performance Analytics Dashboard.)

4. **Apply the data.** Tracking KPIs is one thing. Knowing how to modify operations to improve performance is another. As your measurement program develops, focus on creating disease-specific care management and care navigation programs to reduce the cost of care.

5. **Leverage KPIs in payer contracting.** Ultimately, stronger performance (and performance improvement) should convert to higher payment. Select KPIs that strategically target areas of quality, outcomes, and efficiency that have the biggest impact on payer costs. Demonstrating strong KPIs in these areas allows you to negotiate favorable payment contracts.

**Forward-Looking Strategy**

The transition from volume to value is a long-term goal, but healthcare reform is moving the industry closer to true value-based payment with every fiscal
For over a decade, the American Medical Group Foundation (AMGF) has supported and disseminated research, developed demonstration projects, operated learning collaborives, and fostered engagement and knowledge-sharing across medical groups and health systems. These efforts have improved care—and health—for one in three Americans.

Through AMGF programs, we’ve seen reductions in hospital admissions and emergency room (ER) visits, better quality care, and more patients reaching blood pressure goals. And this is just the beginning of what we can accomplish together.

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Daniel J. Marino is senior vice president and Lucy Zielinski is vice president at The Camden Group, which provides management and consulting services to the healthcare industry exclusively, assisting more than 2,000 healthcare organizations nationwide.

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