Physician Productivity: Measures, Reporting and Use

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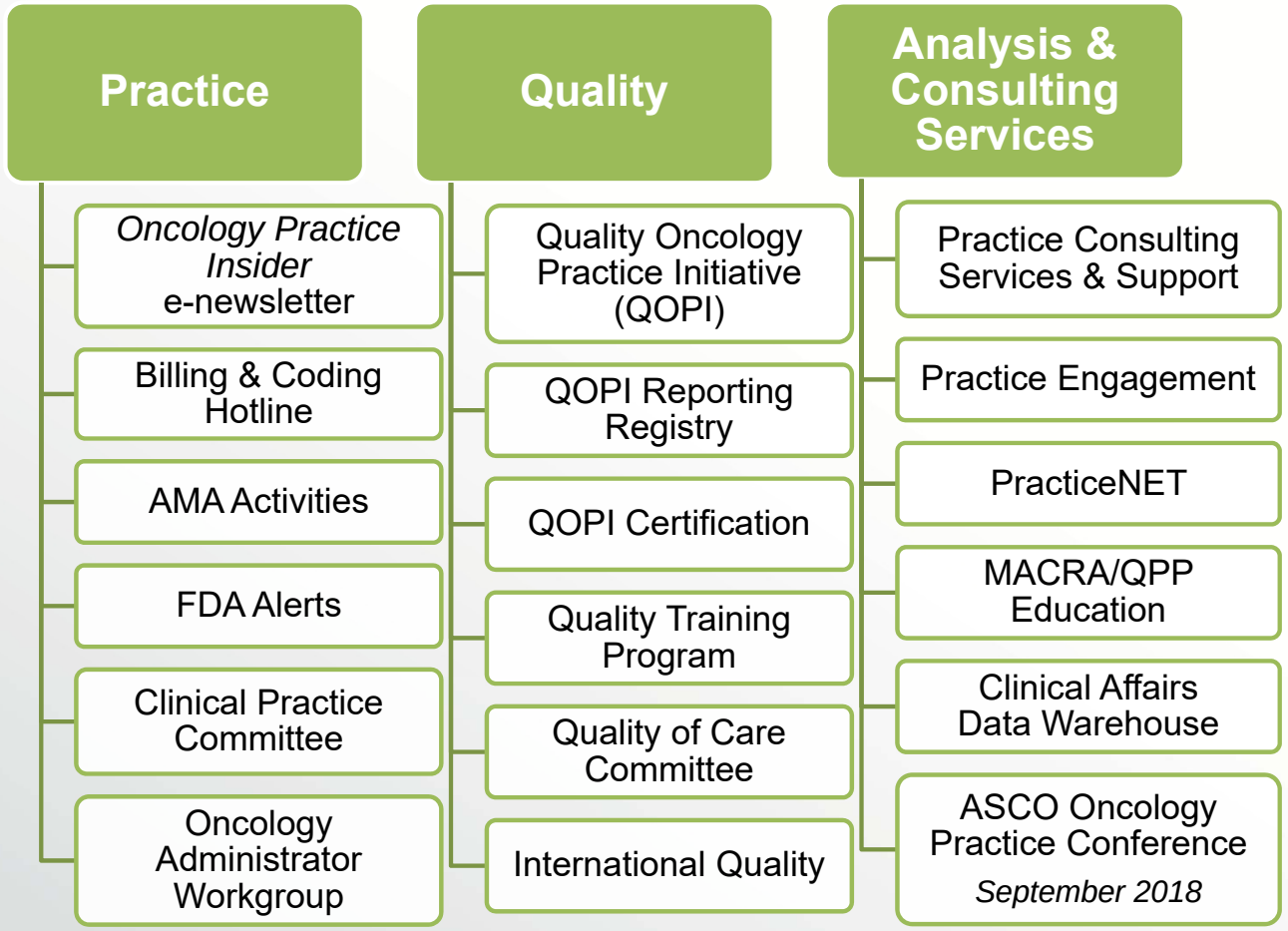
ASCO Clinical Affairs



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Why measure physician productivity?

- More than just physician compensation
  - Staffing
  - Scheduling & facility
  - Strategic decisions
  - Improving the patient experience

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Relative value units (RVU)

- One effective way to measure physician productivity
  - A way to quantify production, one RVU = one unit of work
  - Only meaningful relative to each other; a way to enable comparison with external benchmarks
- Work RVU (wRVU) is most utilized component, particularly for physician compensation
  - ~53% of total RVU across all procedures with RVU values
  - Calculated based on estimate of time and effort expended by provider for the service
- Are they going away?
  - Not any time soon…. even as we shift from volume to value-based reimbursement
  - Still used by Medicare and most (all?) payers
  - Used to create and maintain fee schedules
  - Used for conducting cost account analyses
  - Used to measure productivity and create physician compensation models

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But wRVUs alone do not measure productivity

One model

- Think about productivity from a financial perspective, not just work effort
- Use RVUs as proxy for actual physician expense
- Consider total RVUs as a bigger picture of total productivity
  - (if focus is physician compensation, use only wRVUs)

- Two critical metrics for this RVU-based physician productivity model: revenue and RVUs

- Productivity ratio = % provider revenue/% provider RVU

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Physician productivity measures should include more than just RVUs

- Patient encounters
  - Do not reflect collections; gaming of system is possible by encouraging short patient visits
- Gross charges
  - Easy to calculate but do not reflect contractual adjustments or collections
- Charges adjusted for insurance contracts
  - Easy to produce but based on uncollected charges
  - Payer mix varies between physicians in the group; does not provide apples-to-apples comparison
- Net collections
  - Actual collections; may discourage some providers from caring for uninsured or poorly insured patients

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What else should be measured and rewarded?

- Patient satisfaction scores
- Care coordination activities
- Quality metrics/reporting
- Quality improvement projects
- Participation and contribution to group's strategic plan

- Incentives must be transparent and consistent
- Any behavioral change incentive must constitute at least 20% of the total compensation plan to get attention

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Data vs. business intelligence

- What are the key performance indicators (KPIs) for your organization?
- What metrics are most relevant to the success of the organization?

- Only a few "key" metrics – identifying the right metrics is essential
- Should reflect the organizations goals and will vary by organization
  - Is success focused on total # of patients? Or patient experience scores?
  - Does success = physician compensation and benefits?

- Think about revenue cycle; operational efficiency; financial performance; productivity measures – and then consider how they relate to one another for the health of your organization

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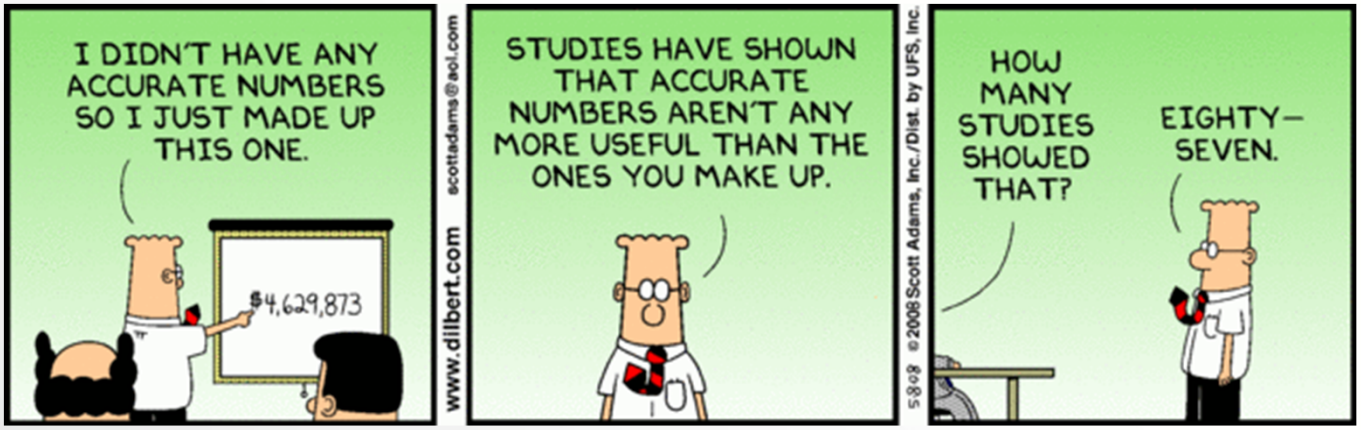
"Flooded by data while thirsting for information," *MGMA Connection*, Jan/Feb 2018

Let’s look at some data



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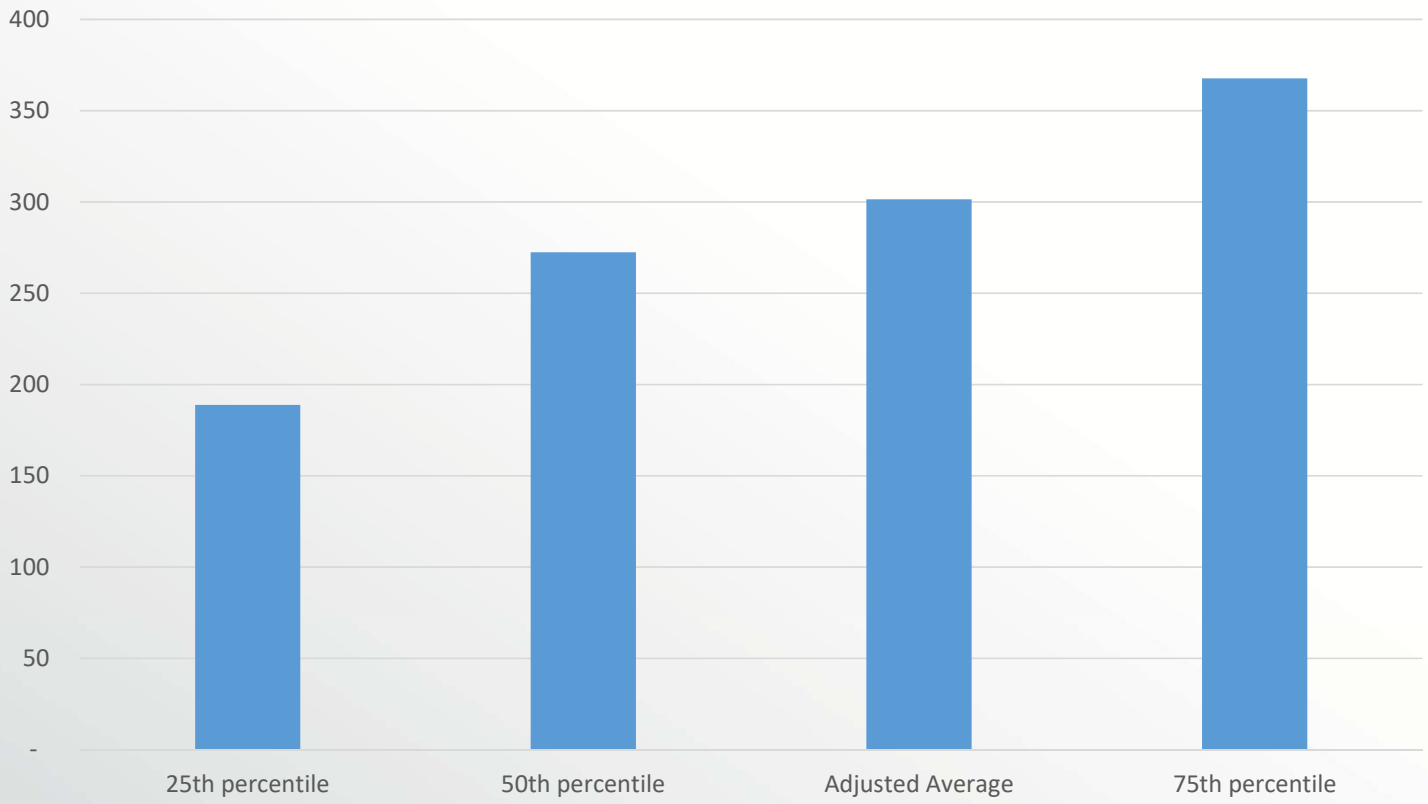
New patients/FTE HemOnc, all settings



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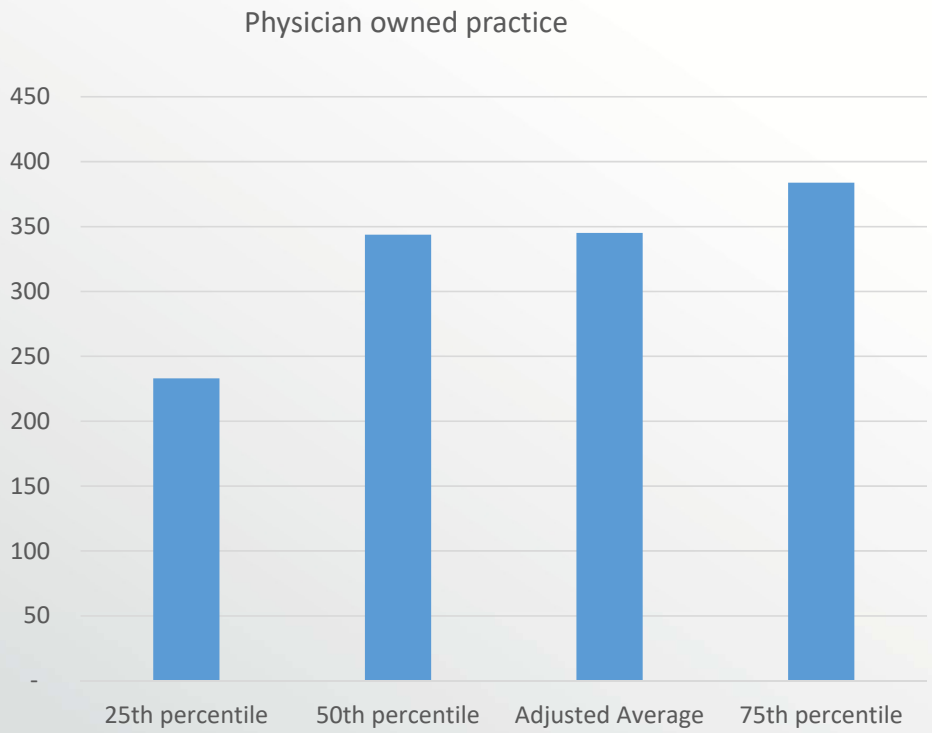
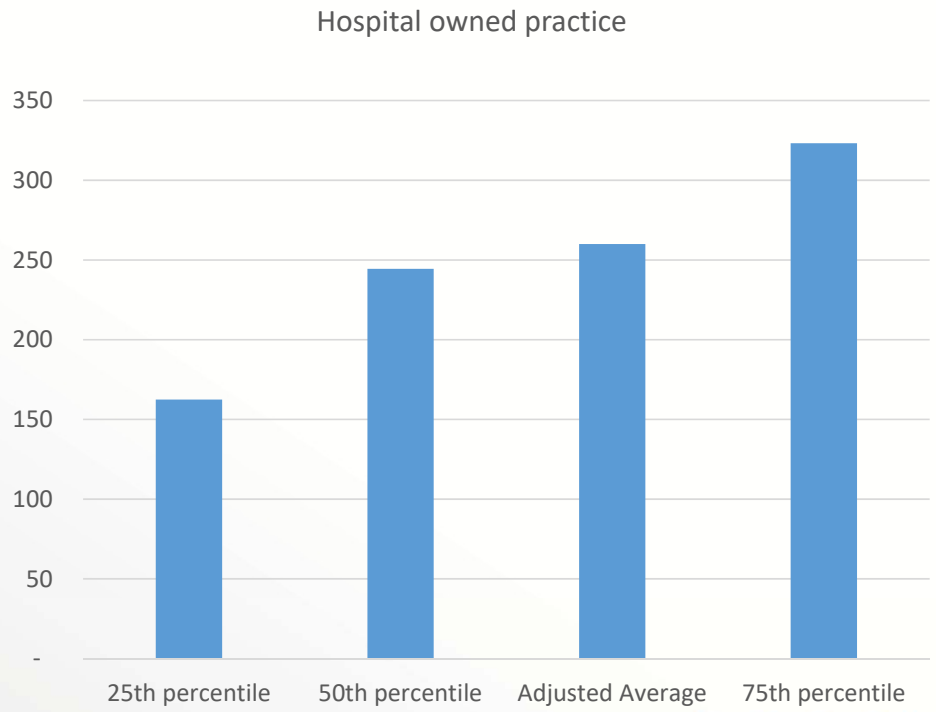
Source: ASCO Survey of Oncology Practice Operations, 2017 report

New patients/FTE HemOnc





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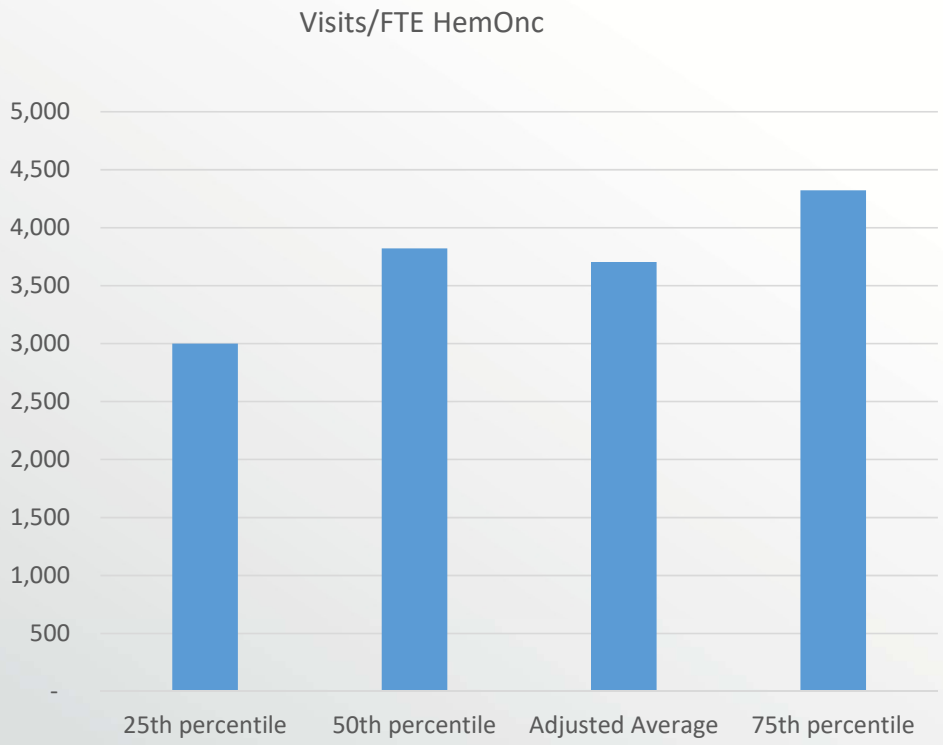
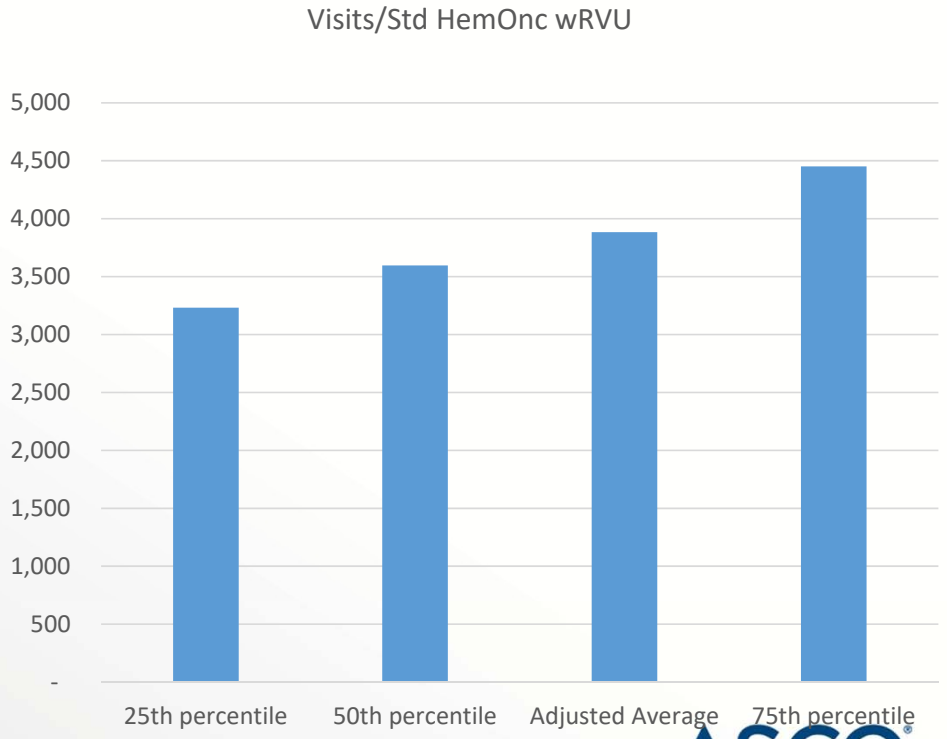
Source: ASCO Survey of Oncology Practice Operations, 2017 report

Established patient visits, office





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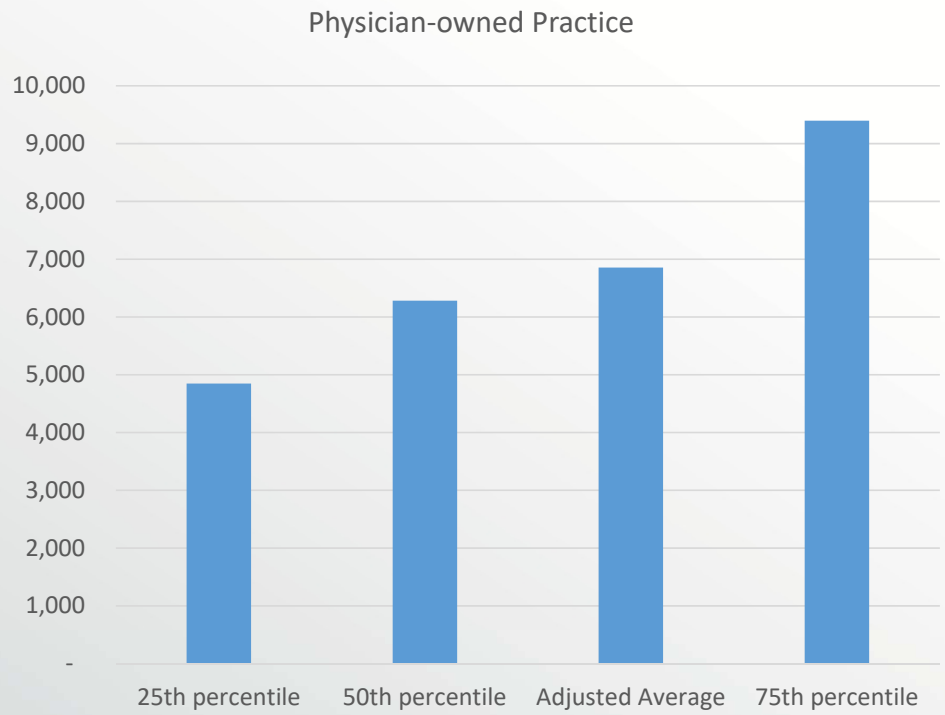
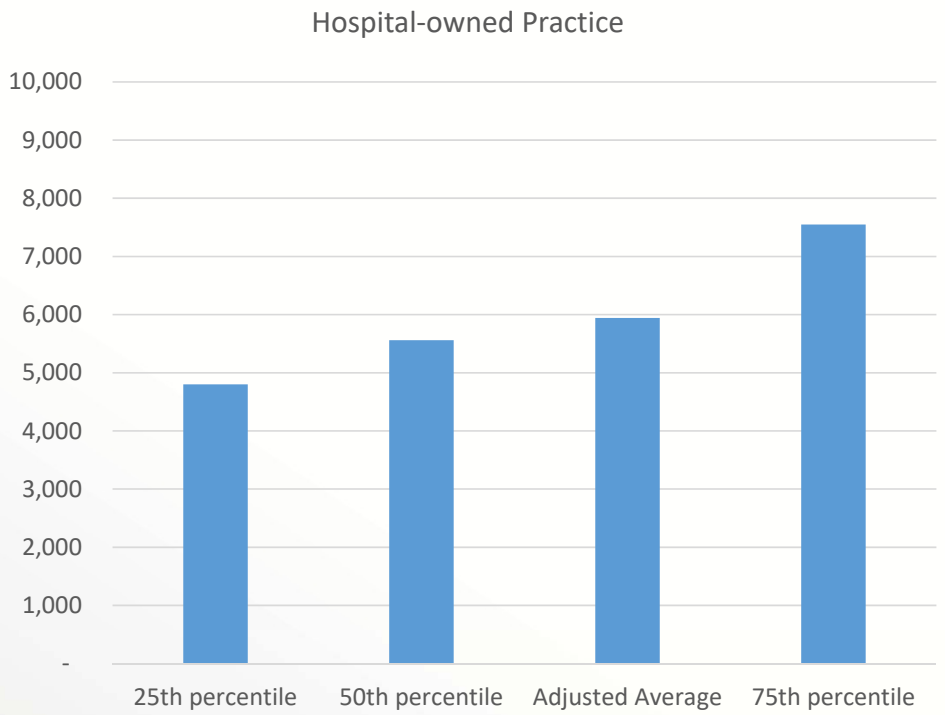
Source: ASCO Survey of Oncology Practice Operations, 2017 report

wRVU/FTE HemOnc





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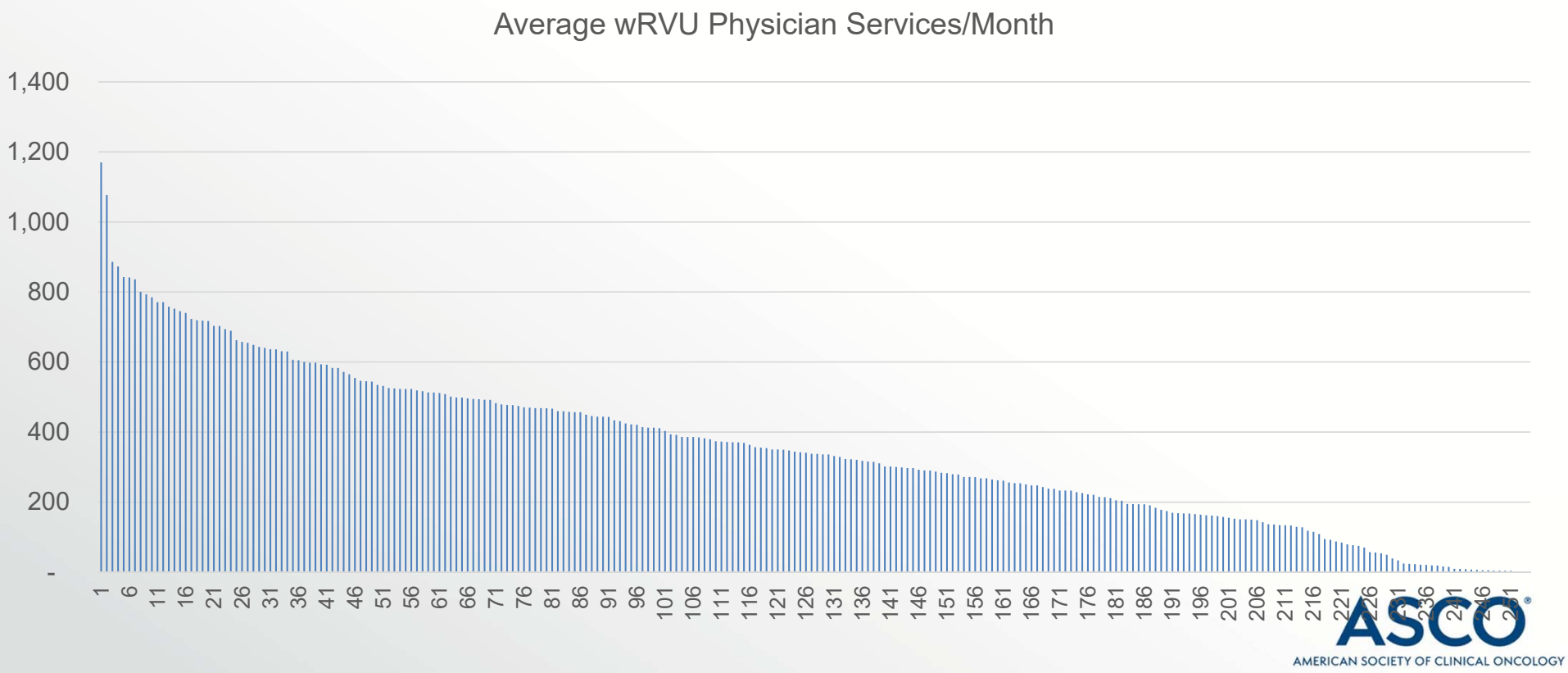
Source: ASCO Survey of Oncology Practice Operations, 2017 report

wRVU Physician Services



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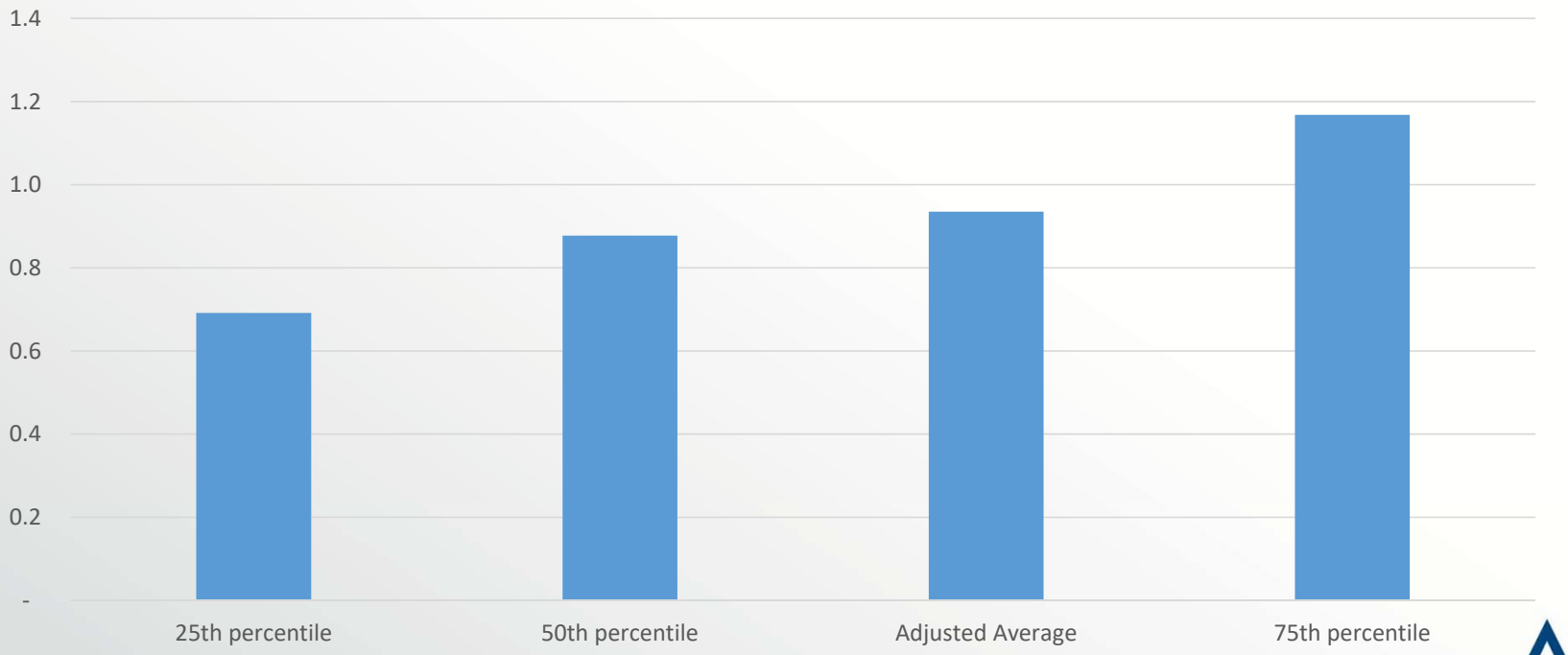
Source: ASCO's PracticeNET, fall 2017 meeting

HemOnc Capacity Ratio, wRVU



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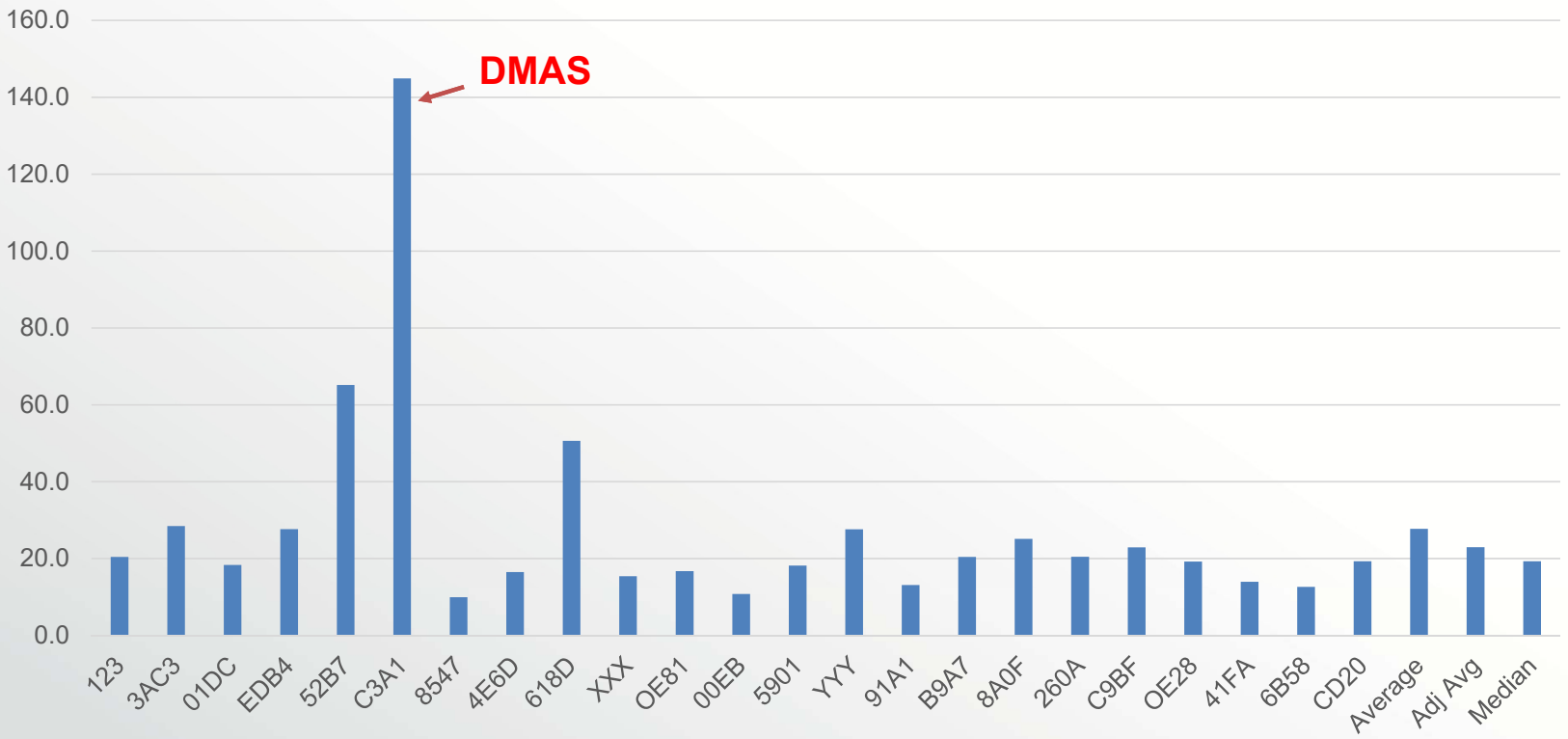
Source: ASCO Survey of Oncology Practice Operations, 2017 report

Ratio of established patient visits : new patient visits, office



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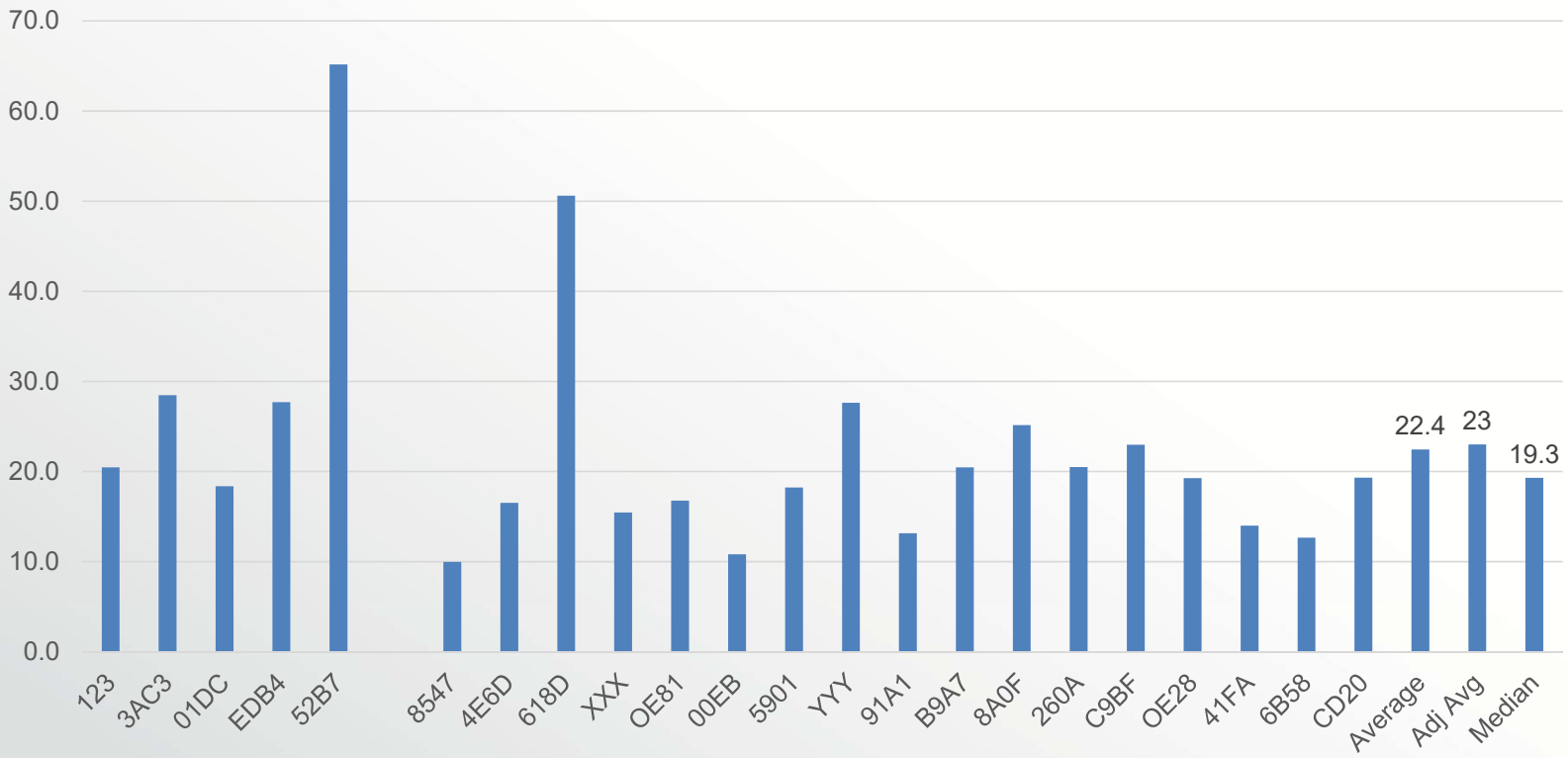

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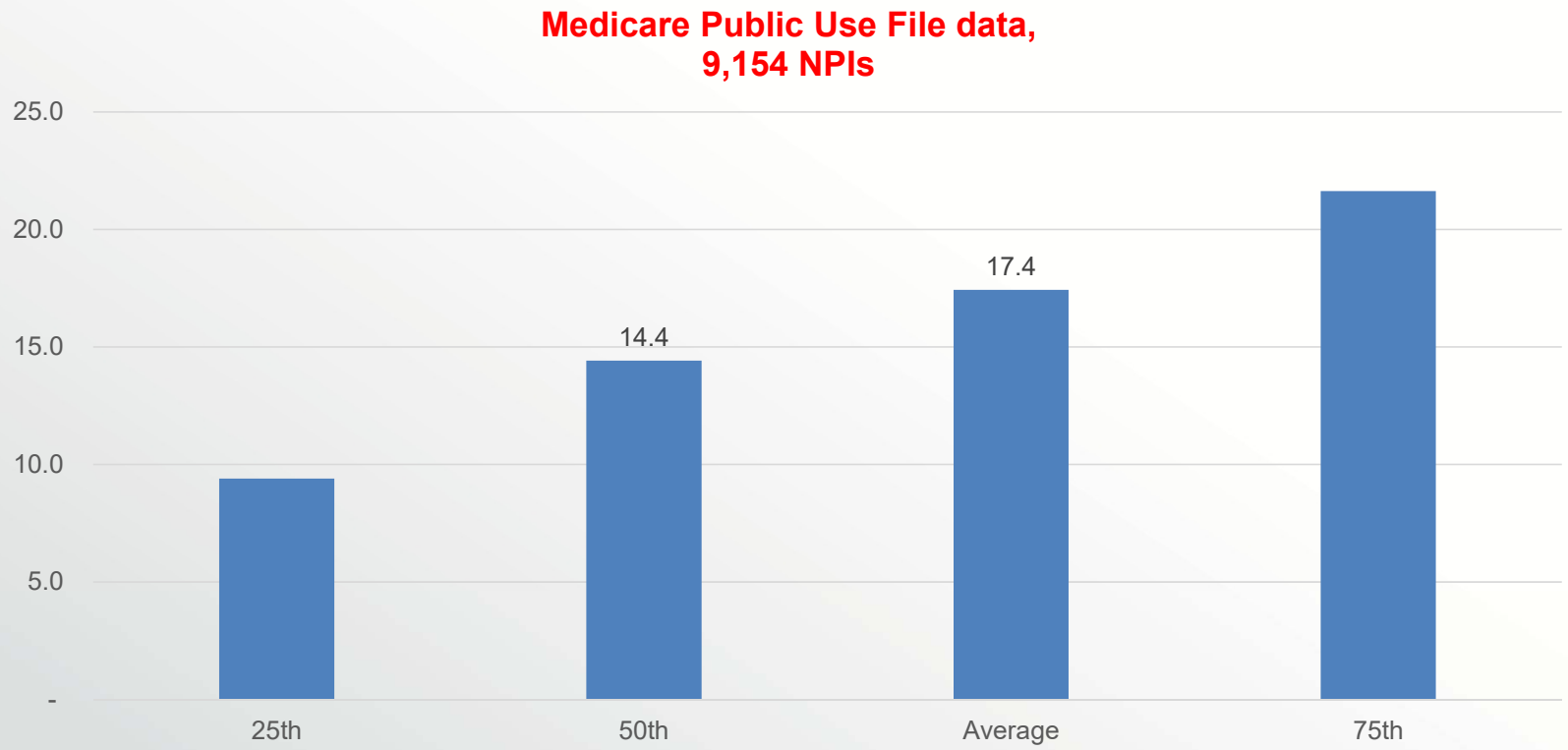

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Source: ASCO's PracticeNET, fall 2017 meeting

What is a PUF?

- Medicare **P**ublic **U**se **F**ile
- There are lots of them now and new ones are being produced by CMS at a steady pace.
- The ones we are using are the *Physician and Other Supplier PUF* for part *B* and *D*; and *Physician Compare*
- *Physician and Other Supplier PUF*, Part *B*
  - Data include utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service for calendar years 2012-2015 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.

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What's in the Medicare PUF?

- NPI – National Provider Identifier
- Provider last name
- Provider first name
- Provider street address
- Provider city
- Provider zip
- Provider state
- Place of service
- HCPCS code
- HCPCS description
- HCPCS drug indicator
- Line srvc cnt
- Bene unique cnt
- Bene day srvc cnt
- Avg Med allowed amt
- Avg submitted chrg amt
- Avg Medicare pmt amt

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What's in Physician Compare that can be linked to the PUF?

- NPI
- PAC ID
- Professional Enrollment ID
- Gender
- Medical credential
- Medical school name
- Graduation year
- Primary specialty
- First - fourth secondary medical specialties
- Organization legal name
- Organization DBA name
- Practice PAC ID
- Number of Group
- Street Address Group Practice
- City Group Practice
- Zip Code Group Practice
- Participating in eRx
- Participating in PQRS
- Participating in EHR
- Received PQRS Maintenance of Certification Program Incentive

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And why are we talking about it?

- Because these data are public, complete, and **very** detailed.
- Others will misunderstand and/or misrepresent “conclusions” that are reached and preached from these data.
- This gives you the opportunity to see how you compare to the population of oncologists.

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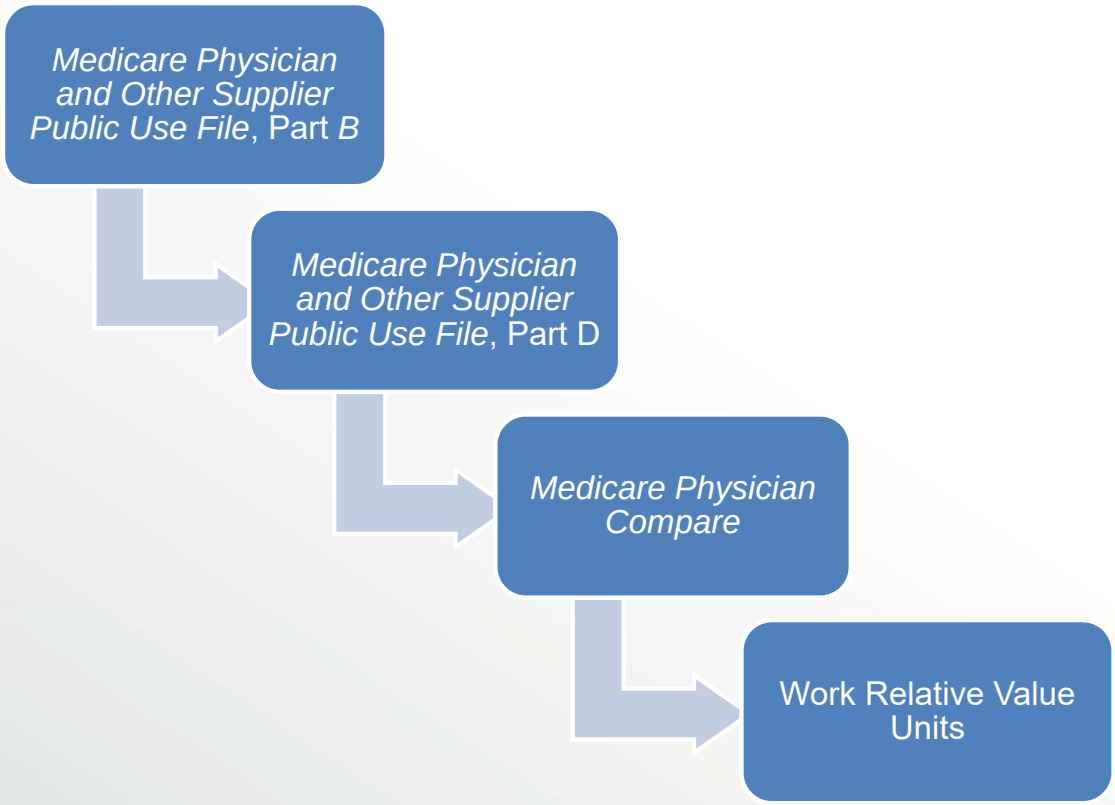
ASCO Provider Utilization File: ASCO PUF



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Limitations

- There are several limitations in the use of this data set
  - Data includes only Medicare fee-for-service beneficiaries; Medicare managed care beneficiaries are *not* included
  - Data includes only services billed by an individual provider based on that provider's NPI number; services billed by an institutional provider are not included
    - Of particular note, chemotherapy services billed by institutional providers are not available in this data

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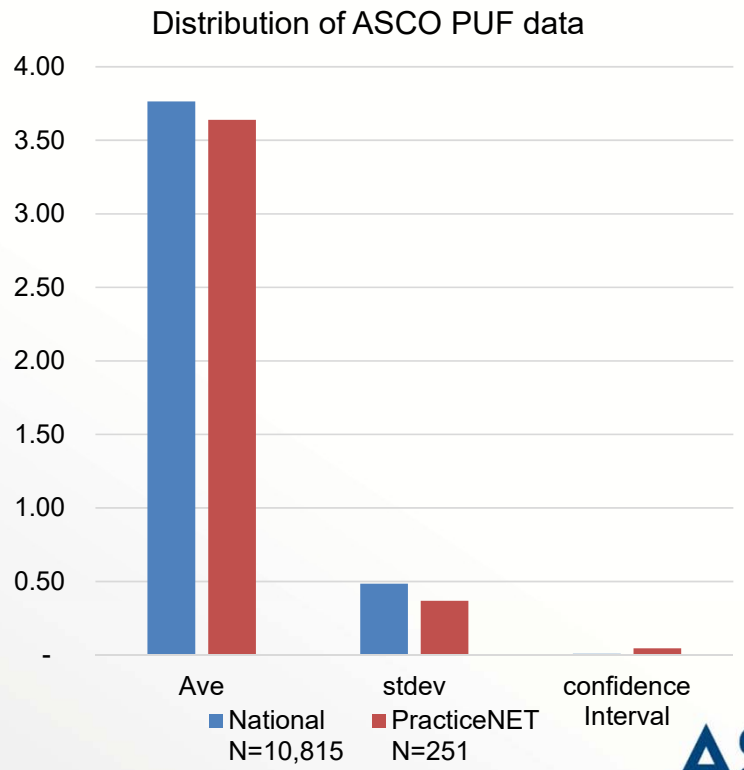
Weighted average for established patient office visits (99211 – 99215)

	Avg	St Dev	Confidence Interval 95th %ile
National N=10,815	3.76	0.49	0.01
PracticeNET N=251	3.64	0.37	0.05



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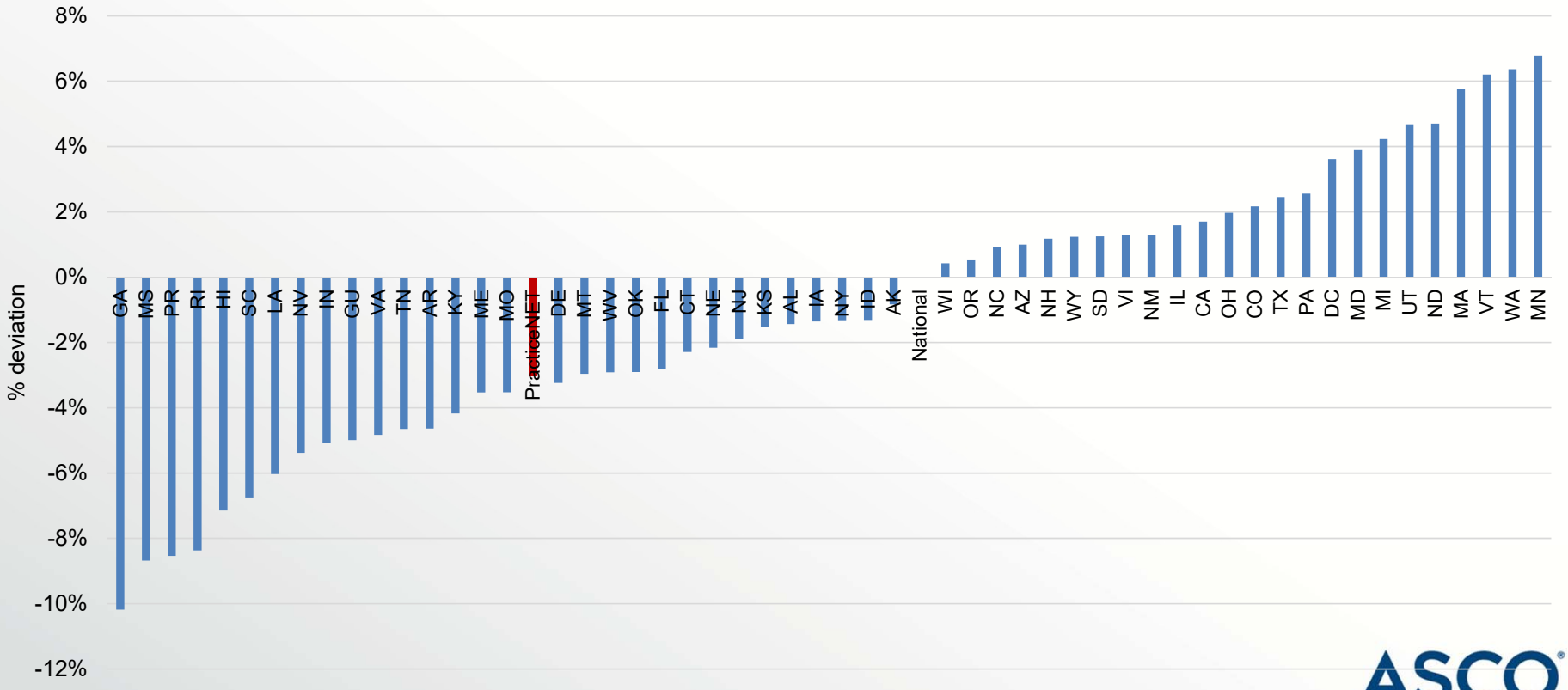
% deviation from national average, weighted average for established patient office visits (99211–99215)



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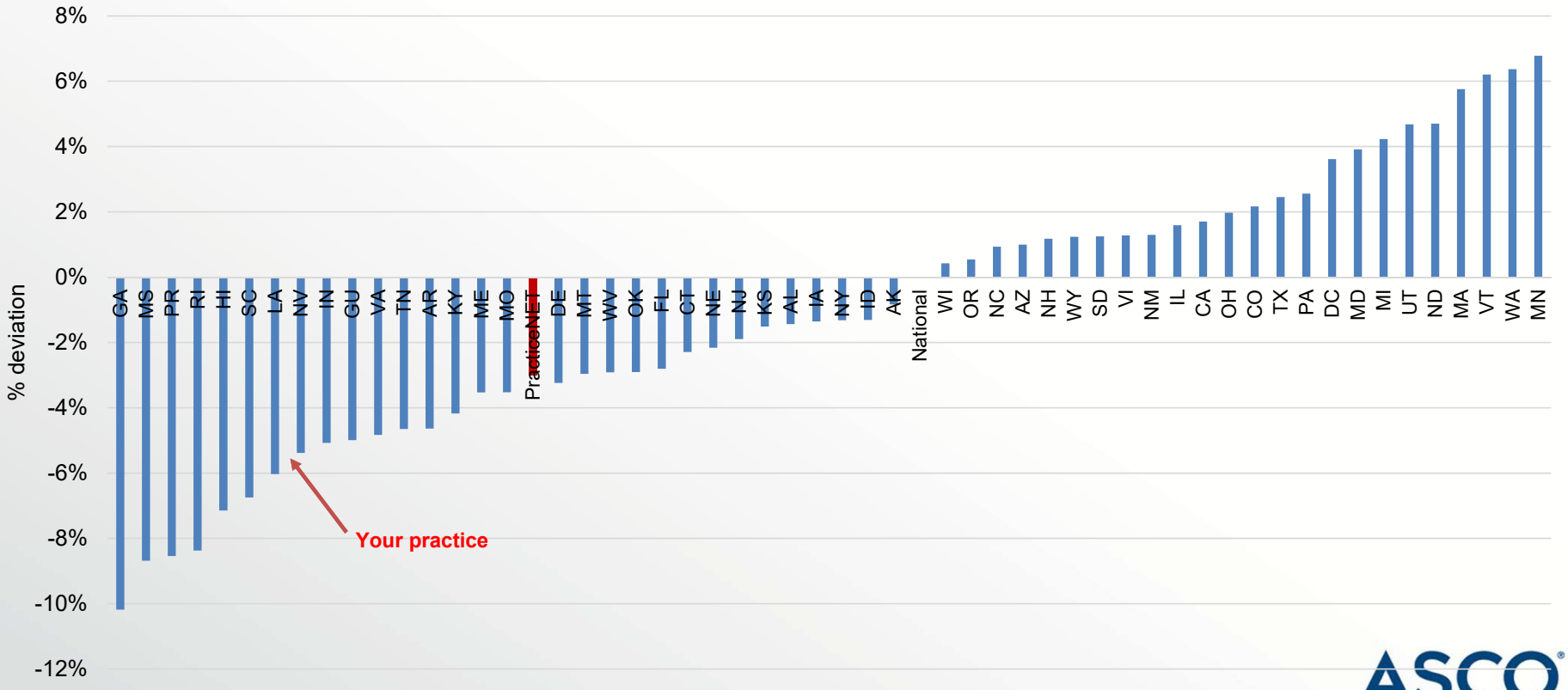
% deviation from national average, weighted average for established patient office visits (99211–99215)



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4 Keys to Physician Productivity

- Looking beyond the wRVU
- Benchmarking…the right way
- Capturing the contributions of Advanced Practitioners
- Using productivity data to elevate strategy

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http://www.hfma.org/Leadership/Archives/2015/Summer/4_keys_to_physician_productivity/

Looking beyond the RVU

- RVUs alone don’t provide a complete picture of performance
- Include other variables
  - Practice revenue
  - Visits
  - Patient contact hours
  - New patients
  - “Panel” size
- Study together to obtain a more complete picture

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Benchmarking the right way

- Benchmarking is a key to having meaningful productivity discussions BUT you must make appropriate use of comparative data
- Ensure that that format, timing, definitions of data are consistent
- Ensure that performance is compared against meaningful and representative peer groups
  - Must be enough similarities between your organization and the source of the external benchmark
  - Are you looking for general benchmarks or specialty-specific benchmarks?

- Medical Group Management Association – smaller physician groups
- American Medical Group Management Association – larger groups
- ASCO – oncology specific, all sizes, all practice settings

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Capturing the contributions of Advanced Practitioners

- Many challenges
  - Direct wRVUs
  - Incident to wRVUs
- May require manual work
- Can you focus on total wRVUs for the combined provider team?

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Using productivity data to elevate strategy

- Productivity data is not just an operational tool
- Productivity data + financial data + market data can provide valuable business insights
  - Consider operational opportunities based on market data (competition) combined with productivity data
  - Consolidate outreach practices?
  - Open new satellite?
  - Reallocate providers based on productivity, patient volume?

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Thank you for caring for people with cancer

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