Are Current Metrics Adequate to Demonstrate the Value of Oncology Advanced Practitioners?

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Presenter's disclosure of conflicts of interest is found at the end of this article.

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Abstract

At JADPRO Live Virtual 2020, Jason Astrin, DMSc, MBA, PA-C, DFAAPA, defined the concepts of productivity and value and discussed strategies for measuring the value of oncology advanced practitioners in order to recognize advanced practitioner contributions to quality care and provide meaningful incentives.

Advanced practitioners drive revenue for oncology practices, but calculating their true value is a complicated proposition compared with other care providers. During JADPRO Live Virtual 2020, Jason Astrin, DMSc, MBA, PA-C, DFAAPA, Director of APP Services, The US Oncology Network, differentiated between the concepts of productivity and value and discussed barriers to accurately measuring the value of oncology advanced practitioners.

PRODUCTIVITY VS. VALUE

Dr. Astrin explained that productivity is the amount of clinical services provided—a professional billing of activity of providers that accounts for the intensity of the work. The Centers for Medicare & Medicaid Services (CMS) has created relative value units (RVUs) to help capture the relative value of clinical services. For any given clinical activity, there is an RVU that is created by combining three factors: work effort (time, skill, expertise, intensity), practice expense (rent, supplies, staff, equipment), and malpractice expense (professional liability insurance).

Dr. Astrin focused on work RVUs to measure and assess the productivity of oncology advanced practitioners. In a fee-for-service world, said Dr. Astrin, if an advanced practitioner bills a Medicare patient under their National Provider Identification (NPI), the dollar reimbursement amount is reduced 15% from the Medicare Physician Fee Schedule, but the work RVU does not change.

"Whether a physician assistant, a nurse practitioner, a clinical nurse specialist, or a physician, the work RVU assigned to a clinical activity remains the same," he said.

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Although work RVU captures the amount of clinical services provided, Dr. Astrin noted that the value an advanced practitioner provides is more difficult to measure.

"Value is what goes beyond costs," he explained. "It's a more qualitative assessment because we're considering efficiency, capacity, and value-based care among other measures."

BARRIERS TO ASSESSING VALUE

According to Dr. Astrin, one of the biggest barriers to assessing value is that approximately 30% of work done by advanced practitioners does not earn work RVUs (Table 1).

"We do a lot of work that isn't always billable, which means there's no dollar amount attached to it," he explained.

Although there are exceptions, advanced practitioners also have little control over volumes. For the most part, advanced practitioners have to see patients provided by their physicians, who are the ones building the practice.

"Because we don't have 100% control over volumes, it isn't fair to evaluate our productivity with that measure alone," he said.

Split/shared service, in which a physician and a nonphysician practitioner each perform a substantive portion of an evaluation/management in the hospital setting, is another barrier to value. An advanced practitioner may round in the morning, examine a patient, and write a note in the chart, said Dr. Astrin, but if a physician reevaluates that patient later in the day, the notes will be combined into a single charge that the physician will submit and receive reimbursement for.

WHERE IS THE VALUE?

In order to illustrate the value of advanced practitioners, Dr. Astrin emphasized measuring increased physician capacity. A physician with a busy clinic who is struggling to take on new patients or bumping follow-ups can offload regular patients onto an advanced practitioner. With openings in their schedule, capacity is suddenly increased, which will ultimately lead to increased revenue and income.

Value can also be calculated via time savings. With surgery and radiation oncology, said Dr. Astrin, advanced practitioners often provide care in long, non-billable stretches for up to 90 days, but this is rarely reflected in the revenue. However, CMS' Radiation Oncology Model (RO-APM) is moving towards bundled, episode-based payments for a number of diseases that radiation oncology treats.

"With this model, radiation oncologists will no longer bill for individual services but will be paid up front with one lump sum," said Dr. Astrin. "They will need to have more time to see more patients and to obtain more 'bundles,' and advanced practitioners can help provide that extra time."

There is also opportunity around the Oncology Care Model, which has been extended another year due to the pandemic, as well as any other value-based care program sponsored by CMS or a commercial payer.

"Much of what is being measured (and ultimately rewarded) is connected to advanced practitioner-led programs, including survivorship, advance care planning, pain management, depression screening, emergency department and hospital utilization, and hospice referrals at end of life," said Dr. Astrin. "These services move the needle of value-based scores, which leads to tremendous rewards from payers."

Finally, the value of advanced practitioners can be seen in improved work-life balance.

"There is a lot of burnout in medical oncology, but advanced practitioners can help reduce some of that stress," said Dr. Astrin.

Table 1. Barriers to Assessing AP Value

- 30% of AP work does not earn wRVUs
- Little control of volumes
- Incident-to
- Split/Shared services
- Value-based care

Note. wRVU = work relative value unit. Information from Ogunfiditimi et al. (2013); Pickard (2014).

CALCULATING VALUE

One of the challenges in capturing value, however, is documenting non-billable work. Using a comprehensive valuation tool that accounts for the weekly time needed to perform prior authorization calls, peer-to-peers, triage, and hospital calls, in addition to billable services, Dr. Astrin and colleagues have created ways to estimate total capacity.

"You're not going to magically create new patients just because you hire an advanced practitioner, but we can calculate incremental revenue and assess the financial impact of time saved," said Dr. Astrin. "Calculating the financial impact of providing value-based services is trickier, especially in a larger practice, but we're working on ways to estimate that too."

The platform created by Dr. Astrin and colleagues tracks advanced practitioners independently, regardless of how their services are reported to CMS. Performance can then be compared among peers.

AP INCENTIVE PLAN

The bottom line, said Dr. Astrin, is that providers must move away from assessing the value of advanced practitioners strictly in terms of productivity. Of most practices that offer an incentive plan, nearly all are rewarding revenue with the expectation that advanced practitioners bill a certain amount, i.e., to cover their costs prior to a bonus payout.

"As we've shown in our discussion of value, however, that's not really fair, and it's not the right way to way to motivate advanced practitioners," said Dr. Astrin. "We don't want our advanced practitioners to be focused on just being busy."

The incentive plan devised by Dr. Astrin and colleagues ties 10% of the bonus to the financial success of the practice, 20% to the productivity (work RVUs) of the team to motivate collaboration, and 30% to the productivity (work RVUs) of the individual advanced practitioner. The remaining 40% of the bonus is tied to objective quality scores.

"Figuring out ways to motivate and incentivize behaviors beyond just being busy has been our challenge," said Dr. Astrin. "The quality piece is a large part of that, but it's still a work in progress." ●

Disclosure

Dr. Astrin had no conflicts of interest to disclose.

References

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