National Practice Benchmark: 2010 Report on 2009 Data

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Abstract

Purpose: Oncology practices continue to experience economic pressures as costs rise, numbers of patients increase, and reimbursements from payers remain flat or decrease. Many practices have responded to these challenges by examining business processes and making changes to improve efficiency and decrease costs. The National Practice Benchmark is a national survey of community oncology practices that provides data for practices to use in managing today's challenging practice environment.

Methods: Oncology practices were invited to participate in an online benchmarking survey. One hundred eighty-nine practices from 44 states responded to the survey, and demographic, operational, and financial data were collected for calendar year 2009 or the most recently completed fiscal year.

Results: Data from 2009 were compiled and compared with previously collected 2007 and 2008 data. The data reveal that total revenue has increased by approximately 6% per year over this 3-year period. During the same period, however, cost of drugs increased dramatically: 13.5% increase from 2007 to 2008 and 16% from 2008 to 2009. Total practice expense increased at virtually the same level as drug costs in 2008 and was flat for 2009.

Conclusion: Survey results indicate an overall lowering of practice expenses even as cost of drugs continues to rise, and are consistent with the slight increase in the number of new patients per full-time equivalent hematology/oncology physician. These measures indicate an overall increase in service delivery efficiency and adaptation by many practices to the changing practice environment.

Introduction

The *National Practice Benchmark: 2010 Report on 2009 Data* (NPB) presents results of the fifth annual benchmarking survey developed and conducted by Oncology Metrics, a division of Altos Solutions (Los Altos, CA). Benchmarking is widely recognized as the best, most efficient way to find opportunities to improve your practice and to monitor progress after corrective action is taken. The NPB provides important and meaningful data for oncology practices to use for effective management in today's challenging practice environment.

The trends presented in Figure 1 show a moving picture of what has changed, what is changing, and what is holding constant in the evolving business model of medical oncology service delivery. This graph tracks total medical revenue, total practice expense, and cost of medical and surgical supplies (primarily drugs) from 1991 through 2009. The difference between the blue line, total medical revenue, and the red line, total practice expense, is an approximation of the amount of money that is generated to pay both for physician labor and as a return on the risk of business ownership by the physician owner/operator. After years of steady and predictable performance, this gap began to expand in 2001 and continued to do so until 2007. However, from that time on, the gap has been narrowing. Much of what is presented in this benchmarking report can be seen as the business unit shift toward efficiency, that is, a lowering of cost of operations even as the cost of drugs rises. That efficiency can take the form of the hematology/oncology physician doing more clinical work, thus more efficiently utilizing the most valuable resource of the practice.

Methods

Medical oncologists, practice administrators, and other key staff members from approximately 2,000 practices across the

country were invited to participate in the NPB. Practices that completed the entire survey received an electronic version of the complete survey report as well as a personalized report comparing their practice to the entire data set on several key benchmarks. In addition, the first 65 practices to complete all applicable questions received a \$25 gift card. Practices were invited to participate via e-mail, and the survey was completed entirely online. Practices were instructed to submit only one survey per practice.

The NPB survey instrument requested data from calendar year 2009 or the most recently completed 12-month accounting period. Practices were not required to complete all questions, and data from incomplete surveys are included in the final survey results.

All submitted responses are reported for the qualitative information collected in the survey such as practice demographics and operational issues. Quantitative benchmarks, however, are reported only for practices that met specific exclusion criteria. To be included in the level 1 quantitative benchmarks, practices had to submit the following data elements:

- Number of full-time equivalent hematology/oncology physicians (FTE HemOncs)
- Total revenue
- Cost of goods paid for (COGPF)
- Number of office consultations and new patients
- Number of hospital consultations

Exclusion criteria were then applied as follows:

- Practices reporting higher drug revenue than total revenue
- Practices reporting higher COGPF than total revenue
- Practices reporting drug revenue less than 0.5% or more than 1.5% of COGPF

Sixty-five practices with 556 FTE HemOnc physicians met these criteria and are included in the level 1 analysis. Additional exclusions were applied to specific benchmarks for data outside the range of credible values.

All practices that qualified for level 1 were also considered for level 2 benchmarks, which include staffing and productivity, inventory, and closed-door pharmacy. Only practices that provided complete and reasonable data were actually included in the level 2 reporting.

Results

Demographics and Practice Operations

A total of 193 survey responses were submitted; four were deemed to be duplicates and were discarded. Responses were received from practices in 44 states. Five states—California, Florida, New Jersey, New York, and Texas—had more than 10 responses; five additional states—Georgia, Illinois, Michigan, Ohio, and Washington—had between five and 10 responses. Each of the remaining 34 states had fewer than five responses. Respondents were asked to indicate their role in the practice, and responses indicated that surveys were completed by practice administrators/office managers (63%), physicians (11%), billing manager (7%), nurse (5%), chief financial officer (4%), and others (10%).

A wide range of services were reported by the survey respondents, with medical oncology (184) and hematology (182) as the most prevalent. Other services include laboratory (142), clinical research (117), imaging (60), genetic counseling (59), closed-door pharmacy (50), radiation oncology (43), gynecologic oncology (23), surgical oncology (11), and other (28).

Figure 2 shows practice structure as reported by survey respondents. Consistent with previous NPB reports, physician-owned oncology practices represent the majority of respondents, but it is interesting to note that this percentage has decreased from 87% in 2007, to 74% in 2008 and 71% in 2009. This is consistent with anecdotal reports of changes in practice structure across the country. Respondents were also asked how long they expect their current practice structure to remain unchanged and viable; 31% responded either “for another year or so only” or that their practice structure is changing now. These results are presented in Figure 3.

Respondents were also asked to indicate the percentage of Medicare patients in their practice without secondary insurance coverage and were instructed to provide an estimate if the actual number was not available. There were 163 responses to this question, and more than 50 practices indicated that 10% or more of their Medicare patients do not have secondary insurance coverage. In addition, 30% of respondents (n = 152) reported referring more than 100 chemotherapy visits outside of the office for financial reasons in 2009.

Figure 1. Oncology business trends per full-time equivalent physician. Data from 1991 to 2003 compiled from Medical Group Management Association (Englewood, CO); data from 2004 to 2009 from Oncology Metrics, a division of Altos Solutions (Los Altos, CA).

Figure 2. Practice structure (N = 189).

Figure 3. Practices' response to the question asking how long they expect their current practice structure to remain unchanged and/or viable. (N = 189).

Level 1 Quantitative Benchmarks

Reporting on quantitative benchmarks was limited to practices that submitted the minimum data elements outlined previously. Exclusion criteria were then applied to the data from these practices to ensure the validity of the responses. This resulted in sixty-five practices with 556 FTE HemOnc physicians being included in the level 1 quantitative benchmarks.

New patient flow into a practice is an important measure of demand for services and is used to assess productivity of the practice. This is essential for strategic planning. Dividing the number of new patients (demand) by the number of physicians (supply)

Figure 4. Number of consultations and new patients per full-time equivalent hematologist-oncologist (FTE HemOnc).

produces a measure of physician productivity, as shown in Figure 4. Practices reported the number of procedure codes for hospital consultations, office consultations, and office new patients for the 12-month period. Procedure codes were totaled, then divided by the number of reported FTE HemOnc physicians, and this was reported as new patients per FTE HemOnc. The average for 2009 is 389 new patients per FTE HemOnc, up slightly from 378 in 2008. It is interesting to note that approximately two thirds of the consultation and new patient visits took place in the office setting.

Another important measure of productivity is the number of established patient visits per FTE HemOnc. The average number of established office patient visits (Current Procedural Terminology [CPT] codes 99212 to 99215) was 2,904; the average number of established hospital patient visits (CPT codes 99217 to 99220, 99221 to 99223, 99234 to 99236, and 99238 to 99239) was 800. It should be noted that these numbers include services rendered by nonphysician practitioners and billed incident to a physician service.

Total medical revenue and total operating expense are among the most important data that oncology practices monitor on a regular basis. Figure 5 shows 3-year trends for these important metrics as well as the COGPF. Total medical revenue is defined as all revenue collected in the period for the provision of medical goods and services. This does not include nonmedical revenue, which is defined as revenue earned for services other than the provision of medical care. Total operating expense is defined as all cash expenses for the period except for W-2 physician compensation. COGPF is defined as the total of all money paid for drugs in the period less rebates or

Figure 5. Three-year trend in total revenue, total practice expense, and cost of goods paid for (COGPF). Percentages represent change from one year to the next.

other cash reductions received in the same period. Each of these data elements is reported as the average per FTE HemOnc.

It is interesting to note that total medical revenue and total operating expense track one another through the 3 years, but COGPF increases in each year. The decrease in total operating expense that we see between 2008 and 2009 was achieved even with a continued rise in drug costs. We believe this indicates an overall lowering of the cost of practice operations even as the cost of drugs continues to rise, consistent with the slight increase in the number of new patients per FTE HemOnc. These three measures indicate an overall increase in service delivery efficiency.

Level 2 Quantitative Benchmarks

Practices that qualified for level 1 are also included in the level 2 benchmarks, which include staffing, productivity measures, closed-door pharmacy, and inventory.

Although total practice expense remained flat in 2009, which we believe indicates more efficient practice operations, the number of FTE staff per FTE HemOnc is consistent with that reported in previous years. We define FTE staff as all staff working in the hematology/oncology line of business for the practice. All staff members are counted, including nonphysician practitioners but not including physicians. Radiation oncology staff and staff working in other lines of business are likewise not included. The average number of FTE staff per FTE HemOnc for 2009 is 8.3. This compares with 8.7 in 2008 and 8.4 in 2007. Clearly the overall number of staff is not the focus of practice efficiency measures.

In addition to FTE staff, we collected data on several specific staff categories including nonphysician practitioner, executive, chemotherapy administration, billing, patient financial advocate, laboratory, and research. Data on compensation for each of these staffing categories were also collected and reported back to the practices that provided complete data sets.

Chemotherapy administration staff are defined as all staff responsible for drug purchasing, mixing, delivery to patients, and management of these processes. This staff category includes pharmacy and nursing personnel as well as nonclinical personnel if they are responsible for any of the listed tasks, particularly drug purchasing. Survey participants were instructed to report the percentage of time all staff spent on these activities. The average number of FTE chemotherapy administration staff per FTE HemOnc for 2009 ($n = 62$) is 1.9 and is identical to that reported for 2008.

Patient financial advocate is a new staffing category that was added to the NPB this year and is defined as all staff involved in the financial advocacy or financial counseling process in the practice. The average number of patient financial advocate staff is 0.33, with 51 practices reporting. These staff may have been included as billing staff in previous data collections. The number of FTE billing staff per FTE HemOnc in 2009 was 1.2. This is a slight decrease compared to the 1.33 reported in 2008.

Another new benchmarking category this year is closed-door pharmacy, which is defined as a pharmacy that provides services to patients and employees of the practice but is not available to the public at large. Operation of a closed-door pharmacy is

Figure 6. Change in inventory as a percentage of cost of goods paid for.

Figure 7. Number of business days sales outstanding.

regulated by each state and may not be permitted in some states. Practices are cautioned to fully investigate state laws before considering adding this service line. In the qualitative data, 50 practices report operating a closed-door pharmacy. In the level 1 quantitative data set, 32%, or 21 practices, reported having closed-door pharmacy, and 17 practices provided financial data. In this small data set, it appears that practices are able to add some revenue to the practice bottom line through this new line of business.

Many practices have made strategic decisions to decrease drug inventory levels in their practice because of a variety of payer and reimbursement issues. In the NPB data request, practices were asked to report beginning and ending inventory levels for the 12-month period. With 51 practices reporting, Figure 6 shows the change in inventory as a percentage of COGPF for the 12-month period. Practices have been successful in decreasing inventory. This frees up capital that was formerly invested in pharmacy inventory and demonstrates an increase in the efficient use of capital rather than an increase in productive capacity.

Another important metric for managing any business is days sales outstanding. This is the time that it takes to collect from various payers (and patients) for services that have already been provided. It is calculated by dividing net accounts receivable by average collections per business day. Net accounts receivable is the total accounts receivable on the books of the practice less the yet to be applied contractual allowances due to those accounts, and less an allowance for bad debt. For this calculation, we used 254 business days per year; 60 practices are included in this data

set (Figure 7). The average number of days sales outstanding for 2009 is 32.

Conclusion

There are many examples across the country of oncology practices struggling financially, merging with other organizations, and even closing, but we believe the data presented here indicate that the business operation of oncology practice is becoming more mature, efficient, and self-aware. This is evidenced by the improvement in several of the metrics presented here and, to a small extent, by the number of survey participants who were willing to share information and the quality of data that they were able to provide. This indicates a broader understanding of the use and importance of peer-to-peer benchmarking. Several years ago, we introduced the concept of a Standard HemOnc and defined it as a medical oncology or hematology/oncology physician who sees 350 new patients per year. At the time we proposed that convention, there were many who considered it an extremely high number. In this survey that standard has risen to 389, quite a remarkable gain in productivity. Knowledge of objective standards drives gains in productivity in an environment where such gains are rewarded.

Just as computerized practice management systems have streamlined the processing and measurement of billing and collection operations, so too will the adoption of electronic health records allow for similar improvements. Health care reform seeks to promote measurement of clinical activity—the way similar patients are treated and the outcomes of that treatment. When we are able to report clinical benchmarks, we can reasonably expect gains in quality and efficiency there too. Then we will be truly advancing our ability to take care of individual patients as well as sustaining our economic capacity to take better care of more people living with cancer.

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Authors' Disclosures of Potential Conflicts of Interest

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