


# Challenges in Reimbursement: Communicating Non-reimbursed Costs to Payers

We present a case where an oncology practice and a payer worked together to define pay-for-quality and suggest potential solutions regarding non-reimbursed time and services.

By Bryan Cote





**F**or all the losses piling up for oncologists in reimbursement battles with managed care, a quiet victory was seen last year in Royal Oak, Michigan in what may have been an early sign of momentum in the pay-for-quality movement. At issue was how the oncology community—faced with significant changes in Medicare and private payer reimbursement—could better track its uncompensated time and communicate those non-reimbursed costs to the payer community. The non-reimbursed services at issue which oncology practices provide include:

- Conducting symptom management and phone triaging to prevent unnecessary emergency room (ER) visits.
- Handling calls and follow-up work required by health plans denying prescriptions.
- Managing diversion of recommended treatments from clinic to specialty pharmacy.
- Dealing with patients who use mail order pharmacies and bring their cancer care drugs to the office for mixing, at which time the office practice staff must verify drug doses/amounts and assess whether the patient received the complete prescription.

At least, for one group, an answer to the non-reimbursement dilemma began to unfold last summer when BlueCross BlueShield (BCBS) of Michigan announced its plan to lower reimbursement rates on 35 of its 75 oncology drugs starting September 2006.

The staff at Cancer Care Associates, P.C. an oncology-hematology practice with seven physicians and four mid-level providers in Royal Oak said the cuts would elevate their costs above payments; in response, the group implemented a three-step plan to stymie the rate decrease and illustrate their value in numbers that were real. The steps Cancer Care Associates took included:

*Step 1: Built a quality pilot.* “We first contacted [BCBS] in July and asked if they would work with us in a kind of pilot program so we could prove to them that we provide high-quality care at a low cost,” said Practice Administrator Linda Richards, MHA. “We hoped the program could be a model to pay us more, but be rolled out statewide.”

Receptive to this idea, BCBS formed a committee that agreed to contact every oncologist in Michigan to gauge interest in a gain-sharing program. Oncologists, in this type of program, would have the option to [cont. on pg 38 >>](#)

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work with BCBS to identify cancer care quality variables to measure, and then evenly split all cost savings with BCBS. According to a BCBS spokesperson, oncology groups have expressed interest in the gain-sharing concept; the program could begin this year.

*Step 2: Kept people out of the hospital.* While awaiting BCBS's response on the gain-sharing pilot, Cancer Care Associates organized an independent, prospective study—funded partially by BCBS—to measure how its triage nurses could keep patients out of the hospital. To keep the study independent, Cancer Care Associates hired a statistician from an unaffiliated local hospital to conduct it. The goal of the study was to educate BCBS on how much in cost nurse phone triaging could save payers; and Cancer Care Associates hoped the results would prompt BCBS as well as other payers to reimburse oncology providers for what is currently an uncompensated service.

Results were promising and Richards reported saving BCBS about as much as \$600,000 in the 2-week study period. Broken down, Cancer Care Associates reported the following to BCBS:

- Received 101 script refill requests through non-reimbursed nurse triaging. Nurses handled all 101 requests via phone, avoiding office visits. This saved the practice \$26,000 to \$52,000, based on \$25 to \$50 per office visit, and saved BCBS \$100,000 to \$200,000 in coinsurance payments.
- Received 66 symptom management calls, avoiding office visits. This saved the practice \$51,000 to \$102,000, based on a \$75 mid-level provider fee or \$150 physician fee, and saved BCBS \$200,000 to \$400,000.

The numbers caught the attention of BCBS and discussions have begun to roll out the study into a larger initiative. This may be helpful to other oncology groups as they assess how to communicate their value to payers.

*Step 3: Illustrated costs vs. reimbursement.* Despite Cancer Care Associates's strides, providers in Michigan still faced the 35-drug reimbursement cut. A spokesperson from BCBS confirmed that they spend about \$200 million a year per year on chemotherapy drugs and other ancillary drugs related to cancer care. With costs this high, BCBS of Michigan regularly reviews its drug fee reimbursement in an effort to align with provider acquisition costs for the products they need. In 2006, four growth factors—Neulasta®, Procrit®, Neupogen®, and Aranesp®—as well as Herceptin represented a large portion of these total oncology payments.

Richards noted, “But we were following NCCN® and ASCO guidelines. When you look at this retrospectively you can see [that our physicians] were writing appropriately.” For example, Richards argued that back in November 2006, 40 opportunities were missed where Procrit/ Aranesp could have been given, according to the guidelines, “but our physicians decided not to prescribe them for various reasons.”

Although Richards' guidelines' argument failed, BCBS reversed its planned reimbursement cut after she sent the payer a simple presentation of cost versus reimbursement. She developed a chart showing actual drug costs in one column that included taking inventory of items and compared the costs to reimbursement by national drug code.

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“It was one way of showing [BCBS] what we had been monitoring in terms of non-reimbursed services and putting it in numbers the payer could understand,” she said.

Richards’ process worked. BCBS of Michigan raised the reimbursement on the 35 drugs so that Cancer Care Associates—and all oncologists in the state—could make a small profit on them.

The national payer community would welcome such proactive efforts. Some medical directors want the oncology community to unite behind a pay-for-performance model that can work for their specialty.

#### Uniting Behind a P4P Model

Dr. Don Stangler, Medical Director for Oxford/United, said he supports oncology doctors in finding ways to communicate their non-reimbursed time and services. He cited a doctor who, in recent years, had reduced admissions due to complications by more than 50%.

“He had 24 admissions due to complications in 2004, 26 in 2005, and six in 2006,” said Dr. Stangler. How did the doctor improve? “He instituted a program so that any patient beginning chemotherapy had to take a chemotherapy complication class,” reported Dr. Stangler. “I would pay for these results. That’s demonstrating performance beyond the usual things we hear.”

However, it seems a disconnect exists between payers and providers; and some obvious misconceptions remain about how a practice treats the patient with cancer.

“One medical director in Connecticut told me he was willing to pay a provider to conduct disease management (DM) in oncology, maybe \$75 a month per patient,” recalled Dawn Holcombe, Executive Director of the Connecticut Oncology Network. “But the provider was already completing DM without reimbursement. The medical director listed off his definition of DM—things like in-bound call education and counseling—and he had no idea the practice already did these things. His perception was that most oncology practices weren’t doing DM, so he was willing to pay an outside DM group \$300 per patient, per month to handle it.”

#### Solutions on the Table

Several oncology groups have suggested that payers give additional reimbursement to groups that keep a denial rate of zero on Herceptin. “We’ve seen a 50% reduction in the recurrence rate with this drug, but we have to jump through all these prior authorization (PA) hoops,” said Pam Rose, RN, who works part-time for three oncology groups in the Charlotte, North Carolina, area.

“I have no philosophical objection to that; it’s a great idea,” said ConnectiCare’s Medical Director Ron Blumenfeld, MD, although he noted that prior authorization has been a useful tool in slowing down cost trends and preventing over-utilization. The bottom line is, how can oncology monitor and communicate its non-reimbursed quality services on its own terms, and should it?

Here’s one possible solution: A four-site oncology practice in New Jersey that asked not

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to be named for this article logged its incoming phone calls over a 5-day period. The practice received 500 calls, and from those calls, 25 people were brought in for evaluation and management of their cancer. From the remaining 475 people, the practice staff addressed questions by phone. Eight patients in all were sent to the ER, and 14 were admitted to the hospital. But not a single call was billable from this study.

This is interesting, said Dr. Stangler, because “This is the example of a measure that can show good outcomes and savings.” An average ER visit is \$300, and an average hospital admission is \$13,000.

## Communicating Value in Tough Circumstances

Among the few practices making strides on the quality front, which have nonetheless faced roadblocks is Wilshire Oncology Medical Group, Inc., a large practice in Pomona, California.

Wilshire faces many of the same non-reimbursement issues—for example, patient access—as other groups. Chief Executive Officer Steve Balalian said that Wilshire’s practice could be consolidated into one location if it were located in the Midwest. But Balalian points out that, since in Southern California time is measured by distance, Wilshire has set up multiple centers. “This multi-site approach has added space and inventory costs and better access for patients, but there’s no code for inventory costs,” he said.

Investing in an electronic medical record (EMR) system allowed Wilshire to track the number of incidents for breast and kidney cancers by stages for a 3-year period. Data was then presented to its delegate group. Unique to California, this group intended to use this

data to begin a dialogue with California health plans about the financial savings and quality services that practices like Wilshire could generate on a plan’s behalf.

However, the message had a funny way of getting lost in translation.

“One delegate group that represented several large health plans fired us because we were emphasizing quality too much, and they felt that wasn’t what their plan clients wanted to hear,” said Balalian. “We told them, ‘we can help you reduce costs if we do things based on our data and catch patients at early stages and treat appropriately so that the patient doesn’t end up in the long-term care or hospital setting.’ Payers will eventually avoid paying additional costs, but that message is tough to convey.”

California is a difficult market for sure, but communicating your value doesn’t have to be so hard. Even small practices can do this, noted Holcombe.

Dr. Leonard Horowitz’s solo oncology practice in Cincinnati, Ohio, is interested in gaining reimbursement any way it can, but this is a challenge with 80% Medicare patients, limited resources and no leverage.

“We handle about 30 phone calls a day triaging patients, and we spend a lot of time adjusting medications, treating patients over the phone, and definitely keeping people out of the hospital,” said oncology nurse and nutritionist Cheri Speicher, RN, OCN.

Practices so heavily reliant on Medicare are in a tough spot. Horowitz’s practice has tried Medicare’s competitive acquisition program (CAP). “But this simply put a Band-Aid on a hemorrhage,” said Dr. Horowitz.

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### Getting Started: Tracking Non-reimbursed Time

For practices that have yet to begin monitoring their services as part of a larger pay-for-quality initiative, here are some start-up recommendations:

- Start measuring the data that might resonate with payers, for example, patient satisfaction. If you haven't measured it, develop a survey that asks patients questions, such as: How long did it take you to get an appointment? Do you feel you understand your treatment?
- Add measures for your patient-care mix, severity mix, and eventually you may measure the average cost of care for breast cancer and admission, non-admission, and re-admission rates for different diagnoses.
- Consider a simple one-week study by counting the number of calls that come into the practice, the reason for the call, the time spent on the call, and the action taken (i.e., appointment, pharmacy adjustment). Include a column for hospital admissions and note callers who did not go to the hospital.

If there's one universal goal of any tracking program it's to help providers and payers and government programs like Medicare join the same huddle.

"Health plans haven't had access to quality measures," said Balalian, "except through claims data from providers. But these don't help the payer understand the clinical quality perspective. The plans look at claims based on encounters and they sometimes reach some incorrect conclusions from this."

### What—and Whom—to Monitor

Wilshire Oncology tracks five services in hopes of elevating quality of care and, at least, cover its costs. "We track these services in terms of hours and communicate our findings," said Balalian.

Here are some recommendations that are based on Wilshire's approach:

**Nursing Personnel:** Administer a questionnaire in an EMR system for your nurses to use. This questionnaire can help track additional follow-ups, administrative tasks and calls, and record the time it takes to accomplish these tasks. Next, convert these hours into costs and report the non-reimbursed expenses, which can be rather significant and costly to a practice.

**Front Office Staff:** Track the phone work completed by office staff who schedule, negotiate and oversee prompt scheduling of tests and consults for your patients to ensure the best care.

**Back Office Staff:** Track the hours associated with handling payer utilization/authorization requirements. Balalian said, "None of these additional tasks/resources are reimbursed, but we must provide them in order to get the right care for our patients."

**Billing and Collections:** Track the cost of carrying and managing additional accounts receivable. For example, monitor the hours and payments your practice may incur to staff or pay for additional billing and collection resources in order to chase after claims. Your state may have prompt payment laws, but you may still have significant claim payment delays and related costs, none of which are reimbursed.

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Doctors/Mid-level Providers: Monitor phone calls and correspondences/letters from physicians and nurse practices. This additional work by your providers is typically in response to payer groups seeking to justify medical necessity of care.

## What Payers Want from Providers

“We want to pay for performance improvement,” said Dr. Blumenfeld from ConnectiCare. “I would want to ask even physicians performing at a high level to improve.”

That’s difficult today for practices who say the time-consuming prior authorization process hampers their growth. Dr. Richard Heller, a practicing oncologist in the Wallingford, Connecticut area thought the 1%-2% bonuses currently available under Medicare’s P4P initiative aren’t worth it. Anthem, United, and Aetna represent only about 30% of my patients in total,” he said. “I’ll say goodbye to these insurers if the [prior authorization] situation doesn’t improve.”

Interestingly, PA challenges have forced Dr. Hervey Weitzman’s oncology practice in Trumbull, Connecticut, to consider a process of tracking and communicating the savings they generate for payers and for the healthcare system at large.

“We had our PA denied on Avastin® even though we had the documentation saying the payer would approve it. They told us that even if they grant a PA, it’s no guarantee they’ll pay for the drug,” said Geri Scott, billing manager. “We need to find new ways to communicate what we do.”

Dr. Ellie Seiler, Anthem’s Medical Director suggested making the state quality improvement organizations (QIO) serve as aggregators of information. In this arrangement, physicians’ offices would fill out a form with a core set of measures and send it to their state QIO or some other aggregator. The form would be transmitted to each payer, and the plans could then select the measures that they would use for payment. One of the values of having all of the data aggregated is that physicians and payers could really learn something about a practice, thereby improving outcomes and saving the system money, said Dr. Seiler. This information could then be made available publicly.

## Does the discussion have to be about the dollar?

Yes and no. Job one, according to Balalian, is for the oncology community to get a voice at the table to help payers define the measurement tools. However, the oncology community may want to keep reimbursement out of its initial conversations with payers and let their data tell their story. **BC**

**Bryan Cote** is editor of *Medicare & Reimbursement Advisor Weekly*, a service which provides first-hand reports and analysis about how Medicare Part B and D, long-term care and managed care reimbursement decisions affect access to drugs and biologics. He authored the report, *The Impact of Cancer Care’s Potential Shift to the Hospital Outpatient Setting*, 1st Edition. E-mail Bryan at [bcote@hcpro.com](mailto:bcote@hcpro.com) for a free trial or more information. Mention *Oncology Business Review*.

*“We had our PA denied on Avastin® even though we had the documentation...”*

## >>OBR DAILY NEWS FLASH

Analysts are bullish on a likely competitor to Merck’s high-profile HPV vaccine to prevent cervical cancer, Gardasil®—Glaxo’s experimental vaccine, Cervarix™, is poised for an FDA filing in the near future. (*CNNMoney.com*, 3/12/07).