

ERA-Based Data and Oncology Products: An Opportunity for Practices to Maximize Cash Flow

by Bobbi Buell, MBA, Principal, onPoint Oncology, LLC

The Healthcare Portability and Accountability Act (HIPAA) of 1996 has been rough for providers both in terms of the privacy provisions and the provisions related to fraud and its prosecution. However, one positive innovation has emerged due to HIPAA—managing cash flow and analyzing paid claims due to electronic remittance advice (ERA)-based databases.

De-identified, aggregated data afford drug and device companies the opportunity to see exactly how private insurance companies are paying out for the use of products. At onPoint Oncology LLC, we have found that ERA-based databases are providing solutions for most practices that can have an instant payback by bringing insurance denials down from 11%-12% to a manageable number of, say, less than 5%. Overall, this reduction in denials is allowing providers and payers to look carefully at the causes of delays and rejections, which is leading to greater efficiencies and lower operational costs.

Healthcare companies, such as oncology pharmaceutical manufacturers particularly in this era of healthcare reform, need the opportunity to notice if practices and other providers are actually meeting costs for their products. The ERA database can be a common ground for discussion as to fair utilization and payment of services.

Today's Processing Environment

In 2005, the nation as a whole (government, private sector, consumers) spent \$2 trillion, or approximately \$6,697 per capita, on healthcare expenditures—roughly 16% of the GDP. A report from the Centers for Medicare and Medicaid Services indicates that by 2016, overall medical expenditures are projected to be approximately 19.6% of the GDP, or \$4.1 trillion. According to these projections, the enormous burden on both payers and providers will more than double within this 10-year period.

Moreover, oncology costs have been rising faster than healthcare costs overall. Five years ago, can-

cer drugs accounted for 13% of what was spent on medications. This year, that spending may reach 22%. As both payers and providers struggle to cope with future demands of cancer care, there is a need to streamline the medical payment process and to control the cost/quality relationship of treatment.

HIPAA set mandatory standards for electronic data interchange (EDI) for all healthcare transactions, including inbound claims (ANSI X12 837) and remittance advice (ANSI X12 835) transactions. This trend will continue in 2012 with the establishment of ANSI X 12 5010, sometimes known as "HIPAA 2". According to this Congressional mandate, if a health-

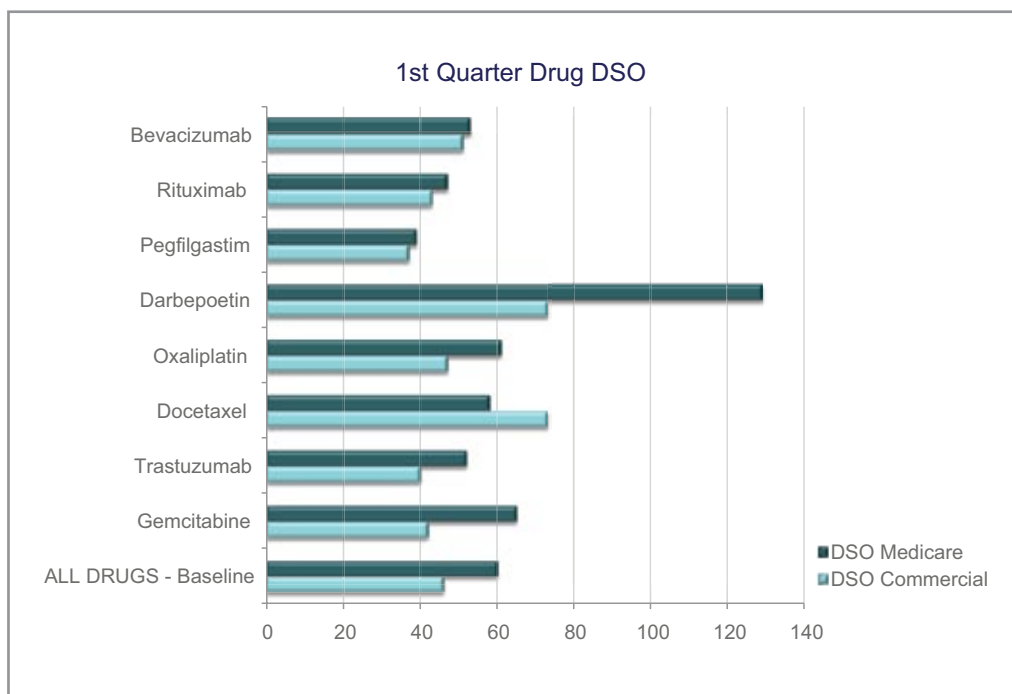
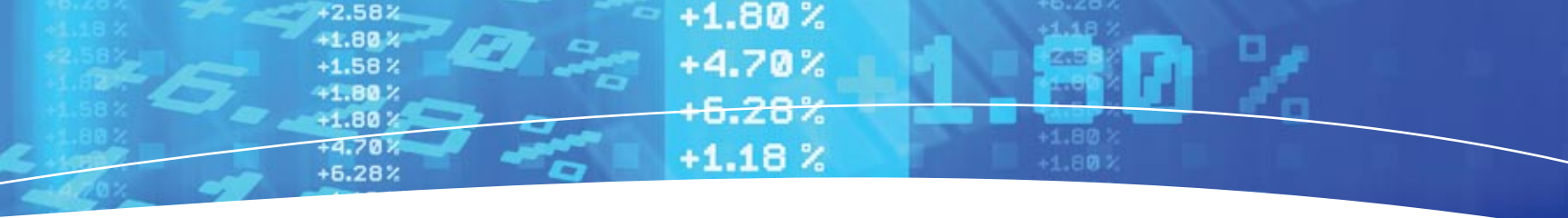


Figure 1. Q1 '09 Days Sales Outstanding (DSO) for Top 10 Billed Drugs. Source: Adapted from RemitDATA Inc. All Rights Reserved.



care provider requests electronic data exchange with a payer (including remittance advice), the payer must honor that request. Most large payers are already compliant with this requirement, but smaller plans and Independent Practice Associations (IPAs) may not be.

Until recently, the health insurance industry and providers have been slow to adopt ERAs, partly due to the fact that many claims-processing systems in physician offices cannot handle the files for seamless cash posting. Electronic claims (837s) submission rates are quite high, but the adoption of 835 databases has been lower because many billing systems do not offer the reporting capability. Thus, there are freestanding, non-billing vendors in oncology who offer tools for ERA data analysis—RemitDATA Inc., Memphis, TN; P4 Healthcare, Ellicott City, MD, and McKesson Specialty Care Solutions, San Francisco, CA.

Challenges for Oncology Payers and Providers

With the decline in drug reimbursement from many insurers, most notably Medicare, cash enhancement tools are necessary to run an economically viable oncology practice. Understanding the reasons why claims get rejected and then rectifying these problems can result in a direct infusion of cash for providers. According to RemitDATA, in the first quarter of 2009, the Days Sales Outstanding (DSO—days from date of service until insurance payment) in oncology for the Top 10 Billed Drugs was alarmingly high (see Fig 1).

Armed with this detail of information, providers can enjoy better clarity and faster turnaround time in the processing of payment information. Additionally, providers can benchmark their practices against others and identify problem products in an attempt to obtain better financial results. Pharmaceutical manufacturers can also use this information to monitor activity and focus their efforts on exactly where payer problems are and fix them in real time. In addition, foundations and other organizations can also be properly funded to ensure that uninsured and underinsured patients are supported.

Last year, the American Medical Association (AMA) published the exhaustive National Health Insurer Report Card (NHIRC) that states it “is to provide physicians and the general public a reliable and defensible

source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying these claims. Billions of dollars in administrative waste would be eliminated each year if third-party payers sent a timely, accurate and specific response to each physician claim.”

Therefore providers, through their professional organizations such as the AMA, are encouraged to call payers to task for claims delays and denial tactics so they’re diminished over time. ERAs can help providers keep the score. Figure 2 illustrates the denial scores for oncology in the Q1 ’09.

While these denials are hardly earth-shattering, the march of private payers to average selling price has instigated razor thin drug margins in [cont. on pg 28 >>](#)

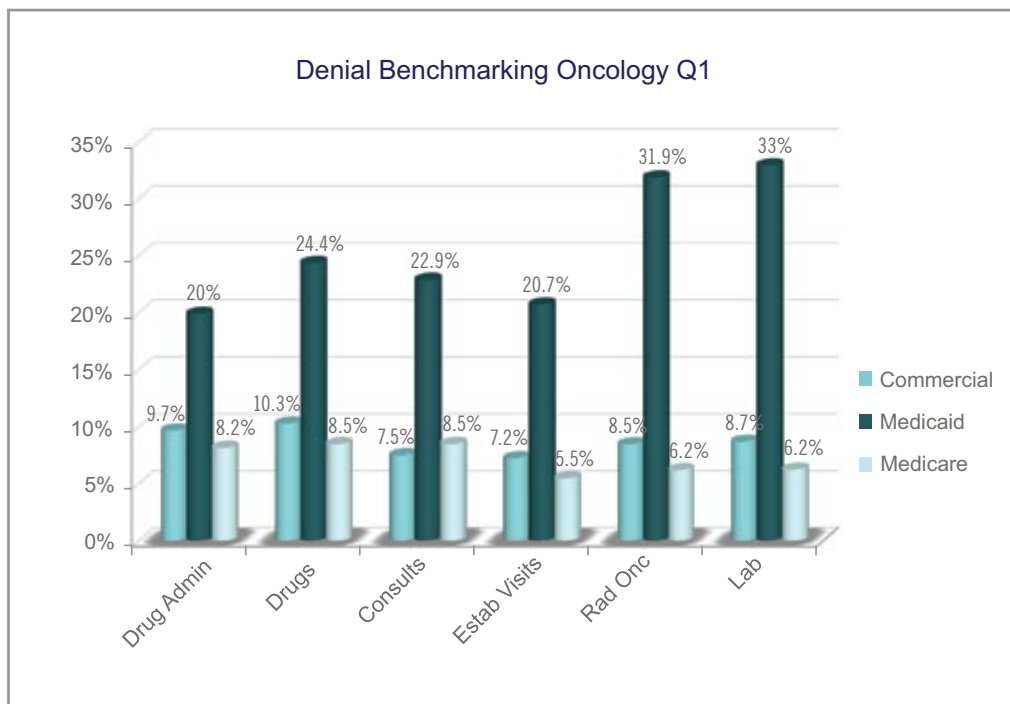


Figure 2. Denial Scores in Q1 '09. Source: Adapted from RemitDATA Inc. All Rights Reserved.

many cancer facilities—both office and hospital-based. A loss due to denials of 8% of drug revenue for the average \$10-\$15 million in collected drug revenue can be \$800,000-\$1,200,000. We do not expect the denial rate to drop to zero, but if it goes to 6.8% which is the Medicare line-item average, it can mean an extra \$100,000 for a three or four provider facility.

When we drill down further into the actual drugs that are most commonly denied, we see alarming trends associated with important and expensive medications (see Fig 3).

If community cancer care is going to survive, close monitoring of this data must occur for providers, payers, and cancer companies.

Product Performance and ERAs

Aggregated data from ERAs can provide valuable information to other

oncology stakeholders which had been previously unavailable to them. Matching an ERA database with diagnosis data from claims or from a registry database enables both payers and providers to assess the quality and costs of care in terms of:

- *Longitudinal analysis of actual payments for a spell of illness:* For example, a patient comes in for breast cancer immediately following surgery and undergoes chemotherapy. Her payments can be totaled and compared with all other breast cancer patients in a similar situation of her age group and geographical region. In addition, patients can have a better idea what their projected costs of care will be.
- *Compliance with accepted regimens:* Pay for performance incentivizes physicians to treat in a standard way depending on the patient's age, co-morbid conditions, and

stage of illness. With paper-based systems, there's no way for a group to assess compliance from the payers' point of view. With an ERA database, that information is readily available.

- *Compliance with contracts:* ERA databases give providers a mechanism to compare contracted rates with what is actually paid. The AMA found that some insurers only complied with contracts less than 70% of the time. Moreover, several payers had no contracted fee schedule at all. Once providers recognize they are being paid less than their costs for a drug or radiation treatment, they may re-negotiate their contract or stop treating the payers' patients altogether.

Now Is the Time for Change

As consultants, onPoint Oncology is seeing smaller practices consolidate into larger entities or become part of a hospital's outpatient department. According to the American Society of Clinical Oncology, there is an ominous future shortage of clinical oncologists and a looming bulge of new cancer patients. Additionally, there is a long pipeline of novel cancer agents. Now is the time to resolve the payment and administrative cost issues associated with cancer care or the number of prescribing facilities may drop precipitously.

Electronic warehousing of 835 ERA payment information married with clinical information (to consist of at least the patient's diagnosis and stage) will provide all stakeholders

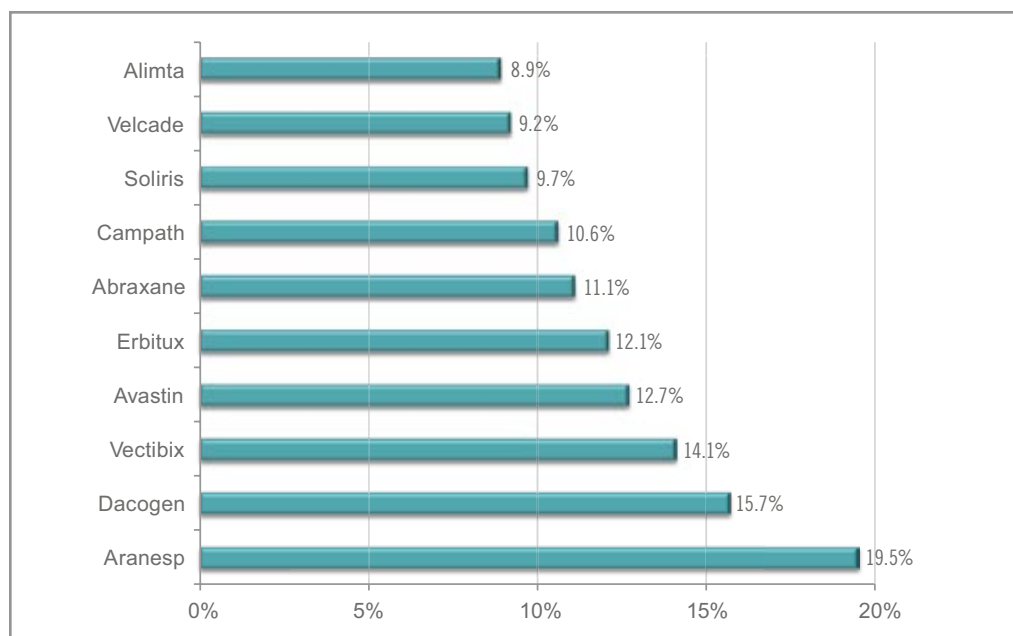


Figure 3. Combined Total of Oncology Drugs Most Commonly Denied (Q1 '09).

Source: Adapted from RemitDATA Inc. All Rights Reserved.



with a more level playing field for all involved in cancer care. For instance,

- *Payers* will know that they have paid a fair contracted rate without excessive administrative costs for high quality treatment. By eliminating countless claim inquiries and erroneous processing, they can expend funds on cancer care rather than on administrative waste.
- *Providers* will be confident that they have minimized rejections and are being paid per their contract for treatment that standardizes quality for most of their patients. They, too, can lower their costs of care by streamlining their charge capture, cash posting (if the billing system accommodates this), and billing processes.
- *Patients* will be better equipped to forecast out-of-pocket costs for cancer care. They can be presented with clearer proactive cost information that will enable them to choose between therapies and/or sites of service; they will also be able to better track costs for both tax and reimbursement purposes.
- *Companies* will understand better which payers are targeting their drugs for denials and delays; they can then tailor reimbursement initiatives to the real problems, rather than relying on hearsay; and they can also provide more comprehensive support to providers and patients.

While providers and payers agree that cancer is a costly disease, they have clashed on how much money

should exchange hands, particularly for drug therapy and supportive care treatments.

There would be more money on both sides if administrative waste were diminished, and payers need to stop using denials and delays as a profit maximization strategy. This costs everyone money that needs to be spent on patient care.

Payers and prescribers might never agree on the amount of money and administrative hassle that there should be in the marketplace, however, ERA-based databases can successfully be used to support reimbursement programs and initiatives.

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About the Contributors

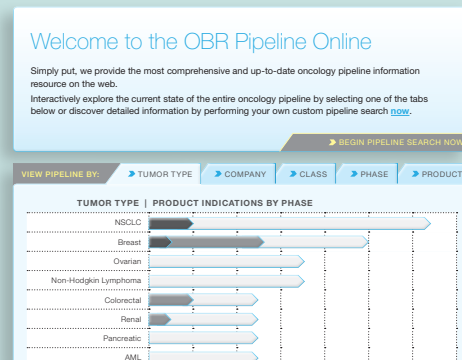
onPoint Oncology

Since its launch in 2008, onPoint Oncology, LLC has been focused on helping pharmaceutical companies and oncology practices interpret and solve complex problems by using clinical and reimbursement data from many sources. Effective data can help the pharmaceutical partner get reimbursement issues handled in a timely manner and can empower the practices to be armed with the tools necessary to help have proper dialog with payers. Bobbi Buell, MBA, a principal in onPoint Oncology, LLC, is a consultant in oncology reimbursement and practice management. Ms. Buell has many years of experience in the healthcare system and is an accomplished healthcare regulatory and reimbursement expert. www.onpointoncology.com

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