




Dispensing Oral Cancer Agents in the Office

Assessing the Pros, Cons, and Profit Margins

By Bryan Cote



In consideration of reduced profits and an abundance of oral cancer agents, many offices are deliberating over whether or not to dispense oral drugs as a part of their practices. But what needs to be evaluated from an operational standpoint? What does it mean for the bottom line? And what benefit does it bring patients? We explore the many issues behind this concept. [cont. on pg 42 >>](#)

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In the face of reduced Medicare infusion fees and uncertainty over commercial insurance reimbursement, oncologists face a bit of a dilemma these days with meeting patient demand for more convenient cancer care. Oncology practices need to continue to evolve and adapt to their changing financial environment. As the number of approved oral cancer agents grows, one consideration for practices is to begin dispensing oral cancer agents in the office setting. But before jumping into this model, practices must address the business, financial, reimbursement and operational questions, as well as patient-adherence considerations.

The Business Questions

Approximately 225 oncology practices in the US dispense oral cancer agents estimates Michael Reagan, Director of Pharmacy Services for the International Oncology Network (ION), one of the three specialty pharmacy companies currently assisting oncology practices in setting up and managing dispensing programs. Some of these practices dispense oral chemotherapy agents only, while others offer support medications like those for nausea through an in-house pharmacy, and some practices dispense both.

One of the first questions an office must ask itself is if it's going to be a one-stop shop for its patients and dispense oral chemotherapy agents as well as supportive care medications. By inventorying its prescribing patterns, an office can determine when and if it should start leaning toward dispensing as well as deciding to what extent

it is going to dispense. According to Reagan, a key indicator for an office practice would be to determine if its prescribing pattern trends upward.

Denise Edgar, RN, an oncology nurse for a small practice in Green Bay, Wisc., researched her office's prescribing patterns and discovered that out of 62 patients, five had received oral chemotherapy agents in the month of February, six in March. Provided the trend upward continues, Edgar expects the practice to begin dispensing both oral chemotherapy agents and some supportive medications by 2008.

According to John Scott Nystrom, MD, a former dispensing physician and now Senior Consultant Hematology/Oncology, Tufts-New England Medical Center, Boston, Mass., if oncologists don't get into the dispensing business they may see a greater erosion of their profit sources from other groups, like specialty pharmacies and the retail setting. One way a practice can respond to the new financial environment is to dispense all the drugs for which it writes prescriptions.

Dr. Nystrom advises practices not to make the mistake others have by setting up a boutique practice that dispenses just a few drugs or dispenses only oral chemotherapy agents, but not the accompanying supportive medications. "If you write it, dispense it," he said.

This philosophy potentially raises a practice's profits by linking its pharmacy treatment decisions with its purchasing decisions. Patients benefit as well as they receive their total therapy from one location.

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The Financial Questions

Dispensing can be marginally profitable for oncology practices, but many groups acknowledge that it is not a cash cow business, nor does it need to be. “We do not generate a huge profit from our dispensary,” said Terri McGuire, RN, Southwest Medical Center, St. Louis, Mo. McGuire has worked with two other oncology practices in recent years and said that none have generated more than \$50,000 a year in cash copays from their office dispensary. However, McGuire credits Southwest’s dispensing business as a key driver for the 300 new patients that have joined the practice—and have remained—since 2004.

“That’s the financial benefit to doing this—patients like that they can see the doctor and go no farther for treatment,” she said. Patient volume is what will eventually determine the extent of profit, not high-margin drugs ordered infrequently.

To illustrate the profit-margin potential for dispensing oral cancer agents in-house, Dr. Nystrom presents an example of a physician who worked 200 days in a year for a practice averaging 20 visits a day:

- Scripts per visit: 3
- Gross income per script: \$6
- Variable costs per script: \$0.17
- Average gross income per script: \$5.83

In this example, the gross income comes to \$69,960 per year; however, margins will vary depending on patient mix. A higher margin is likely for practices with a significant Medicare

population and for those dispensing all cancer-related medications for which scripts are written.

In total, according to Dr. Nystrom, practices that transition to a dispensing physician model can anticipate between a 2% to 9% return on their investment (ROI). Practices ought to dedicate a 3-to-5 year strategic commitment to turn a profit from dispensing and must carefully weigh a number of cost, implementation and reimbursement factors. These factors include:

- Dispensing fees: Plans will pay physicians modest dispensing fees for oral chemotherapy agents and oral anti-emetics used as part of an anti-cancer regimen, usually between \$2 and \$5 per patient per month.
- Copays: Are based on the cost and the patient’s plan. These are more difficult to gauge since they will vary. Patients will pay out of pocket and most copays range from \$20 to \$30, said McGuire.
- Medicare: The federal payer doesn’t allow for doctors’ offices to bill for time spent calling patients or for writing or calling in prescriptions to the pharmacy.
- Software: Most major insurers will reimburse physicians for dispensing, as long as the physician holds a dispensing license and the office uses the correct billing system for claims processing. Currently, practices can purchase these systems from three vendors: Allscripts, Physicians Total Care (PTC), and ION. The average cost is about \$6000, which includes the software and start-up costs. Initially, software **cont. on pg 44 >>**

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may cost about \$1500; bank on spending about \$200 a month on software support.

- **Hardware:** Costs require no more than a desktop PC, a secure room, and a locked storage area.
- **Pricing:** There are a host of government pricing-related costs to factor, including the drug's wholesale acquisition cost and its maximum allowable ingredient cost.

The Reimbursement Rules

Medicare is the critical payer for practices taking the dispensing plunge, due in part to a handful of requirements and payment issues. These requirements include that practices qualify as an in-network pharmacy for Part D plans.

For Broome Oncology, an upstate New York practice that instituted a dispensing program in late 2005, profits have not been a focus. Lead nurse Carol Rogers remarked that practices are foolish if they think dispensing is a profit center; a practice should dispense as a way to benefit the patient. However, practices cannot survive on patient advocacy alone.

Broome employs 30-plus nurses, a pharmacist who is board certified in oncology pharmacy, and three staff pharmacy technicians. More than 150 patients enter the group's two office locations daily and, of those, about 40% receive treatment. The practice's payer mix is more than 50% Medicare, with 90% of these patients holding some type of secondary insurance.

Broome Oncology dispenses four oral agents: Cytosan®

(cyclophosphamide); Temodar® (temozolomide); Xeloda® (capecitabine); and Etopophos® or Vepesid® (etoposide).

"As long as the drugs have the J-codes from Medicare, we [will] dispense from the office and bill the patient as part of the office visit," said Rogers. "[If] the drug costs \$100, Medicare may pay \$90 or \$110 but, either way, we won't mark up our charges."

Rogers often advises non-Medicare patients to retrieve their prescriptions from retail pharmacies. If the beneficiary's policy pays 80%, that extra 20% coinsurance can add up quickly. She said she refers patients to another pharmacy if doing so saves them money. "For most of the Blue plans and Aetna [for example], we send the patient to the retail pharmacy rather than dispense from our office," she said."

Dispensing may be attractive for practices irked by inconsistent Medicare reimbursement for injections and infusions paid through the Part B program. Sal Del Prete, an oncologist in Stamford, Conn., became disgruntled last year because the maximum allowable limits for certain drugs he administered would often change quarter to quarter, due to Medicare's average sales price (ASP) system. According to Del Prete, patients cannot afford to switch tolerated therapies, much less pay for the higher priced drugs; and community oncologists cannot run a practice with such fluctuation and unstable reimbursement.

Oncology practices, like Del Prete's, may be able to diminish some of this financial uncertainty by dispensing as most major payers reimburse practices for dispensing. Some med-

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ications and treatments that insurance plans would not have paid for before are now available because the prescription is being billed through the pharmacy benefit and paid for by managed care.

Some local payers have been slow to embrace the physician dispensing model. In March, a commercial plan in Texas told ION's Reagan that it did not want to reimburse doctors for dispensing oral cancer agents. "[The payer] didn't understand that if they were willing to spend money on infusion fees, then why not pay for [the oral medications] and lower their infusion fee reimbursement." Reagan convinced the plan to reverse its policy this year.

The Operational Options

For many practices, the most manageable way to receive and dispense medications is through a vendor that provides the drugs in pre-packaged, unit-of-use containers. According to Jennie Smith of the National Oncology Alliance, with this method, your practice can provide medications accurately and quickly to patients who can take them home immediately.

Those looking to save money may consider purchasing bulk bottles that contain pills in 100, 500, or 1000 quantities. A staff member would then be required to count out the appropriate amount of pills for each patient, thus raising the risk for error.

"I'd strongly advise against pill counting in the practice," said Dr. Nystrom, citing the risk of theft and the liability. If a practice decides using the bulk method, it is recommended

that a liability carrier be consulted.

When selecting vendors, make sure they provide flexibility in terms of purchase quantities, contract terms, and the medications available within the vendor's formulary. For oncology practices, it's critical that the vendor can provide Schedule II controlled substances. Dr. Nystrom advises practices to avoid long-term contracts, and to make certain vendors offer credit for returned drugs and to set in place minimum restocking fees. Specialty pharmacies such as Physicians Total Care may build the cost for purchasing pre-counted pills directly into the bulk price a practice pays for acquiring a drug.

Deciding What to Carry

Broome Oncology only stocks oral antiemetics and chemotherapy agents, but not other products such as pain management medications. They opted to carry only a select number of drugs most needed by their patients in an effort to offer a strictly cancer-focused service.

Broome also carries a low inventory and identifies the drugs its prescribers select most. Hannah LoPiccolo, lead pharmacist at Broome, advises that if a practice is interested in dispensing, it needs to determine if it wants to invest in a pharmacy staff.

Lacking retail pharmacy experience is a red flag for practices considering a dispensing model. Do not expect a nurse, for example, to oversee the responsibility of submitting pharmacy claims to health insurers. Consider hiring a pharmacist with **cont. on pg 46 >>**

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State Regulatory Reference

Nearly all states have some type of regulations governing the dispensing of drugs by physicians. Check your state laws as some require mail order dispensing only.

Forty-three states allow physicians to dispense pharmaceuticals to their own patients without regard to quantity. Only 6 states place some sort of restriction on physician dispensing (Texas, Virginia, Utah, Arizona, New Hampshire, and Massachusetts). Practices in these states have the option of establishing an in-house retail pharmacy.

At the federal level, the Federal Trade Commission (FTC) endorses physician dis-

pensing, claiming that it “increases service and price competition among practitioners, and between practitioners and pharmacists, to the benefit of consumers.”

Medicare’s Stark law should generally not be a big deal for physician offices. That said, the law prohibits physicians from making a referral to a medical facility for the furnishing of designated health services covered by Medicare if the doctor has a financial relationship with the facility.

Resources: *Physicians Total Care* (physicianstotalcare.com); *International Oncology Network* (iononline.com); *National Oncology Alliance* (noainc.com).

retail pharmacy experience, and pharmacy technicians. This duo can help your practice manage the software and insurer dialogue, noted LoPiccolo.

In the same vein, Dr. Nystrom said pharmacy experience is helpful, but not critical. Oncology practices can dispense oral medications without a pharmacist and pharmacy technician on staff, although to succeed a practice must at least dedicate one staffer to manage the dispensing program.

Before making the decision to become a dispensing practice, check with your state’s laws for licensing and dispensing (see the State Regulatory Reference box for details).

The Adherence Anomaly

Whether a practice plans to prescribe oral chemotherapy as a dispensing physician or plans to hire a pharmacist and apply for a pharmacy license, it must provide patients with information on the drug’s indications and contraindications, side effects, and drug interactions. As greater numbers of patients are receiving oral chemotherapy, the threat of critical educational gaps may escalate and could derail the clinical value of oral medications.

At least three of the 11 patients Edgar has evaluated in her quest to determine if dispensing has value for her office have, apparently, had adherence challenges. “They didn’t receive any initial education about when and how to

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take their drugs,” said Edgar, who spoke with each patient affected. “Our patients trust us with their care here in the office...[and so] we think dispensing can help us to reduce adherence problems. It brings that educational discussion [into the practice].”

Dispensing in-house doesn't completely solve adherence risks. According to Steven Russek, RPh, Vice President of Clinical Services for Accredo Health, several studies suggest a lower rate of adherence for patients who do not receive their drugs from a specialty pharmacy. In a multi-physician led study, Patient Non-Compliance With Self-Administered Therapy, investigators found that of the 51 patients studied, 43% did not comply with the criteria for Cytoxan or prednisone and that some patients had exceeded the prescribed dose.

However, according to the study, patients treated in an office or clinic setting are less likely to adhere than those treated in hospital or academic facilities. To address adherence concerns, Russek offered that practices that dispense may want to dedicate case management staff to call patients with reminders about their treatment and discuss the reasons patients are not complying.

Dispensing: A Savings Solution?

In a study conducted by Cancer Care Associates, a group practice in Royal Oak, Mich., featured in the March issue of OBR, prescription medicine and chemotherapy medicine questions represented about 30% of 371 phone calls received over a 5-day period—by far the highest percentage for any one topic. By adding a dispensing program that features



prescription education for patients before they leave the office, oncology practices can expect, hopefully, to see a reduction in medication-related calls.

While it's unlikely that doctors will base a treatment decision solely on financial considerations, Rogers says, “It's unrealistic to assume doctors can simply ignore finances, especially if oral and IV drugs offer equivalent outcomes.” If an oral therapy is equal in efficacy and safety to its injectable counterpart then practices may have an opportunity to save considerable dollars by dispensing. For example, patients may spend two to three hours in an infusion chair receiving chemotherapy at an overhead cost of \$250 an hour. Overhead costs for dispensing are around \$10 per prescription.

By all accounts, in-house oral dispensing is here to stay, but the speed and degree of its growth hinges largely on whether physicians will embrace the change inside their own office walls and diligently evaluate the litany of business issues. As practices weigh the pros and cons of dispensing, taking cues from nurses such as Denise Edgar and Carol Rogers may be helpful. Each comes at this from different points of view on the process, but each shares a common connection: an interest in making dispensing a patient benefit rather than a profit-turning business. **BC**

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