Should Practices Make Changes in Today's Uncertain Reimbursement Climate?

by Judy Stone

Payment provisions issued under the Medicare Prescription Drug, Improvement and Modernization Act (DIMA) have major implications for office-based practices. By all accounts, the outlook for 2004 is relatively stable. Practices can expect to see revenues similar to those in 2003, if practice patterns and volumes remain unchanged. The impact of DIMA for 2005 and beyond is grim, however. Not only will practices see major drug payment reductions for older drugs, newer drugs will remain at the low margins implemented in 2004—and the transition payment for drug administration procedures will drop from 32 percent (2004) to 3 percent (2005). In other words, the transitional payment we gained on administration codes in 2004 will be lost except for 3 percent. And the news gets worse. In 2006, we lose the 3 percent as well.

Changes mandated by the new Medicare law place office-based oncology practices under pressure. Many office-based practices are worried about their future. Initial analysis shows that practices may lose as much as 50 percent of Medicare reimbursement under this plan in 2005. Since Medicare averages about half of the oncology business, this reduction equates to a 25 percent pay cut.

Such looming cuts for 2005 have practices questioning whether they can continue to accept the same volume of Medicare patients, and some are even considering whether to accept Medicare patients at all. Who knows what will happen if private payers follow Medicare's lead.

While ACCC and others in the oncology community continue to fight on behalf of patient access to quality care, change is already underway, and the transition period is full of uncertainty. As practices seek practical steps for survival, they must first understand the implications of DIMA as it relates to restructuring and/or adding new practice services.

Here are some ways office practices can best prepare to meet these changes.

Q *Given major DIMA-mandated changes in the Medicare reimbursement and payment structure, will drugs continue to play a major role in the value-chain of oncology practices?*

A As long as practices continue to administer chemotherapy in the office setting, drugs will continue to play a significant role. Prior to 2004, oncologists earned revenues on drug margins but were grossly underpaid for their services. With the recent CMS regulations and the impact of changes slated for the future, drug margins are going away. Drug purchasing, charge capture, and reimbursement will become increasingly significant to the survival of a practice.

In the long run, changes in drug reimbursement will have an equalizing effect on pharmaceutical purchasing. In other words, it will have a leveling effect on drug pricing. CMS will say, "this is what we will reimburse," manufacturers will have to report their selling prices to CMS, and CMS will take an average of those prices and use it to establish reimbursement.

In the short term, practices must diligently analyze their top 20 most costly drugs on not less than a quarterly basis to be sure they are purchasing at the best available price. Practices should regularly survey various GPOs (group purchasing organizations) for the best available pricing.

Another impact of this change relates to the fact that nationally 20 percent of Medicare beneficiaries do not have secondary insurance. This leaves the patient responsible for 20 percent of the drug payment. While practices have always faced financial risk from patients who cannot pay their 20 percent portion, without the margin on drugs, practices must become more diligent in guaranteeing payment from the patient prior to beginning treatment. Although a conversation about copayment is extremely difficult when dealing with cancer patients about to receive their first dose of

chemotherapy, that discussion becomes increasingly necessary.

Q *Some projections show a decline in practice revenues from drugs of 12 to 14 percent in 2004, and even more in 2005. How can practices best prepare? Is this the right time for major staffing or practice reconfigurations?*

A Practices really have to be on their toes, capturing all charges and billing everything they can legitimately bill. Rather than a major reconfiguration or staffing change, practices may need to step "out of the box" and look for all the training and information available to understand the changes under the new Medicare law and their impact on the practice. Go to state society meetings. Practice leaders must have the education and tools necessary to ensure that your practice is running as efficiently as possible. The key to survival is an efficiently run practice that is correctly capturing every charge possible and billing appropriately under the guidelines.

In a sense, practices will need to broaden their focus. Tracking drug costs and reimbursement will remain an essential element of an efficiently managed practice, but understanding administration CPT codes, RVUs, and the rules of reimbursement will become critical. Practices should turn their attention to analyzing costs by treatment protocol. In other words, do not look at each element singly but at the cost of the entire protocol. By understanding all aspects of reimbursement by protocol, practices can ensure that everything they can bill for is, in fact, billed.

Chemotherapy administration is complicated. Understanding new protocols and keeping up with new therapies is an ongoing process. If a practice is considering adding a pharmacist, look for one with specific oncology experience. It may be unwise to make major changes in the current uncertain economic environment. If a practice is using a dedicated staff member—such as a nurse manager—to oversee all aspects of chemotherapy management, ensure that the nurse has dedicated time away from patient care for this task.

An investment in training and the education of your existing, experienced oncology staff can help bring your office through this transition. Make sure your staff receives training, information, and the tools necessary to ensure practice efficiency. Educate your entire practice about the changing focus, and why correct coding and billing are more critical today than ever before. Now is a good time to allocate dollars for educational and networking opportunities available through national and local oncology meetings.

Q *Are some practices likely to be harder hit by the changes under DIMA than others? What does this mean for patient access to care?*

A As far as Medicare reimbursement in 2004 is concerned, physician practices should remain fairly stable if patient patterns and volumes are constant. Still, some private payers are beginning to devastate practices by reductions to drug reimbursement that are in line with Medicare, but without increasing their administration payments to offset this loss.

Smaller oncology practices that do not offer ancillary services work on smaller margins. If Medicare's administration payments drop in 2005, practices will be in trouble. If practices limit the number of Medicare patients or stop accepting Medicare completely in an attempt to change their payer mix, practices may still be in trouble. Private payers tend to mimic Medicare. Relying only on chemotherapy services, smaller practices are likely to be the first to close. The loss of these practices will no doubt have a significant impact on patient access to quality cancer care in their communities.

Judy Stone is the administrator of Carolinas Hematology-Oncology Associates in Charlotte, N.C.