Oncology Practices Brace for ASP

Hospitals to feel the effects, too

Average wholesale price (AWP) will soon be history, and oncology practices are already bracing for the newest reimbursement methodology coming from CMS—average sales price (ASP). Recently, CMS released estimates of physician office drug reimbursement rates; and the agency is planning to release information regarding the methodology of how it calculated ASP. Physicians planning 2005 budgets and services are having to make hard decisions affecting cancer patients—without complete reimbursement information.

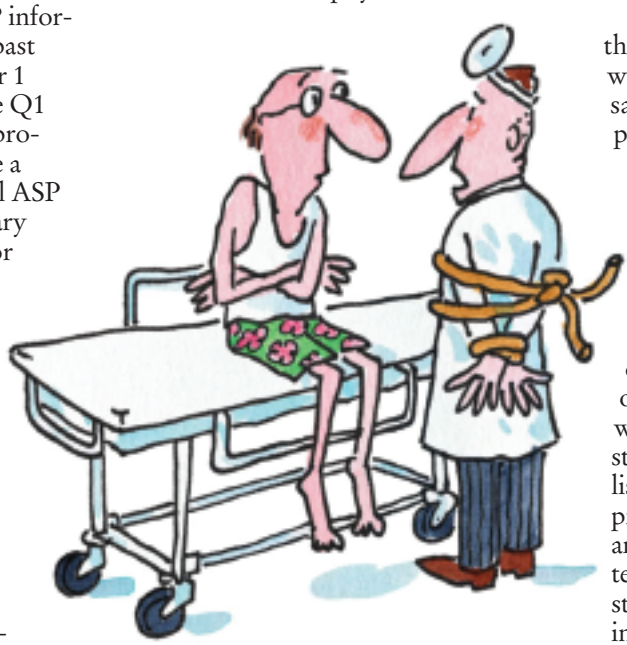
The ASP data used in the proposed rule are based upon ASP information provided to CMS this past March/April reflecting Quarter 1 2004 drug price data. While the Q1 2004 ASP data are used in the proposed rule, it is only to provide a general sense of what the actual ASP rates will be, and this preliminary information will not be used for the purposes of establishing payment in 2005. Although the list of cancer drugs included in the proposed rule is incomplete, the drugs listed do account for approximately 70 percent of a practice's drug revenue. (See Table 1 on page 9.)

While analysis of the proposed rule and its financial impact on oncology care are continuing, many in the healthcare community are saying that ASP+6 percent could compel some oncology practices to scale back services and others to close their doors for good. The decreases in reimbursement could be significant enough to alter practice patterns, and it is not clear that hospitals will be able to absorb scores of transferred chemotherapy patients.

With only a few months until ASP goes into effect, *Oncology Issues* interviewed member physician practices to better understand how they are now preparing for Medicare's new reimbursement methodology. While all have expressed concerns, some are taking a go-slow, wait-and-see approach. Others are streamlining their practices and even contemplating hiring freezes and early retirements.

California

"In preparation for ASP, we are analyzing our top 20 regimens to see on which drugs we will be underwater," said one practice manager of a large urban oncology practice in Northern California with 10 physicians and two clinic sites. "And we've been actively re-negotiating our managed care contracts." The practice, which is in a competitive managed care area, has been actively involved for more than a year getting ready for ASP. The practice is also talking to a local hospital about a possible joint venture and exploring diversifying the practice services by looking into entering the imaging market.



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In a rural area of California, a practice manager for a small oncology practice said that they are educating patients about how the changes in reimbursement may affect the practice. "And we are upfront with staff about the possible need to reduce their hours." This practice manager is concerned that shifting some cancer patients for treatment may strain local hospitals.

Florida

According to one physician at a multi-centered practice in Florida, his practice may lose 35 percent of its revenue, factoring in drug price, costs, and other practice expenses.

"We're very concerned," said this Florida medical oncologist who has been practicing in the same locale for 23 years. "It's pretty scary times," he added.

The practice is talking with other large medical oncology groups in parts of Florida to jointly purchase some drugs to help hold down costs. And it is looking at ways to diversify into other product lines. For example, offering PET/CT services at its office rather than joint venturing with another practice or a free-standing radiology center or establishing an in-house pharmacy. The practice is also planning to set up an electronic medical record system to increase staff efficiency, standardize treatments, and improve its ability to track the cost of treatment programs. Selling the data on its treatment patterns is being considered as another revenue source for the practice.

The practice has also looked at ways to cut costs, including decreasing staff through attrition and cutting back on in its counseling services. The practice has not considered implementing cutbacks on disability or retirements since none of its medical oncologists, who are mostly in

their mid-50s, plan to retire soon.

Elsewhere, at least one hospital is already seeing some patients shifted its way from the physician-office setting, but not in huge volumes, according to the cancer program administrator of this seven-hospital system located in central Florida. The hospital system is looking at the operational and financial impact of a shift in practice patterns when larger volumes of cancer patients move from the physicians' offices to the hospital setting for chemotherapy treatment. "We know we don't have the capacity to handle the majority of volume our private practices currently have on a daily basis," said this administrator.

In other locations within Florida no shift in service is discernible—yet. One 278-bed hospital located in northern Florida has not seen an increase in number of patients coming from medical oncology practices in its locale. Should such a shift occur, the hospital has already made plans on how to take up the additional patient workload.

New Hampshire

No changes in practice patterns. That's what an administrator with a large medical oncology/hematology practice serving primarily a rural population said for 2004. The practice, which sees about 2,800 new patients each year, has five locations—two independent and three hospital-based.

To prepare for 2005, however, the practice has added a pharmacist to its staff to more closely manage inventory and to keep track of drug costs and usage.

While the practice has not done any formal analysis to project how ASP+6 might affect its reimbursement picture, the administrator anticipates that unless some changes occur, "In 2005, I think we are going to be in trouble and see a significant decrease in revenue."

To prepare, the practice is changing the role of its account representatives. These staff members will assume more financial counseling duties, including meeting with patients, identifying those without secondary insurance, and working with the doctors and nurses to determine the best site of service for the patient. In the past, the practice was able to treat all patients in the office setting because the practice had the ability to absorb patients without secondary insurance. Although the practice has not had to shift any patients to the hospital for care as yet, the scenario will be different in 2005 when the transition payment for practice expenses drops to 3 percent.

Taking a conservative approach, the practice is looking at a possible

hiring freeze in the fourth quarter of 2004. And although the practice's primary office locations are feeling squeezed for space, any decisions about expansion are on hold. Given the current reimbursement picture, "We may not be able to expand our facility," the administrator said.

Still, a small community hospital in a rural area of New Hampshire said it has seen no change in the number of patients coming in for chemotherapy. The cancer program typically sees about 500 new analytic cancer cases each year. Although the hospital has held discussions about the possible impact of the impending reimbursement changes, it is taking a "wait-and-see" approach until more information becomes available.

Ohio

This mid-sized suburban oncology practice is responding to the impending threat of ASP+6 with advocacy. Several staff members are actively involved in letter writing campaigns, congressional visits, and meetings aimed at securing new codes to cover services that are currently provided but are not reimbursed such as treatment planning, support group work, and counseling services.

In the short term, the practice is putting plans for expansion on hold. "At this point, we are at the breaking point. We could use another physician."

A hospital administrator at a three-hospital healthcare system in central Ohio reports that she is "seeing an increased number of patients coming through from oncology practices." Primarily these additional patients are those without insurance or with minimal insurance or patients covered by Medicare alone. In addition, patients being treated off-label are increasingly being sent to the hospital for care, the administrator said.

For this hospital, the increase in the number of chemotherapy patients has meant increasing staff and extending service hours. So far the hospital has been able to meet the increased demand for services.

Rhode Island

Medicare patients at this Rhode Island practice have been told that if they don't have secondary insurance to pay the 20 percent copay for treatment with expensive drugs costing thousands of dollars, they need to go to the hospital outpatient setting. "The practice can't afford to provide this service," said the medical oncologist.

Shifting patients to the hospital setting creates additional hardships for the patient. For example, patients first need to come to the physician office to be examined, have blood count tests, and other services, and then go to the hospital the next day. Some patients will need to spend twice as much time undergoing treatment—time spent away from their jobs, family, and other support systems. This scenario is even harder on elderly patients or those who do not like to drive more than they have to even if the hospital is only a few miles away.

The Rhode Island practice has initiated a hiring freeze on administrative staff and may even downsize. One associate in the practice is thinking about retiring earlier and others are thinking about giving up oncology and doing primary care medicine or some other endeavors such as consulting on the side.

Elsewhere in Rhode Island, the cancer program administrator of a new cancer center that opened in 2004 was fortunate in that the institu-

tion has the space and staffing to accommodate any increase in outpatient chemotherapy treatment. The 700-bed hospital has its patient care advocate work directly with the small number of patients shifted from the local oncology practices.

"We are carefully monitoring the use of our drugs, providing effective drugs at the best cost, monitoring third-party reimbursement, and working closely with our Finance Department to make sure to optimize our contracts and reduce our costs," said this hospital administrator.

Tennessee

The practice administrator of a small city practice in Tennessee conducted a preliminary audit of how the practice might do under the upcoming Medicare ASP+6 percent methodology. The practice found that it would lose between 7 and 14 percent on the cost of its top 20 drugs. Medicare is nearly half of this practice's business "so, we'll be in trouble," the administrator said.

This practice has already received notices from some commercial insurers saying that they will be picking up the Medicare methodology and lowering their reimbursement as well.

A representative from a drug company recently stopped by the practice to let them know their drug, which the practices prescribes for a number of cancer patients, would be going up 6 percent. "I worry in an ASP+6 percent system, will I be able to give this drug for the six months prior to Medicare updating their reimbursement," the practice manager said.

This solo practice has been forced to become stricter about collecting deductibles and copays up front from patients.

For the first time in 34 years, this small Tennessee practice has begun shifting several patients to the hospital outpatient setting. "We have never, never done that before, but there were a couple of drug regimens that were so expensive to buy that they caused us to be so far in the hole we had to do it," said this practice manager.

The closest hospital to the practice is about 15 miles away, and the hospital is not set up to deliver chemotherapy optimally, the administrator said. One patient who was referred to the hospital experienced 23 hours for check-in, lab work, and ordering of the drug, and infusion compared to four hours for comparable services in the office setting.

In another instance, noted this practice manager, a medical oncologist in a nearby city indicated that his practice would lose $700 on the drug

treatment so the patient was sent to a small rural hospital that had never given chemotherapy. The medical oncologist in the group did decide to treat the patient anyway but at a financial loss to the practice.

"You can't do it very often," said this administrator.

"We're being very cautious about new drugs coming out and making sure that Medicare or other insurance companies will reimburse for the drug," said this administrator. "We need to be more up-front about getting the drug pre-authorized and preapproved to make sure the drug will get paid." The practice does an analysis of drug reimbursement on a quarterly basis.

Over the past four to five years, a 300-bed hospital in Tennessee has seen an increasing number of patients being shifted from a local medical oncology practice to the hospital for outpatient chemotherapy treatment. The hospital believes the medical oncology practice cannot afford the inventory of some expensive anticancer drugs and then wait months for third-party reimbursement that is likely to be inadequate.

According to the cancer program administrator, the hospital is trying to accommodate these patients by grouping them one or two days a week—a more cost-effective way for the hospital to provide treatment to these patients. The hospital has set aside a large patient room in its oncology unit and assigned an oncology nurse to those specific patients. This nurse focuses solely on delivering chemotherapy to these patients. In effect, the hospital has developed its own outpatient chemotherapy clinic. The process has worked out very well from a customer-service standpoint as well as a cost saving to the hospital.

In preparation for the new ASP+6 percent methodology, the hospital's cancer program administrator is meeting with the local oncology practices to discuss and plan for the future. The hospital may have to undergo renovation, for example, in order to take care of the patients being shifted from local oncology practices.

Another difficult aspect of accommodating this shift in outpatient cancer care, said this administrator, is finding enough oncology nurses because "there's a huge shortage. Hospitals and medical oncology practices may start competing over the limited number of oncology nurses."

Virginia

To prepare for ASP, the practice administrator of this two-clinic, three-physician practice in southern Virginia has done a preliminary analysis based on 2003 service and volume numbers. "If our services remain the same as in 2003, we are expecting a 20 to 50 percent cut in reimbursement in 2005," he said.

With the knowledge that a significant decrease in revenue is likely in 2005, this practice is taking some proactive steps to remain viable. Hiring freezes have not been initiated; however, a physician retired in 2004 (the practice previously had four physicians), and the search for a replacement is underway but not being aggressively pursued.

In day-to-day operations, the practice is streamlining its processes and has become more stringent about collecting copays upfront. They do not let accounts receivable age.

The practice administrator has a grid ready to plug in numbers and carefully analyze drugs for all regimens by payer categories. Still, he predicts, "We are going to be underwater on several drugs. There will be regimens where the drugs will not be covered, and we will have no other choice but to treat the patient in the hospital."

Already, this practice has had to refer some elderly cancer patients to the hospital. Forty-four percent of the practice's patients are covered by Medicare.

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