Managing Managed Care

Working with private payers to help your practice maintain control of patient care

BY DENISE PIERCE

For two years now, oncology practices have been challenged by complex changes in the Medicare system. Starting in 2005, oncology practices are paid for drug and drug administration costs under a new reimbursement methodology—average sales price (ASP). In 2006, oncology practices will choose between purchasing their drugs or getting them through the newly created competitive acquisition program (CAP). With this intense focus on Medicare reimbursement, oncology practices may not be aware of the big changes taking place in the private sector. Depending on their payer mix, most oncology practices should now shift gears. Instead of focusing solely on Medicare, oncology practices need to gain a better understanding of the coverage decisions, coding changes, and payment methodologies used by their private payers.

ILLUSTRATION/GETTY IMAGES

The Story So Far

Health insurance is a vital form of financial protection, but it is also a significant area of healthcare expenditure. In 2004, the average annual cost of family coverage, when provided through an employer, was $9,950.[1] And that dollar amount continues to skyrocket, bringing increased demands for cost control from the payer, the employer, *and* the consumer.

Today, private payers are attempting to contain costs and to respond to employer demands for decreased premiums by aggressively changing how they oversee the delivery of healthcare resource utilization. From large national corporations, such as Aetna and United Healthcare, to local and regional plans from Blue Cross and Blue Shield (BCBS) and other insurers, America's private payers are undergoing an evolution. Until recently, however, many oncology practices have had limited awareness of this change.

Oncology practices that want to make sense of the changes in the private payer sector must begin by understanding the underlying trends.

For the past five to seven years, private payers have focused on controlling utilization of drugs and services related to high-cost and high-volume diseases, such as diabetes, hypertension, congestive heart failure, depression, and asthma. These payers have developed and implemented numerous mechanisms to achieve this goal, including integrating disease management programs, creating strict

formularies on drug options, and developing tiered pharmacy programs to drive patient and physician behaviors to use drugs that are deemed more cost-effective for the clinical outcome.

After establishing utilization management programs for the top volume/cost diseases listed above, private payers have moved on to the next level of high-cost diseases—including cancer. While oncology may not necessarily have the highest volume of patients, cancer treatment consistently incurs the highest cost for many payers. What follows is a look at some private-payer reimbursement trends that may affect oncology practices.

Oncology Disease Management Programs

Although several private payers are attempting to create their own oncology disease management initiatives, Quality Oncology remains the primary disease management vendor in the area of oncology. In 1997, oncology disease management was initiated by Foundation Health in South Florida. Foundation Health required all participating oncologists to submit their cancer treatment plans to Quality Oncology. This move increased the need for "conversations" between Quality Oncology's full-time oncologist and community oncologists. Although the oncology community offered significant resistance, Foundation Health held fast and Quality Oncology involvement became a mandatory criterion for payment of services. Quality Oncology continued to grow and expand their programs. Today the organization has contracts with Care First BCBS, Pacificare, Wellpoint, BCBS Florida, and Great West Insurance. In 2004, Quality Oncology signed an employer-based oncology management program with Delta Airlines.

The challenge for disease management programs is that the company must demonstrate a cost savings for the payer in order to get paid for their services. Ideally, efforts to reduce cost can be a collaborative effort between the disease management company and those providing care. For example, identifying ways to reduce hospitalizations for febrile neutropenia or severe nausea and vomiting is beneficial for everyone—payers, disease management companies, providers, *and* patients.

Sometimes, however, the relationship between disease management and oncology providers can be far from ideal. For example, disease management companies that target drug selection as a means to control costs can adversely affect physician discretion and clinical decision-making. So, what can oncology practices do? The best defense against disease management companies attempting to drive treatment decisions is for oncology practices to fully document patient outcomes and clinical resources that support their clinical decisions (see page 34 for important steps to do so).

Pay-for-Performance Initiatives

For several years, private payers have been "dipping their toes" into pay-for-performance initiatives, initially setting goals for primary care physicians on use of certain laboratory testing, screening, and other variables that could affect preventive measures for several diseases. For the oncology community, the pay-for-performance concept is taking a different shape—with efforts being directed more toward evidence-based treatment decisions. Similar to disease management, the pay-for-performance momentum strongly emphasizes the increasing need for oncology practices to demonstrate and support quality care.

Decreasing Drug Reimbursement

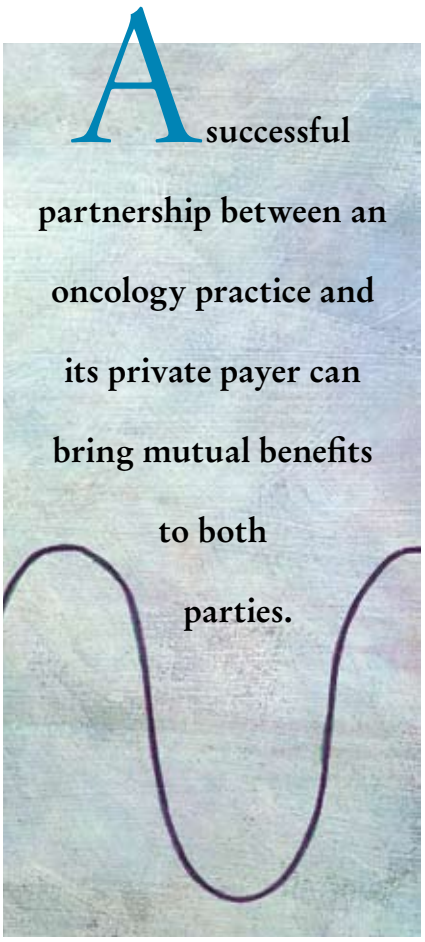
Taking their cue from the Medicare program, most private payers are decreasing payments for drugs. Oncology practices must stay on top of these private payer changes and know their drug costs and reimbursement. Private payers are consistently eroding the average wholesale price (AWP) payment methodology, but are not necessarily integrating an ASP-based calculation to mirror Medicare. No matter what the reimbursement methodology, oncology practices must ensure that their costs are being adequately covered by their private payers.

Oncology practices must also understand that many private payers do not understand the scope of services required for cancer care. Private payers employ very few oncologists as medical directors. Instead, the private payer's "view" or understanding of oncology is often seen through a generalist's lens. Unfortunately, this can increase the risk of obstacles for ongoing quality patient care. To work through these "obstacles" and help private payers understand the unique nature of oncology care, practices must develop strong relationships with their payers.

Under these established relationships, private payers can then be educated on how practice expenses translate into quality patient care. While this education will likely *not* preserve drug reimbursement levels, it can develop the rationale of appropriate compensation for the delivery of treatments and ongoing patient care during the treatment process.

Building Blocks for the Future

As a medical specialty, oncology's primary services are intrinsically linked to the delivery of chemotherapy and supportive medications. The unique nature of oncology care presents a challenge for private payers, as well as an opportunity for oncology practices. When entering into a working relationship with private payers, oncology practices need to remember that—just as their practice



is tested by significant issues—private payers have their own set of concerns (see Figure 1).

Some of the challenges facing private payers include:

- Managing growing medical expenses
- Creating appropriate measures for evidence-based outcomes
- Sharing healthcare resources across all disease states
- Responding to employer demands to reduce healthcare benefit costs.

Oncology practices have other concerns, which are sometimes divergent from those facing private payers. For example, oncology practices must balance decreased reimbursement payments with increased treatment costs and still provide quality patient care. Another challenge is how to integrate novel treatment and supportive care options, while still ensuring coverage and payment of services. In addition, oncology practices must find the resources to educate their staff about complex and ever-changing reimbursement methodologies and coverage restrictions—in the private payer sector *and* the Medicare program.

A successful partnership between an oncology practice and its private payer can bring mutual benefits to both parties. The first step: oncology practices should develop and implement an exchange of key information. This ongoing, educational dialogue can help the practice 1) maintain control in patient care decisions and 2) be paid appropriately for providing that care. It can also help the payer meet some of its challenges, such as creating appropriate measures for evidence-based outcomes.

Effectively Positioning Your Practice with Its Private Payers

Contract negotiations play a significant role in effective positioning and financial viability with private payers; however, preparing a payer positioning strategy that establishes your overall practice goals and objectives—including clinical, economic and patient access to care—is critical. Oncology practices must then take this true clinical care perspective and translate it into the financial components that must be in place to support the clinical decision-making process.

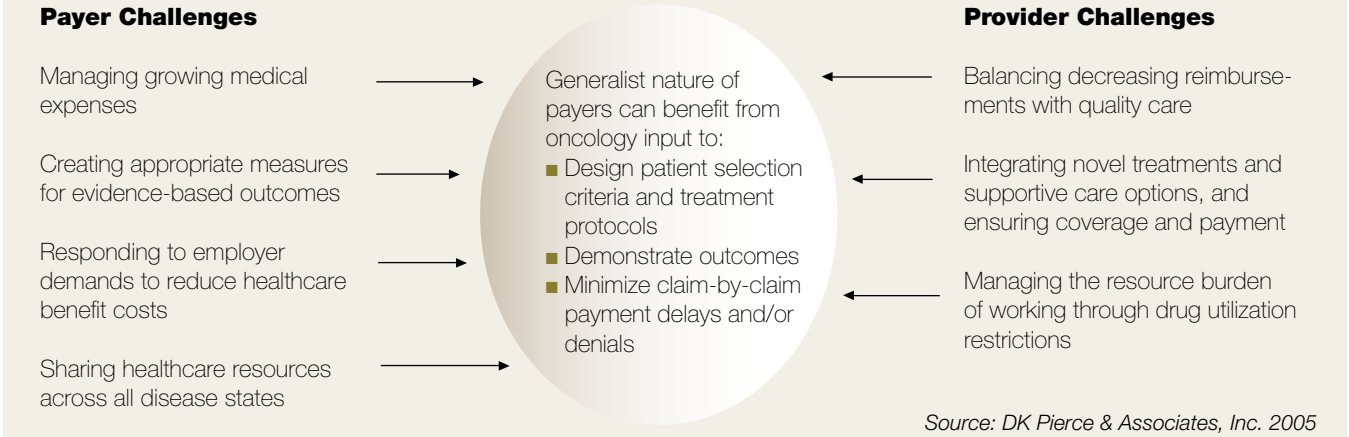
To ensure the best possible positioning with private payers, oncology practices must follow several key steps. Before getting started, however, practices must have buy-in from their oncologists. The role of the oncologist is two-fold: 1) to determine what information is pertinent to complete these steps and 2) to participate as an interface or point of information exchange with the private payers.

Step 1—*Determine an intended outcome for each provider/payer relationship.* First identify the private payers that affect the largest portion of your patient population. The best return on time and resource investments will be realized by working with the payer or payers that have the greatest financial impact on your practice. Even if your practice has current issues with the payer, developing a non-adversarial working relationship will help avoid future negative changes. Second, your oncology practice should also identify specific issues it wants resolved. For example, your practice may need to work with a certain payer regarding restrictions on indications for a specific drug. A more global issue may be the eroding drug reimbursement. If your private payers are reducing drug payments, are they increasing payments in under-funded areas such as drug administration? Your oncology practice should clearly identify each issue and what resolution it hopes to achieve from the appropriate private payer.

Step 2—*Create and communicate your practice profile.* Help your private payers understand your patient demographics. For example, your practice might specialize in certain tumor types or have a unique referral process for specific problematic cases. Because your private payers' perspective is more general, they need to understand that cancer care can vary significantly, depending on how patients present and your practice mix of patient and tumor types. This knowledge also helps your private payers understand that treatments will significantly vary across practices.

Step 3—*Document support for quality care in your practice.* For each primary tumor and patient type that your practice treats, outline the basis and process for your clinical decisions. Your private payers need to know if you follow NCCN or ASCO guidelines, or if your practice maintains a library of published, peer-reviewed literature to support your clinical decisions. Document the patient selection criteria you might apply and the outcomes that have resulted from your practice decisions.

Figure 1: Private Payer and Provider Challenges
These challenges provide the backdrop against which successful working relationships can be built.



Source: DK Pierce & Associates, Inc. 2005 Oncology Reimbursement Market Analysis.

Preparing and presenting this information to your private payers can help stave off unwelcome interventions such as profiling or disease management initiatives. It can also help your practice answer the underlying question of all private payers, "*What is quality cancer care and how do physicians arrive at those decisions*?"

Step 4—*Help payers understand how utilization controls can affect patient access to care.* This step is particularly important for oncology practices dealing with restrictive prior authorizations such as those that require submission of medical documentation or review of medical necessity on each patient encounter. Practices should identify obstacles that may delay treatment decisions for patients, or increase workload for staff. Then work with your private payers to create appropriate prior authorization guidelines. Using the clinical decision-making criteria established under Step 3 above, establish guidelines that can help private payers meet their requirements to track utilization of a given drug, and still ensure that the prior authorization does not adversely affect patient treatment.

Step 5—*Discuss off-label drug use and how it affects patient outcomes.* Off-label drug usage has been and will continue to be a significant variable in the treatment of patients with cancer, causing it to come under increased scrutiny from private payers. Your practice should identify any drugs that it consistently uses for off-label indications—particularly those drugs that are consistently suspended by the payer for long medical reviews—then gather documented patient outcomes to present to the payer. Have available peer-reviewed published data that supports the use of specific off-label indications that are important to your practice. This data can help establish acceptable "consideration criteria" that may expedite medical review and claims processing. Additionally, meeting with private payers to discuss specific patient cases and the outcomes achieved can "paint the picture" of what quality care means for the patient.

Step 6—*Demonstrate practice expense requirements for the delivery of quality care.* As mentioned above, most private payers do not understand practice expenses associated with the delivery of quality oncology care. Many private payers may reduce drug reimbursement without ever understanding the implications for an oncology practice. By demonstrating the time and cost associated with preparing and administering drugs, as well as monitoring the patient during and after drug administration, oncology practices can build the rationale for appropriate compensation of those care-delivery services.

Going the Extra Mile

Although the time and resources involved in working with your private payers may at first seem daunting, this involvement will be the hallmark of savvy oncology practices—both now and in the future. The outcome may not always be what your practice identifies as the ideal one, but it may be an incrementally positive step supporting quality care. The overall value of establishing coordinated relationships with your private payers, which offer ongoing education and facilitate information exchange, can bring concrete benefits to your oncology practice. For example, having a successful working relationship with your private payers can reduce the need to deal with individual problem claims related to lack of coverage or poor payment. It can also help minimize claims payment delays and support appropriate financial viability for the practice. Perhaps most importantly, ongoing dialogue and a solid professional relationship with your private payers can help ensure your practice's discretion in choosing the appropriate treatment for the best patient outcome, and maintaining control of patient care.

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References

[1]Kaiser Family Foundation. Employer Health Benefit, 2004 Survey. Available online at: *www.kff.org/insurance/7148/index.cfm*. Accessed August 26, 2005.