Welcome to the Vortex—

Negotiating and Building Relationships with Your Payers

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Life used to be easy. Medicare fee schedules were published and codes changed modestly. After brief discussions on fee schedule changes, private payer contracts were renewed annually. Today, the relationship between provider and payer has become much more complicated. Medicare rates and policies are a source of constant frustration and change, requiring oncology practices to get involved in policy discussions with Congressional members and to interact daily with Medicare carriers. Private payer contracts are also in flux.

Fee schedules for both professional fees and drug reimbursement need to be tightly negotiated. Questions about quality of care and pay for performance alternatives abound. Rate changes for some specialties may dramatically affect other specialty services. When it comes to oncology policy, external entities are holding as much sway, if not more, than the contracted oncology physicians. Questions are even being raised about the delivery models for oncology care that have emerged over the last 10 years. In short, today's oncology community is taking nothing for granted.

Get Engaged!

In a recent study, 51 percent of oncologists surveyed reported that in the next five years they anticipated making some strategic changes to their practice, including mergers, sales, acquisitions, or closing their practice.[1] However, an alarming 43 percent of oncologists reported that they did not anticipate *any* changes.[1]

Many oncology practices and community cancer centers are focused inwardly on minimizing operating costs, managing drug inventory as efficiently as possible, and implementing technology tools, such as e-prescribing and electronic medical records (EMRs). What they do not realize is that external, non-physician-owned entities are playing an increasing role in their immediate future. Every day, these external entities are courting payers, seeking to manage oncology on behalf of small, medium, and large payers. Before entering into payer discussions and negotiations, oncology practices and community cancer centers must first know *who* these entities are and *what* they offer payers.

Companies seeking to take the lead in oncology management, such as ICORE, CareCore Oncology, and P4 Healthcare, and specialty pharmacy organizations are in discussions with key regional and national payers. These companies are seeking blanket contracts for states and regions with insurers like Anthem, Wellpoint, UnitedHealthcare, and others. Even companies that were working to bring oncology practices and community cancer centers along in the negotiating process may choose to abandon that strategy and find it more productive to work from the top down with payers.

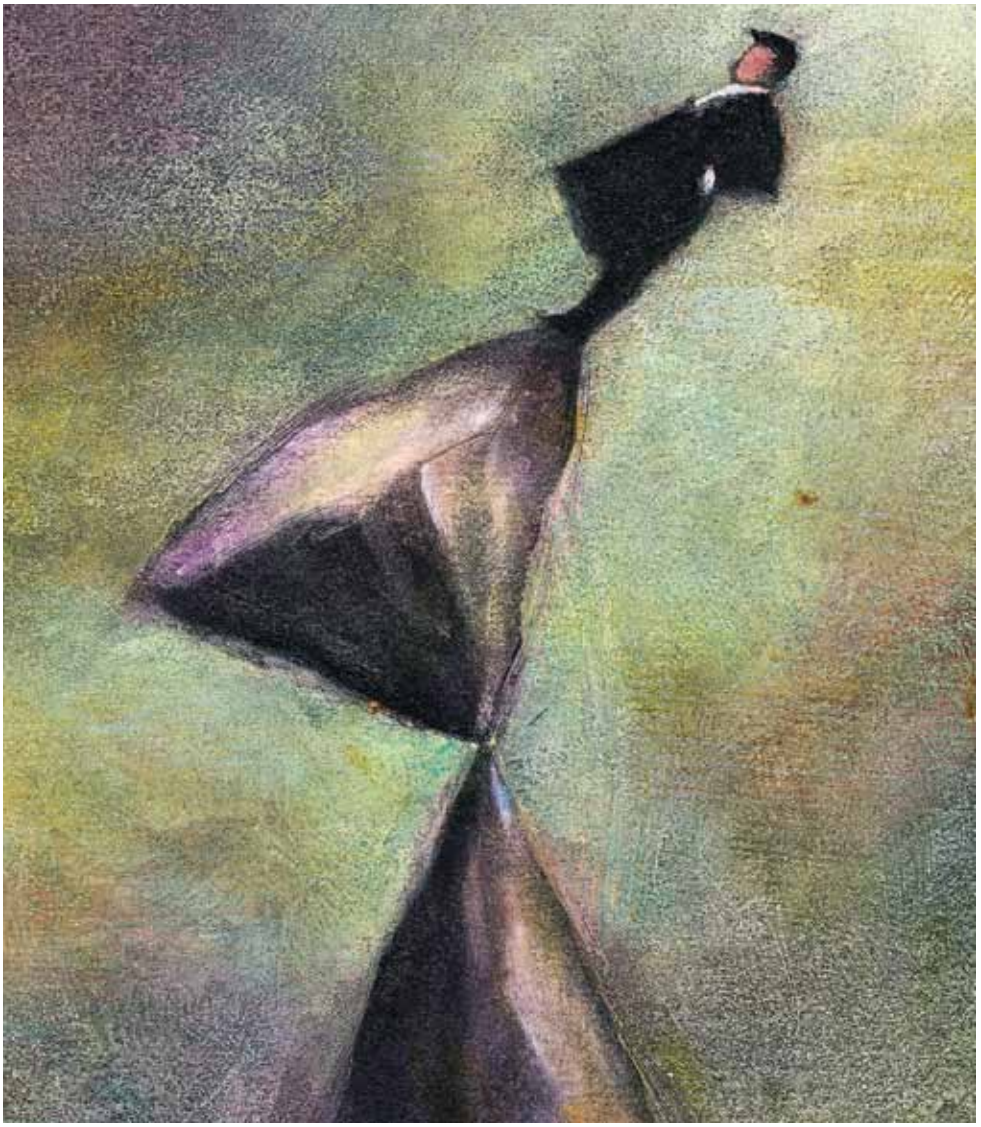
So what can oncology practices and community cancer centers do? First, be proactive—plan for change and identify and explore major payer initiatives in your region. If you fail to notice change and adapt your strategic planning accordingly,[2] you will likely be blindsided by payer decisions when it is too late to effect any change. For example, here's what happened recently in Florida. In early 2009, Blue Cross and Blue Shield of Florida engaged ICORE to manage oncology costs and treatment choices through the use of drug formulary restrictions, prior authorizations, and pre-certifications. These changes were considered onerous by the practicing oncologists in that state. At the time this article went to press, the final outcomes of the resulting standoff between the affected oncology providers and their patients versus the payer and the third-party manager were not yet resolved. Although the new contract was to be effective July 1, 2009, physicians had until September to choose to sign their contract renewals. The contract negotiations between Blue Cross Blue Shield of Florida and ICORE had been ongoing for about a year, however, the first physicians in the state knew of these discussions was when they received the announcement letter.

Additionally, Magellan Health Services, which owns ICORE, purchased First Health (a Medicaid insurer) in July 2009 from Coventry, a large national insurer. Part of the purchase agreement provided that Coventry was to roll out Magellan's ICORE oncology management services in five of its key markets before the end of 2009. Starting Dec. 1, 2009, ICORE oncology management will also take place in Missouri.

Understand the Payer Perspective

Oncology practices that seek to approach payers should understand that they are competing for the payers' attention with these external companies whose marketing message is "We can save you millions of dollars on your oncology spend." Payers have a markedly different mindset than most oncology practices and community cancer centers. Payers see oncology as a cost center. Each site of service and each regimen is a cost that can and should be compared with alternative options. Payers expect practices and centers to be run as efficient businesses, with evidence-supported decisions and cost-effective streamlined operations.

Further, payers are beginning to question the choices being made in the treatment of cancer. Many payers are feeling pressured by employers to justify their management of the premium dollar. Other payers are asking if cancer care can be delivered in alternative settings such as pharmacy- or payer-owned infusion centers. Today, payers are using multiple tools and strategies to help manage cancer care treatment and costs, including adopting Medicare reimbursement policies and rates, using specialty injectable



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programs, blanket prior authorizations, and more.

Adoption of Medicare policies and rates. Increasingly payers are recognizing that ASP+6 percent (the Medicare reimbursement rate for drugs provided in a practice or freestanding cancer center) is not sustainable, and they are turning instead to rates of ASP+12 percent or +19 percent. However, only a small number of payers are also adjusting professional reimbursement rates.[1]

Specialty injectable programs. Specialty pharmacies and pharmacy benefit managers (PBMs) are actively suggesting to payers that their programs for compliance, disease management, and patient support and education offer a safe and less costly alternative to the "buy and bill" model used today. While anecdotally, many payers speak to their preference for eliminating the "buy and bill" model, liability issues and additional costs and drug waste have caused some payers to reconsider. Still, this topic is a hot issue that will be addressed on an individual level by almost every payer. And oncology practices and community cancer centers need to know if *their* payers are exploring such programs.

Blanket prior authorizations. Often these programs are implemented when payers suspect inappropriate use or choices of care, or it could be just as simple as payers putting in a program to prove to their customers (employers) that they are appropriately managing the oncology spend. Payers use blanket prior authorizations as a screening tool—both to gather information on the care being delivered and to restrict approved care to follow specific payer-driven parameters. These authorizations also become a pathway to payer-driven guidelines and preferred-treatment regimens.

Care management entities. Faced with the complexities of oncology care and the multitude of oncology drug choices, payers are listening to external care management entities that promise to manage drug costs and choices and to narrow variation of care through approval processes. Often, practicing oncologists will not be aware of payer discussions with such entities until the announcement of a policy change. At times, these care management entities operate in a manner that is masked to the practice or community cancer center, gathering data on clinical practice patterns and drug costs to be used later in payer policy changes. For example, Magellan's ICORE program operated for years as a specialty pharmacy, offering private guidance to payers on oncology drug choices, pricing, and utilization, and now has turned its focus to more visible oncology management goals, starting with the initial contracts with Blue Cross Blue Shield of Florida and Coventry.

Partnering with external parties for oncology guidance, direction, and/or drug management. For the most part, these programs are being explored on a large regional or national basis. To date, these programs have been developed on an individual basis with participating practices and community cancer centers, and the oncology community at large has not been invited to participate. Oncology-based entities with these type of pilot programs include US Oncology, CancerCare Northwest, University of Pittsburgh Medical Center (UPMC), and CCE (Cancer Centers of Excellence). Other partnerships are more commercial, such as centralized negotiating entities like P4 Healthcare. Still others come from outside the world of practicing oncology and focus on building oncology management strategies, like CareCore Oncology and ICORE. None of

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these partnerships and entities uses the same set of guidelines and drug management policies, and all are seeking to differentiate their results from the central care population by cost savings.

Viewing oncology as a drug management issue, more than a disease specialty. Oncology is such a complex field that, to date, there has been little unanimity about how to manage the disease and its costs, even among large national payers. For oncology practices and community cancer centers, this scenario presents costs and operational challenges because they must deal with multiple individual payer approaches and payer contract issues. It presents similar challenges to payers since the provider base is so diverse. Any single payer could be contracting in its regional markets with numerous small practices of five or fewer physicians, multiple hospital-based cancer centers, one or more nationally networked practice(s), and one or more academic institution(s).

PBMs and companies such as CareCore Oncology, ICORE, and P4 Healthcare promise payers savings on drugs as a primary outcome of their process, and risk losing sight of other disease management issues for the complex specialty of oncology.

What about Specialty Pharmacy?

Speaking at a recent payer-focused meeting, a key leader in a major specialty pharmacy chain stated that "it was time to let doctors doctor, and to let pharmacists manage drugs." This comment reflects a sentiment often expressed by specialty pharmacy and by some payers—that it is time to move management and even oversight of oncology drugs used in clinical practice into the specialty pharmacy arena; that oncologists are better suited to identifying cancers, than managing drugs.

As an industry, specialty pharmacy developed out of the need for patient support, education, and assistance in the procurement and oversight of hemophilia drugs, and soon branched into other specialties and diseases. At a recent national specialty pharmacy conference a majority of sessions addressed oncology and oncology drug management. The specialty pharmacy industry looks at the growing pipeline of oncology-oriented drugs and sees a lucrative business opportunity. Additionally, moving oncology drugs from the medical benefit into the pharmacy benefit gives payers more flexibility in building consumer insurance benefit designs, and gathering key information, such as the NDC code, so that payers may request volume rebates from pharmaceutical manufacturers through their PBMs.

Some companies have increased their visibility under the specialty pharmacy and oncology management umbrellas, as part of their marketing initiatives with private payers. At the recent Academy of Managed Care Pharmacy held in Orlando on April 15 – 17, 2009, speaker Bill Sullivan of Specialty Pharmacy Solutions offered examples of specialty pharmacies that he determined were offering "innovative services" in the management of specialty pharmacy drugs. Number four on his Top Ten Innovators in Specialty Pharmacy list was a name familiar to many in the oncology world—P4 Healthcare. The company was lauded for its oncology programs, which "integrate P4-administered and payer-endorsed pathways into the oncologist marketplace with proactive communication, education, and significant financial incentives for positive patient adherence."[3] When payers start to consider companies as "specialty pharmacy" and "oncology managers," it also affects the perspectives of the oncology community.

What Does This Mean for *You*?

The traditional "4 P's" of marketing—product, price, place, and promotion—no longer work in healthcare. Innovative oncology practices and community cancer centers are now focused on stabilizing their business processes, with emphasis on the following new rules—"4 C's"—for marketing and competitive negotiations:

- ***Continuum***—Developing upstream and downstream connections and collaborations. For example, refining relationships with referral streams, helping primary care to manage cancer screenings and prevention activities, and better collaboration with hospitals to capture costs and implications of hospitalizations and symptom management.
- ***Care***—Defining and measuring patient satisfaction, establishing and monitoring outcomes measures, developing formal treatment plans, and improving follow-through, quality, and choices.
- ***Cost***—Looking at cost a number of different ways—per day, per treatment, per patient, per disease, etc. Understanding that the costs of cancer care extend far beyond the costs a single office or practice can track in their patient charts.
- ***Comparativeness***—Building registries to understand populations and care using real-world data and incorporating internal and external information on relative comparisons.

Strategies to Help Prepare for Payer Negotiations

Oncology practices and community cancer centers should review their marketing portfolios and competitive position in the context of these 4 C's. And prior to entering into negotiation with payers, build your own value portfolio (or "brag book") that outlines your program's

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Strategies to Help Address Completed Contracts or Proposals

Sometimes, before an oncology practice or a community cancer center has a chance to approach a payer regarding a new collaborative relationship or to enter into contract negotiations, they are presented with completed new contracts and program proposals. Often, these new contracts are the result of the payer contracting with an external entity for oncology management services or some type of drug management. If your oncology practice or community cancer center is in this position, here are 11 key steps to take:

1. ***Don't be afraid to ask for help.*** Often an experienced external expert can catch trends or changes that you may not anticipate, or identify seemingly "innocuous" clauses that may be significant down the road.
2. ***Review the new proposal carefully.*** Understand what is being asked of your program, your physicians, and your patients. Identify areas that may have been ignored or not addressed by the proposal.
3. ***Know your numbers.*** Run the proposed fee schedules and rates against your total patient volume—not just the top reimbursement codes. Often a few codes may look attractive, but after looking at the whole picture, you may discover that the new contract or proposal may not cover your operating costs.
4. ***Identify overhead burdens or additional costs.*** Sometimes your program may incur additional costs or overhead to be compliant with the new contract or proposal. Find out if those "new" costs are covered in the proposal. If not, ask why.
5. ***Look carefully at reimbursement bases.*** Payer contracts can and should offer rates for professional services that appropriately reflect your operational costs. Knowing your own costs will help you negotiate appropriate professional rates, allowing you to then negotiate rates for drugs that approximate breakeven on acquisition and handling costs—a win/win for you *and* the payer. With today's reimbursement climate, it no longer makes sense to accept contractual terms that push high margins on drugs. In fact, high margins on certain drugs tend to mean that payer wants you to use that drug instead of another drug. Look carefully to see if that choice is one you would make for your patients from a medical standpoint.
6. ***Assess the impact of the new proposal on your patients.*** If you have legitimate concerns about certain regimens or drugs that you feel are being "pushed" by a payer, it is fair to ask why and discuss your concerns with the payer.
7. ***Consider if you can afford to accept the contract.*** Fear of losing market share will not help your program if it accepts contracts for large numbers of patients on which it loses money on each patient. You cannot make up losses with higher volume at loss rates. If other programs choose to accept such a contract, it may be that they do not understand the loss issue, and will not be around long enough for you to worry about their short-term increase in market share.
8. ***Examine any third party involvement in the contract.*** Know the role(s) the third party is expected to play.
9. ***Know your responsibilities with regards to patient data.*** If your program is expected to provide data to the payer or a third party, know what data you are providing, where the data will go and how it will be used, and/or if the data is being sold, aggregated or not, at any point along the line to other entities. Ensure that your program receives copies of all reports that include your data (appropriately blinded) so that you can actively engage in analysis and discussion about the data with the payer. Ask if you will have access to additional data on the full costs of your patients upstream and downstream related to this contract or proposal. Your payer is looking at this information, and you have the right to expect to see the same information and to be involved in any analytics and discussion. Finally, try to identify if there is a way that the submitted data can be turned around and used against you in future years with this payer.
10. ***Understand that it's your decision.*** You always have the right (and obligation as your patients' advocate) to point out concerns and issues with any proposed payer contract. These issues may be universal enough (and *not* focused on specific rates) that they are voiced by other providers in a geographic region. Your state oncology professional association may agree to voice concerns about liability, new waste, overhead burdens, and general increases and barriers to care relevant to any particular contract. It has been common in payer/provider negotiations for the providers to be the first to acquiesce for the good of their patients. Now that margins are excessively tight and oncology practices and community cancer centers are actually incurring costs to provide care to some patients, providers can no longer afford to compromise to the point of loss in negotiations. The most responsible action for your patients is to ensure that your physicians will continue to be there for them.
11. ***Understand Your Liability.*** Ultimately, the oncology practice or community cancer center is liable for the treatment provided. If incentives or programs within the contract ask you to make choices or obtain key drugs from sources that could affect your liability, do not hesitate to point this information out to the payer. In fact, go one step further and ask for a waiver of liability where the payer is making a medical decision regarding treatment for their member(s). Odds are you will not receive one, but you will have made the point regarding your concerns. From that point, you can take a stand to agree or disagree with the policy or program.

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business case. Critical areas that need to be addressed include:

Know Your Market and Strategy. Take the time to do some strategic planning. Understand your actual and potential positioning.[2] A strategic retreat could be pivotal in obtaining buy-in and setting course for the cancer program. (For more on this topic, see "Strategic Planning for Practices" in the September/October 2008 *Oncology Issues*.)

Quality of care. This information should be defined in clear, measurable terms. For example, "In the last year, our program ranked in the 91st percentile of patient satisfaction ratings," versus the more generic, "Our program provides patient-focused care that our patients love."

Formal treatment programs and processes. These programs and processes should be identified and standardized. Examples could include pain management, oral drug compliance, symptom management for full completion of therapy, and fatigue measurement and management.

Operational policies. These policies will be an important step to help avoid management from external entities. In other words, payers may accept your internal treatment approval documents as an alternative to an externally managed document or process. For example, a payer might negotiate tight management of off-label choices as an alternative to an external process. Keep in mind, your formal processes, programs, or policies must be diligently double checked, monitored, and regularly reported on before payers will consider them to be a true working program.

Formal quality review processes. If your cancer program can show you have established tangible standards of care and a review process to ensure that these standards are met and continually improved upon, you will have far greater negotiating power with payers.

Data, data, data. The more you know about your internal costs of care, and the costs of care (upstream and downstream) that payers incur for your services, the better. Ask your software vendors (or drug distributors) what data they track globally (even de-identified) and ask for access to those reports. You may receive very interesting information that could help your program benchmark for trends and utilization.

Size matters—unfortunately. You may be the best oncology practice or community cancer center in the region, but if your market share is not substantial for any given payer, chances are you will be left out of any key oncology negotiations. Increasingly, practices or smaller community cancer centers are aligning with other groups, institutions, or networks to solidify their presence within their own markets. Keep in mind, however, that a large group or network that only has a small presence in any particular payer's regional or local market is likely to offer little additional value from a negotiating perspective. That said, this type of alignment may still offer benefits and value in terms of economies of scale and operational issues that are worth considering.

New collaborations with complementary delivery schema. This component of your business case should include up- and down-stream data and address the other aspects of care that touch your patients before, during, and after the care you provide. Identify opportunities for better integration, reduction of redundancy of diagnostics, better communication, collection of communal information, and a way to link technology or records.

It's Only the Beginning

Traditional approaches to payer contracting and negotiations will not serve oncology practices and community cancer centers in 2010. Rather, succeeding at payer relationships and negotiations will require a higher degree of sophistication. Start by understanding that oncology providers are not the only entities bringing the topic of oncology to the table, and that failure to develop an active, ongoing relationship with key payers, may end with you being left behind and at a significant disadvantage. Key payers may propose large national oncology management contracts from the top down—whether or not they have been actively engaged in negotiations with your practice or program.

Today's payer relationships and negotiations are complicated, and more likely to require the involvement of an external consultant to navigate the rocky waters. A neutral, third-party consultant can help assure that providers and payers are on the same page when entering into negotiations. This professional can help each side understand the other's position and issues prior to sitting down together to build a new relationship or work on a new program or policy. An outside consultant who understands the issues on both sides can also help diffuse deep emotional history and bring both parties forward to a new collaborative relationship.

However your oncology practice or community cancer center chooses to negotiate with its payers, remember the 4 C's—*cost*, *continuum*, *comparativeness*, and *care*. And, as always, the size of your program, the data it collects, the quality of its care, and its overhead and costs will play a significant role in any payer negotiations.

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