Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: (1998) In the Round: A BMT Discussion Group, Oncology Issues, 13:6, 30-32, DOI: 10.1080/10463356.1998.11904792

To link to this article: https://doi.org/10.1080/10463356.1998.11904792

In the Round: A BMT Discussion Group

At ACCC's 15th National Oncology Economics Conference on September 16, 1998, twenty-five cancer care professionals gathered for a roundtable discussion about bone marrow transplantation. The roundtable was led by Albert B. Einstein, Jr., M.D., F.A.C.P., Associate Center Director, Clinical Affairs, with the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Fla.

Presented here is an abridged version of the dialogue. Quoted participants include: Rhonda Dawkins, Response Oncology, Memphis, Tenn.; John Garner, Arlington Cancer Center, Arlington, Tex.; Matthew J. Goermar, Arizona Oncology Associates, Tucson, Ariz.; Cathy Murphy, A.R.T., Washington University School of Medicine, St. Louis, Mo.; Diane M. Otte, R.N., M.S., O.C.N., Alegent Health, Omaha, Nebr.; Diane Robison, Providence Hospital, Mobile, Ala.; Robert Speer, Covenant Healthcare System, Inc., Milwaukee, Wis.; and Joseph Verdirame, M.D., Alegent Health, Omaha, Nebr.

Dr. Einstein: One of the important issues at the Moffitt Cancer Center concerns how the payers are reacting. In the past, the issue was whether they paid for any transplants at all. We have moved beyond that. The questions now are how much are they going to pay for transplants and what is the methodology.

I think we are seeing a clear migration toward contracting with national care networks as opposed to working with the local regional HMOs. In talking to my colleagues in the community who have stem cell programs, they are seeing this trend as a threat. The smaller programs are having difficulty obtaining national types of certification and major contracts. Therefore, although there may be a stem cell program for breast, for example, the patient has to go to a tertiary facility, whether the patient or physician wants to or not.

I'd like to explore the experiences you are having across the country with regard to contracting with national payers versus the local payers and whether this trend is affecting your ability to accrue patients to the transplant program.

Mr. Goermar: I think we see a pretty good mix. We have some big payers in our marketplace in Arizona. Some payers have contracts with the university program. If there is one center of excellence in the community, it is almost given a contract by default because it's the only program. We approach some of our payers by asking if we can also be used as a center of excellence. Some of the big payers have started to respond to us.

Dr. Einstein: What do you have to offer them?

Mr. Goermar: I don't know if we are cheaper, but we have outcomes. The university's program is just getting started; I think there is one outpatient protocol open. We have twelve protocols that are open. I think the payers have been very receptive to what we are doing. We provide them with as much data as we can with respect to clinical outcomes.

The programs the payers are most familiar with are inpatient programs. So, we have developed an education process that shows what an outpatient program is and what the benefit is to the patient. One of the biggest benefits is continuity of care if the patient is a patient from our practice.

We have twelve medical oncologists in our group, as well as radiation and gynecologic oncologists and hematologists. We are just doing autologous, not any allos.

Ms. Otte: In our area we have looked at getting contracts with some of the bigger payers. Volume is one of the issues we have had to deal with. You can't even apply for their accreditation process unless you have a certain volume of patients over a certain period of time. And each payer has different criteria.

Dr. Einstein: In terms of criteria that these major payers are requiring, we have: volume, outcomes...

Ms. Otte: Quality? Are they going to build that a priori rather than looking after the event?

Dr. Einstein: Quality. How do you define quality?

Ms. Otte: Use a measurement tool.

Dr. Einstein: I think payers look at volume as being a surrogate for quality. The more experience you have, presumably the better your outcomes.

There is also the issue that a transplant is not necessarily a transplant, meaning there are different kinds of transplants. A breast cancer patient who is having a simple stem cell transplant, for example, is quite different from the patient who is having an allogeneic transplant for leukemia.

In the community setting, how many people are doing allogeneic? (two participants)

How many of you have your own independent program versus a program that is linked to a network? (ten participants)

A program affiliated with a larger organization? (two participants)

How many of you have dedicated medical directors for the program? (thirteen participants)

Ms. Otte: Is a certificate of need universal any more? I understand it is not.

Dr. Einstein: It is in Florida.

Ms. Murphy: Does anyone have their own cryo lab?

Dr. Einstein: Excellent question. How many practices run their own cryo labs independent of the hospital? (two participants)

Ms. Otte: We have a contractual relationship with the Red Cross and the university.

Dr. Einstein: In terms of contracting, how many people are involved in case rates or global rates or that kind of packaging as opposed to fee-for-service reimbursement. (nine participants)

How is that being modeled? What is your experience?

Mr. Garner: We did our own model. We just recently signed two contracts. One is with a health plan that is about 150 miles from the Dallas/Fort Worth area. The second contract is with a national medical management network.

We used a combination of historical numbers relating to our experience with stem cell support. We do have those breast cancer patients that simply get stem cell support, and we have leukemia patients as well. It is a wide range. We primarily use an RBRVS model based on historical CPT code utilization to come up with our case rates and applying our practice overhead costs to the model.

We are continuing to work with the payer to revise the model as referrals come in from the network. The payer helps to validate the information that we have provided and the information that we receive.

Mr. Essex: Is there a global price just for the physician practice, or is there a hospital component as well?

Mr. Garner: There is a hospital component. We are taking the risk for the hospital component. There are some outs also. We have some provisions within those contracts. It is limited to a certain number of inpatient days at this point

Mr. Essex: And the hospital is not at risk at all?

Mr. Garner: The hospital is not at risk at all. We are assuming some risk, but the health plan is still absorbing some of that risk also because the inpatient days are capped at ten.

Ms. Dawkins: Are you doing a per diem with the hospital, or are you paying a fee for service for their charges?

Mr. Garner: We do a per diem with the hospital.

Ms. Dawkins: So they are at risk.

Mr. Garner: Yes, to that extent, they are, but we don't pay fee for service.

Dr. Einstein: At Moffitt Cancer Center, we take our transplants and divide them into four groups: the straight-forward autologous stem cell, the more complicated stem cell, the allogenic, and the unrelated donor. Then, with some payers we establish a global rate that includes professional and facility fees. We divide the whole continuum of care into episodes. We have the collection component first. The actual transplant starts with the chemotherapy induction for the transplant through to whatever seems reasonable in terms of the length of stay. Although most patients will end up being readmitted, we try to keep that risk as narrow as we can.

We have a third component, which is aftercare. We have some payers who want us to do a global rate from the time of transplant all the way to a year of aftercare. We have resisted that and have tried to have the global rate apply only to the transplant episode. We try to do some discount fee-for-service for a period beyond that. We also try to exclude certain kinds of services from the contract where the costs have soared. We put a cap. We arrived at our numbers looking at the last year's data and figuring out what the costs were.

Another problem has been working with the physician group as part of the global rate, trying to come to some agreement in terms of paying the physicians. We are working on a formula of a percent of charges, which works out better with some contracts than with others. We did a major survey, trying to get some information about other programs' experiences, particularly as they relate to how to split global fee agreements between physicians and hospitals. The average split was somewhere between 8 and 18 percent for the professional component. However, getting good, reliable information is difficult.

We have ended up taking models to the payer and trying to educate those who are not familiar with the ins and outs of doing transplants. They would like you to sign on the dotted line for this amount for an autologous. We have to turn around and say to them, 'No, there is a difference between generic versus specific types of transplants. You really have to look at different kinds of transplants.' You must educate payers about reasonable ways to look at transplants. Then, most of them sign off. We have been able to negotiate reasonable

national contracts as well as regional contracts.

Ms. Murphy: What about payments for Medicaid programs?

Dr. Einstein: They pay $1,000 a year for all outpatient care in Florida.

Ms. Otte: How about Medicare. Has anyone had an experience with that?

Mr. Goemar: Yes. It has worked pretty well. Arizona is very heavily managed, so we are actually working with the HMOs rather than with Medicare directly. We contract with case rates for services. We have only had one fee-for-service patient.

Dr. Einstein: Anyone else have experience with modeling for case rates?

Ms. Otte: We have one experience with Mutual of Omaha. They are a partner with our system. They thought all their patients should go to the University of Nebraska, since that is their designated "Center of Excellence." It took us about three years to educate their staff about what transplants were all about. Their big focus at that time was outpatient transplant. We kept asking, 'Where is the outcome data to support outpatient transplants?' They couldn't show us that outpatient transplant made a big difference.

Mr. Speer: We have done a few globals, but we are new to this and feeling our way. In terms of professional fees, we worked it out with physicians to share the pain, share the gain. Everyone takes an equal discount.

Ms. Otte: Part of the frustration is that for every individual patient who gets transplanted in our community hospital, it just takes so many man hours—letter after letter after letter. Volumes of things have to be faxed back and forth to the payers.

Dr. Einstein: Once you have the contract, it becomes easier... But still, we are finding that tracking our costs on a patient-by-patient basis is very cumbersome and laborious.

...has anyone begun to think what might happen if the randomized trials that are underway don't show any value in high-dose chemotherapy transplants for breast cancer?

Dr. Verdirame: Do your providers want you to differentiate between inpatient and outpatient?

Dr. Einstein: With stem cells, yes. That's why we have two categories for stem cells, one being outpatient, the other inpatient.

Any problems with viewing transplant as a standard form of therapy?

Mr. Goemar: Generally payers accept it, but we have run into payers that don't want to pay for it. However, whenever a patient has gotten an attorney involved, it's always been approved.

Dr. Verdirame: Over the last eighteen months, we have found that more and more insurers eventually pay for it. But it can take two to three months or longer for approval—after letters and phone calls.

Dr. Einstein: Autologous bone marrow transplant activity is being done on protocols right now, generating data. In terms of your programs, has anyone begun to think what might happen if the randomized trials that are underway don't show any value in high-dose chemotherapy transplants for breast cancer? You have to think in terms of your programs; you are investing money and generating revenues, presumably. A sudden change in the outcomes, how will that impact your growth?

Ms. Otte: I think about what impact it will have on oncology as a whole. Over the last eight years, insurance companies have said this is experimental therapy, so show me the data. We show them the data, get the lawyers involved, and we get it paid for. All of a sudden new data comes out. Think of what is going to happen with other innovative therapies as far as payers are concerned. It's not just bone marrow transplant.

Dr. Einstein: My point is that this is still experimental therapy. It's not proven therapy. Even if the results come out a little bit better, it's not going to be optimal. The question for me is: Where we will be in a couple of years? You can argue from the payer point of view that it didn't work, so we will not reimburse for it. Or, you can argue from a scientific point of view that this way didn't work, but we have to find better ways to do it. Therefore, we are justified in doing additional experimental research.