

December 2019 Town Hall

Town Hall Objectives & Panelists

Financial advocacy experts discussed subjects that can benefit patients and financial navigation programs, including how to:

- Best communicate the importance of the open enrollment time period
- Communicate the importance of a financial advocacy team to assist with oral antineoplastic therapies
- Develop tools to update staff on Medicare and Affordable Care Act (ACA) changes during open enrollment
- Access resources in the community that offer guidance on available insurance plans
- Determine when to review patients' insurance benefits.

Panelists Included:

- **Clara Lambert**, ACCC Financial Advocacy Network 2018-2019 Committee Chair; Oncology Financial Navigator, Advocate Good Samaritan Bhorade Cancer Center
- **Nikki L. Barkett**, RN, BSN, OCN, Oral Antineoplastics Nurse Navigator, University of Arizona Cancer Center
- **Sarah Hudson-DiSalle**, PharmD, RPh, Oncology Pharmacy Manager, Medication Assistance Program and Reimbursement Services, The James Cancer Hospital and Wexner Medical Center, Ohio State University Department of Pharmacy
- **Abra Kelson**, LICSW, Supportive Services Supervisor/Program Director, CSC-NWMS, Northwest Medical Specialties, PLLC

Resources Highlighted

During the Town Hall, panelists referred to the following websites and resources:

- [ACCC Financial Advocacy Boot Camp](#)
- [ACCC Financial Advocacy Toolkit](#)
- [ACCC Financial Advocacy Services Guidelines](#)
- [Making the Business Case for Hiring a Financial Navigator](#)
- [Centers for Medicare and Medicaid Services' \(CMS\) National Training Program](#)
- State health insurance assistance program resources:
 - medicare.gov/contacts/
 - shiptacenter.org
- Agents, brokers, or patient navigators private insurance guidance resource:
 - localhelp.healthcare.gov/#/

Part I: Panelists' Insights

Communicating the importance of Open Enrollment and how to update staff on ACA/Medicare Changes

Sarah Hudson-DiSalle, PharmD, RPh

- Open Enrollment is when you can enroll, make changes, or switch plans. Like encouraging patients to have annual visits with their primary care provider or oncologist, this is the time to encourage patients to have their benefits checked. Make sure the patient's needs match their plan, so they do not end up in a situation where they do not have enough coverage for their medical needs.
- Open Enrollment periods are finite. Medicare is a 6-week program. It ended Dec. 7, 2019 for Part D and Advantage, and open Enrollment for Medicare Part B – Advantage Plan without Part D started. The Affordable Care Act (ACA) (Healthcare Exchange) window was extended until today, December 18, 2019. The window used to be a much longer enrollment period of 14-weeks but has shrunk to 6-weeks. These states have extended the ACA (Health Exchange) Open Enrollment period: Colorado, Connecticut, California, Florida, Minnesota, Maryland, Maine, Rhode Island, New York, and the District of Columbia.

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- If patients missed the window, they have to rely on a special enrollment period. This is usually triggered by a life- or qualifying event (e.g., they move to a new state, get married, or have a child). These events open up a special enrollment period where patients can enroll in an ACA plan. Patients need to know that they should see a financial navigator, financial counselor, or whomever in the organization can guide them.
- It is really important to remember a financial navigation program's success in helping patients depends on starting early. Make sure you develop an outreach strategy with your team to look for vulnerable patients.
- The [CMS National Training Program](#) helps with things like, Medicare basics, appeals, types of Medicare plans, and how to find resources to help patients with limited income. There is no charge other than travel expenses to participate. Participants can then return and help their entire organization and community.
- You should know the deficits in your community—for example, high [numbers of] Medicare, high Medicaid, uninsured or underinsured patients. Work with navigators, agents, brokers in the community to cast a broad net to figure out how to meet patients' needs. Create a Facebook page or newsletter that invites this network to a community benefit to learn about opportunities regarding the ACA, Medicare, Medicaid, etc.

Communicating the importance of a financial advocacy team

Nikki L. Barkett, RN, BSN, OCN

- I meet with all patients on oral antineoplastic drugs about new patient education, adherence, and adverse event management. On our team, the PharmD performs refills and test result monitoring, and a patient pharmacy advocate handles insurance prior authorizations and finding assistance/grants for patients.
- Clinicians play an important role on the financial advocacy team. Patients also have an important job in trying to manage their oral therapies.

Accessing resources in the community and determining when to review patients' insurance benefits

Abra Kelson, LICSW

- Each state has a state health insurance assistance program that helps individuals navigate Medicare. Go to medicare.gov/contacts/ or shiptacenter.org to find your state's health insurance assistance program.
- These programs provide one-on-one counseling for Medicare beneficiaries and their family to assess their healthcare coverage needs, determine general eligibility for healthcare and coverage programs, evaluate and compare health insurance plans and programs, and help with Medicare enrollment.
- If someone needs guidance on purchasing a private insurance plan, go to localhelp.healthcare.gov/#/ and enter a ZIP code or city and state. This will produce a list of local agents, brokers, or patient navigators that can help. If applicable, you may be directed to your state's marketplace, where you can find people that can help individuals compare plans.
- It is important for patients to review health insurance benefits every year. Patients' medications, doctor, and/or treatment plan could have changed, so it is important to review whether they are still getting adequate coverage or need to check with their healthcare team to see if they are going to continue to contract with their insurance. Another thing to consider is income changes, or changes in eligibility for Medicaid, low-income subsidy, or the Medicare savings program.
- At Northwest Medical Specialties, we scan insurance cards and verify coverage at every single visit.

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Part II: Audience Q&A

Question: What kind of reports do you run to identify at-risk patients to pre-screen?

Answer: We typically look for patients who are at risk of becoming uninsured or underinsured (e.g., patients on ACA plans, patients who have original Medicare and no secondary coverage, and patients on disability who have Medicaid and are going to Medicare—sometimes they lose Medicaid at that point in time).

Question: This is a new role for our program, and I would like to know the best tips and tricks of getting started!

Answer: Start small and try to determine what area needs the most help, as well as what is most feasible – this will set you up for success. Areas of focus will depend on the size of your organization.

1. Ask questions to better understand your current landscape and what is needed most:
 - a. Is there a disease group or other group that has the most need, and how do you identify those patients?
 - b. Do your front-line staff know how to reach your financial navigation staff?
 - c. What type of resources are available at your facility that you screen for and how do you get those instituted?
 - d. Are there free drug opportunities for patients? Do you provide charity?
2. Access existing resources to help you guide the way. Start with ACCC's [Financial Advocacy Tool Kit, guidelines](#), and [Boot Camp](#).
3. Bring the multidisciplinary team together to develop a workflow for screening and identifying high-risk patients, for example, stakeholders representing physicians, nurses, financial counselors/navigators, social workers, pharmacy staff, billing staff, pre-auth staff, etc.

Question: What is the most effective way to stay current or receive notifications on the changes occurring in the world of healthcare laws and coverage?

Answer: We recommend signing up for lots of listservs, like the Leukemia & Lymphoma Society and CMS listservs. Also, you can sign up for local oncology and hematology associations and advocacy groups or larger professional organizations like the Association of Community Cancer Centers (ACCC), Hematology/Oncology Pharmacy Association (HOPA), and/or American Society of Health-System Pharmacists (ASHP). They can inform you on the most current legislation and how that will affect your patients.

Question: Is the financial navigator a different person or a part of the social worker role?

Answer: It looks different depending your cancer program. There are certainly social workers who do work in the financial navigator capacity. Financial navigation is a service that is provided by a wide variety of roles, which can include financial navigators, social workers, and authorization roles. All have different functions, but in our own way we all contribute toward financial advocacy.

Question: What is the difference between financial navigators and patient navigators?

Answer: It depends on the cancer program. In my program, patient navigators are focused on removing barriers to care. They look at practical problems, like transportation, housing, food, and if patients need help at home. Financial navigation focuses on assistance for treatment or medication — for example, searching to find foundations, co-pay cards, free drugs, insurance optimization, etc.

Question: Are there any trends showing that programs will begin using specialty pharmacies for the infusion and/or injection of drugs given in your facilities?

Answer: There is a push to use a lot of specialty pharmacies. You need to work with your pharmacy and your state, which will be dependent on state regulations. For example, whether you accept white-bagged

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medication will depend on if you have that state mandate. We recommend interacting with health policy folks at the hospital and managed care teams to understand this. Also, know that you can push back on managed care plans.

Question: For the programs that have a financial counselor or navigator, do they deal with all patients and their medications or are they just specific to chemo infused drugs only?

Answer: As an example, at The James Cancer Hospital we actually split our teams into oral and infusion agents, but we are also a much larger center. When we started our program, they dealt with any medication a patient was on as long as our providers were going to be prescribing and following that medication.

It is not only limited to oncology medications—there are many resources out there for other chronic diseases that requires the same skill set as oncology. You can sometimes work with primary care providers to get patients enrolled in assistance for those other medications, too. You can also teach peers in rheumatology, neurology, or any other specialties these skills and resources for finding assistance.

Question: Is there a list of questions to ask a patient to help determine whether they fall into the financial toxicity status?

Answer: When we first reach out to a patient, we ask them about any financial difficulties. Do you have trouble paying your bills? Do you have trouble buying food? If they say yes, we will dive in a little bit deeper. Do you have trouble with insurance coverage? What is your financial hardship? Depending on their answers, we will refer them appropriately.

Question: Where is some good literature to help show the need for multiple positions for the financial navigator role? Currently we have one navigator. Are there articles that express the need for multi-person teams?

Answer: ACCC recently released [Making the Business Case for Hiring a Financial Navigator](#). This article will be a great resource for you.

Question: How are services coordinated for patients with high financial toxicity? For example, are services on hold until the financial coverage is addressed to reduce burden on the hospital and reduce financial burden on the patient?

Answer: It depends on the philosophy of your organization and what the patient expresses. Does your organization meet with patients to identify risks of financial toxicity? Do they create a patient focused plan with multidisciplinary input at that time?

For example, at The James Cancer Hospital we perform a benefits investigation. If you find that patients are disproportionately insured, you can engage those patients in a conversation about what they can expect to pay for the treatments and give them the opportunity to express how they want to move forward. Worst case scenarios would be a patient saying, "Well, if I had known it would have cost this much I would have never started." If we find that they are disproportionately insured, we will leverage the pharmaceutical manufacturers or get them enrolled in any type of disease-based or co-pay assistance program available. We then work with our revenue cycle folks to understand that those patients are enrolled into programs.

It is also important to continually touch base with patients that are on high-cost therapies.

Question: Have you ever referred people to social media platforms to help pay their bills?

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Answer: We would suggest not doing that. One of the reasons is that you really open yourself up to some liability. If that is a practice that your organization is currently doing, it is important to meet with your compliance officers to ensure that you are not violating any federal or state statutes

Question: Do any of you meet with the patient and go over the cost of treatment and their insurance benefits prior to the start of treatment?

Answer: Our financial assistance people do meet with each patient prior to starting treatment (both IV and oral) just to give them a rough "guesstimate." They may not know the exact treatment that they are going to be on, but they ask the physicians what they think. The financial advocates meet with the patient again at every change in treatment to share out-of-pocket costs, co-pays, and deductibles so that there are not any surprises.

Question: Is the financial navigator role separate from the revenue cycle/financial counselor role, and would it be considered part of the cancer center or the finance department?

Answer: As a financial navigator who has worked in two different cancer centers, I report directly to the cancer center. I am part of the navigation team, so I am not a part of the revenue cycle or the finance department. However, it is very important to have a good relationship with the revenue cycle and the finance department.

Question: How would you help a patient who does not get Medicare Part B coverage until July but needs to start treatment now and does not meet the income requirements for a free-drug program?

Answer: That is a difficult case study that we have probably all been through. As for not qualifying for free drug, if it is an infusion agent, I would actually try to see if you can appeal on a financial hardship case. See if you can get the income limit to come below what is listed for the program (e.g., look at what the patient's out-of-pocket expenses that they are incurring by not being covered by insurance that pays for the infusion drug). Also, maybe go back to your team and see if there is a different regimen that they could use that may decrease the cost until the patient's Medicare kicks in.

Question: Does anybody have a specific tool to determine estimated out-of-pocket expenses?

Answer: When we are doing costs of care, we are providing out-of-pocket costs for treatments to the patient. That is something that the authorization department is getting from insurance and providing to the patient. But for general overall cost of care, we use the Oncology Care Model (OCM) Predict Tool.

Question: How do you get through to the patient who has too much pride to admit financial toxicity?

Answer: I meet with the patients face-to-face when I am evaluating them, and I really just get in there. I establish trust first and make sure I am doing the necessary patient education. I save the hard questions for the end of the conversation, and I meet with them one-on-one in a private office so that there is not a large audience. They do let me know once they are comfortable with me. I have established that trust. I think also it is just helpful to normalize the experience and let them know that it is unfortunately something that many people face.

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Question: Do you have any suggestions regarding keeping the billing office aware of which patients are receiving co-pay assistance so that we are given time to make payments to the patient's account so the patient is not sent to collections?

Answer: We have worked extensively over the last three years to develop a program with our revenue cycle team, and we really leveraged our information technology (IT) services. We have an Epic platform and created a way to message the revenue cycle team so that they were notified. We actually designated a drug assistance program or foundation as a secondary payer and it would take the place of the patient's responsibility. Whatever would be left would hit the secondary payer next. There is a dedicated person on that team that finds those co-pay assistance bills, and we have a similar process in our specialty retail pharmacy, as well.

It is a collaborative effort, and I would encourage you to bring different departments together to figure out how to do that. The worst-case scenario would be a patient that gets a bill when they have co-pay assistance, and they pay that bill. You also need to communicate to the patient on what to do if they receive a bill.

If a foundation, like a local organization, works with us to pay a patient's bill, we will call our billers directly to let them know the patient will be receiving assistance. We ask them to set up a payment plan with the person and will notify them when the patient is approved so they are able to flag the account so it does not go to collections. It all requires close coordination and communication between departments.

Question: What have you found effective in mitigating workload burden?

Answer: Planning at the beginning of the year for any changes, whether it is prior authorizations, re-enrollment for assistance, or open enrollment, is very important. This also involved knowing what resources are available and making sure staff is motivated and knows what to expect with upcoming changes. There is a need to also bring these communications to frontline staff.

Also, be proactive versus reactive by implementing processes and workflows to screen patients regularly to provide intervention before a crisis happens. This lessens your burden because you are providing more preventive services instead of constantly putting out fires.