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Oncology Business Management™

INSIGHTS INTO ONCOLOGY BUSINESS PRACTICE

COVER STORY

Payer Hurdles Weigh on Practice Time, Revenue

BY LAIRD HARRISON

For Peter Ellis, MD, it's the rising costs and declining reimbursements, for Tom Gallo, MD, it's the preauthorizations, and for Paul Y. Song, MD, it's the narrow networks. Like many other oncologists today, these practitioners are grappling with new payment policies that lead to the inevitable aggravations.

"We are at just the beginning of a wave of change when it comes to how practices will be paid and judged by insurance carriers," said Gallo, executive director of the Richmond-based Virginia Cancer Institute, a group of eight practice locations.

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Rapid growth marks the 25-year history of The Center for Cancer and Blood Disorders of Fort Worth, Texas Shown here is its facility on Magnolia Avenue

PRACTICE PROFILE

Steady Growth for Community Practice Despite Uneven Field

BY CLAUDIA M CARUANA

The Center for Cancer and Blood Disorders (CCBD) of Fort Worth, Texas, has come a long way in 25 years, but it might have done even better were it not for the uneven playing field that invariably has community practices at the low end, said group medical director Richard Page, DO, PhD.

Richard Page, DO, PhD

Staying competitive in a healthcare market is hard to do when laws and policies continue to give an edge to large, corporate hospital-based systems and networks, Page told *Oncology Business Management.* "This results in site-of-service disparities in access to care, methods of payment for services, and steerage of patient referral networks, which ultimately affect the value of care for cancer patients," Page said.

Despite the many challenges facing small oncology practices today, CCBD has evolved from a four-oncologist practice in 1990 to a string of nine separate locations in the Tarrant County region, which encompasses Fort Worth Two of the original physicians continue to work in the practice part time.

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FEATURE

Financial Toxicity of Cancer Care Hits the Young Hardest

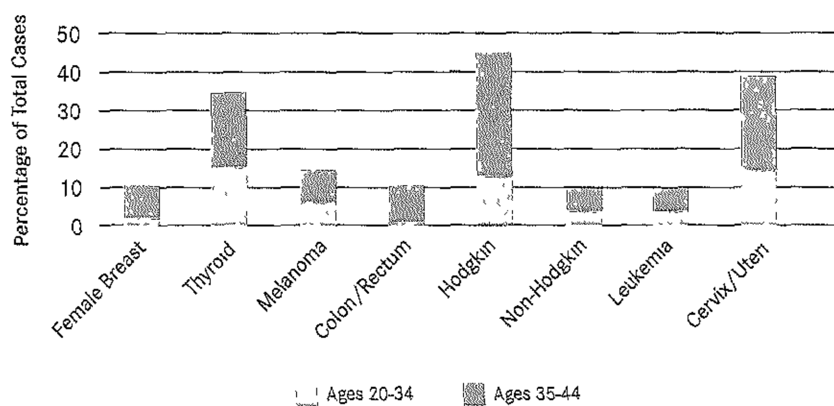
BY SAMANTHA WATSON, MBA; AND MICHELLE S. LANDWEHR, MPH

Treatment of young adults with cancer poses a special challenge to physicians as these patients often have much more limited financial resources Consequently, the financial toxicity of cancer care hits them harder, leads to a reluctance to comply with treatment regimens, and leaves an after-treatment legacy in the form of accumulated medical debt.

The following article describes the particular financial circumstances of this patient population and suggests the need for especially sensitive handling by providers, owing to the embarrassment patients are likely to suffer.

There are currently 630,000 young adults in the United States with a history of cancer[1] Due to the overwhelming costs of cancer, many find themselves struggling financially post treatment–facing ruined credit, depleted savings, looming homelessness, and other dire circumstances (**Figure**).

Figure. New Cases of Cancer Among Young Adults per Year by Percentage



Source SEER 18 2008-2012

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The Center for Cancer and Blood Disorders of Fort Worth, Texas, has grown to include multiple locations over a 25 year period Management attributes the success to a patient-centered approach and a separation of business and medical responsibilities

Steady Growth for Community Practice Despite Uneven Field

BY CLAUDIA M. CARUANA

(continued from cover)

Hiring for the Long Haul

Much of the success of the practice has to do with a policy of hiring physicians who will stay for the long haul and become investor-owners, Page said.

"We have enjoyed strong incremental growth We would actually like to have grown and expanded our footprint much more rapidly. However, to support the startup salary for new physicians for their first two years, our 'capital partner' is indeed the wallet of the current physician partners. Therefore, when we hire a new doctor, we are looking for a true lifelong partner who will be successful, productive, and happy–not just someone to fill a need. It is truly the culture of our independent practice that allows us to hire the very best doctors that contributes to our success."

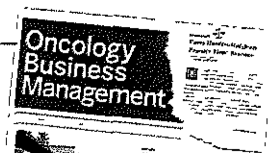
In 1994, the original partners merged with another practice, which, CCBD says on its website, became the foundation for the current degree of comprehensive care offered by the practice Growth has been organic, rather than through acquisition, CEO Barry Russo said. The practice specializes in medical oncology, radiation oncology, gynecologic oncology, and breast surgery. Patients with nonmalignant blood disorders, such as platelet problems, sickle cell, thalassemia, and other serious anemias, also are treated at CCBD

Clinical trial involvement makes up a large portion of activity. The centers have participated in more than 80 clinical trials, many resulting in FDA approved new chemotherapies.

Adding Good Business Sense

Page and Russo said that it has been essential to inject an element of business acumen into their operations, as merely knowing their subject as doctors would not have been enough. Therefore, they have taken care to incorporate this type of savvy into their management structure.

"Providing comprehensive cancer care is an extremely complex medical



and business practice that carries high financial risks on slim margins," Page said. "The best model to achieve success is to have a leadership dyad with a strong clinical physician-leader combined with an accomplished practice manager with the 'business smarts.'"

Barry Russo

Page said it's hard to find sufficient business talent in a physician, and so it's better to divide up the responsibility by hiring separate management leaders who know either medicine well or business inside out. "Very few physicians have the capacity to master and maintain both skill sets The traditional 'physician-with-the-spouse-running-the-books model' has become history"

An advantage of having a business-minded person on the practice team reveals itself when working with payers to obtain the best possible rates. "We have to know how to negotiate better with the insurance companies for fair fees," Page said.

One problem that isn't as easy to overcome is the tremendous revenue advantage many large medical institutions have through the 340B drug discount program, which allows outpatient drug providers to get manufacturer drug discounts as deep as 40% while obtaining reimbursement at much higher levels from Medicare and private payers. Russo said that puts practices like his at a huge disadvantage. "In many cases, especially related to Medicare reimbursed drugs, community oncology practices are under water on drugs . meaning the practices pay more for drugs than Medicare reimburses them. For most community oncology practices, the overall margin is around 3%, which gives you an idea of the level of discounts they are able to negotiate."

CCBD, whose physicians do not treat children, saw 7000 new patients last year, many coming from as far away as 150 miles Although the practice does a small amount of radio and print advertising in northern Texas, most patients are referrals from other physicians. There are some self-referrals, probably 5% to 7%, Russo said, "but because 90% of our referrals come from other docs, we spend most of our time marketing directly to docs."

Like other community practices with multiple locations, CCBD can offer its patients the convenience of clinics closer to their homes than a large, centralized facility would be However, most people in need of cancer treatment will focus their initial energies on selecting an oncologist usually referred by their primary care provider or surgeon They choose that physician, not necessarily a location, Russo said.

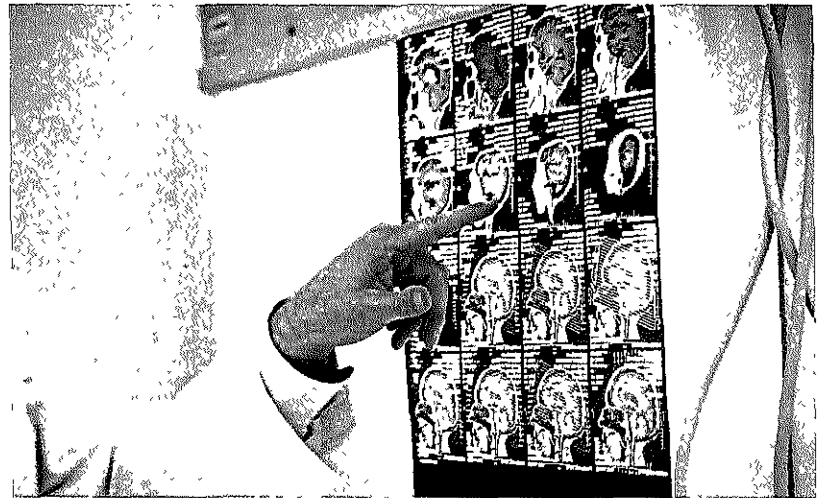
Around-the-Clock Service

The practice keeps its doors open six days a week and the rest of the time an on-call physician is made available This also helps to keep patients out of the hospital, Russo said "Our clinics are open until 6 PM during the week, and we are also open on Saturdays to try to solve most patient issues to keep them out of the emergency rooms. If we are not able to solve the patient's clinical issue, however, we will send them to the hospital"

Officials at CCBD say their nursing care and ancillary services also are important to their success Amanda Hodges, RN, OCN, director of clinical programs and support service, has been at the practice for 15 years "We're there for them and address their concerns," Hodges said of the patients.

Financial issues are at the top of the list of patients' concerns, and the practice does what it can to help manage the direct and indirect costs of their care. A major concern patients have is whether they can work during treatment, Hodges said "Paying for co-pays, prescriptions, out-of-pockets, and deductibles–these seem to increase every year. Transportation to and from appointments, the cost of gas, and childcare during treatments are also important to them," she added.

"Our social work team works closely with patients for the financial side


A Center for Cancer and Blood Disorders physician uses imaging material to determine the extent of disease progression

of these concerns. There are very limited resources available to assist with many of these, and most people do not realize the burden on patients from not having access to assistance. There are often programs, support groups, and covered visits for patients to access a provider for emotional distress, but no financially covered support for caregivers or family members We are lucky to have a foundation that supports our psychotherapy program to include family members."

However, CCBD has found additional help for its patients, Hodges said. "We access some local foundations for assistance for cost of gas and transportation concerns that help with supplying gas cards and rides for patients. We also have volunteers and specially designed programs to work with individuals or groups to help patients understand and adjust to the temporary and permanent changes in their appearances" resulting from cancer treatment

CCBD also recognizes the value of relationships between staff and patients. Hodges said oncology nurses are not assigned to specific patients, "but when a bond is formed between a nurse and patient, we try to maintain that continuity of care."

For the most part, she adds, "Staff members float to several locations and work with all patients. We have a team-based approach that includes the nurse navigator team, clinic medical assistants, infusion nurses, triage nurses, and when needed, case managers. Our case-managed patients work with the same case manager throughout their treatment."

Hodges, who has also worked in a hospital oncology setting, believes community practices enable health workers like herself to offer patients more flexibility and greater access to care. This is because licensed staff, such as nurses and social workers, have more autonomy to make decisions in the best interest of the patients, she said.

"Physicians are accessible and approachable; all members of the team are invested to ensure that the patients receive the highest quality of care available, and the administration team works side by side with patients every day." In contrast, she said, "The hospital setting may have larger budgets for services, but often [there is] red tape that makes new processes difficult to implement" ■

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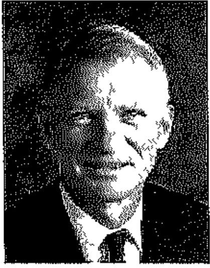
Peter Ellis, MD

pended on payments from our private payers to make up for the lack of reimbursement from Medicare," said Ellis. "The problem is that private practices are typically small groups, three or four guys practicing, and they have no negotiating power with the payers and don't have the leverage that hospitals have."

The combination of administrative demands, increased drug costs, and lower reimbursements is forcing many oncologists to join hospitals or to band together, so that they can share their expertise and resources.

The Center for Cancer and Blood Disorders (CCBD) in Fort Worth, Texas, has joined with Sarah Cannon Research Institute, which has taken on much of the paperwork for clinical trials management. "That allowed my research staff to be able to go back to triaging and taking care of the patients," said Ray Page, DO, PhD, the president and director of research for CCBD.

Such alliances can lead to savings, he said. "Practices look for relationships and alliances to try to create some of those economies of scale. You can negotiate some slightly better rates, not only for chemotherapy, but purchasing and maintaining equipment, electronic records, needles, Band-Aids, chemotherapy chairs, and toilet paper, for that matter."

Although hospitals are able to charge much higher rates than oncologists in private practice, even working for a hospital doesn't necessarily free an oncologist from any concerns about changes in payer relationships.

As a radiation oncologist employed by Cedars-Sinai Medical Center in Los Angeles, Song may not have to argue over the phone with payers or worry about the cost of sanitary supplies, but he does have to pay close attention to billing, because all of his charges are reviewed for anything he might have missed. "Cedar cares about every last penny," he said.

More important, he finds that the Affordable Care Act (ACA) has separated him from patients. Some signed up for new health plans under the act and found themselves in narrow networks of providers that don't include Song.

Payer Networks Don't Include the Best

Many insurers are not building their provider networks from the best oncologists in the profession, he said. "They don't really look at quality or metrics or patient satisfaction, they just look at who gives you the cheapest rate to treat this population, even if the number of doctors they contract with is not sufficient to meet the needs of a certain population that they're covering."

Paul Y Song, MD

Sometimes the list of doctors in a network changes between the time the patient signs up for a health plan and the time they try to make an appointment, Song added. He plans to retire from oncology soon and devote himself to advocacy to stop this kind of practice.

Already, he spends time advising patients on their health plan choices. He recommends against Medicaid health maintenance organizations (HMO), for example, because of the narrow networks.

And he also often recommends against health plans that are rated as bronze under the ACA. The low premiums are attractive to patients, but the deductibles and copayments are sometimes more than patients can afford. "For the average plan in the US, the deductible is around $6400. A lot of people don't have that kind of money sitting around, that's for sure."

Another problem that has cropped up with the expansion of coverage: lots of people default on their premiums. Since the plans give patients a grace period, Woofter said, patients may appear to have insurance when they actually don't. Woofter only learns that their insurance has lapsed when she tries to file a claim.

Such new wrinkles have forced oncology practices to very closely scrutinize their patients' coverage. "The practices have to be very good at managing their accounts receivable and making sure they have processes in place to identify any patient responsibility and to collect that patient responsibility," Gallo said.

That doesn't mean the ACA has no advantage for oncologists. The elimination of maximums on lifetime benefits and the ban on denying coverage to people with pre-existing conditions have helped some people to afford care, said Woofter.

ACA Has Improved Quality, Accountability

"Some of the good that I've seen is a push toward having more quality and accountability, and pushing practices to have more value-based care, and not just the volume associated with fee for service," Page said.

Page's CCBD is participating in the Community Oncology Medical Home (COME HOME) program, through which participating practices are working to show they can save CMS money by setting up better systems of triage and creating their own treatment pathways.

Ray Page, DO, PhD

CCBD has centralized first responders for all of its nine locations, and added dedicated triage nurses and evening and weekend clinic hours, among other changes. This process has prepared the clinic to participate in initiatives such as CMS's planned Oncology Care Model and similar programs by private insurers, Page said.

Page's group is also working with United Healthcare and Aetna, which have launched their own oncology medical home programs. Aetna's program reimburses physicians based on "processes that lead to outcomes," said Kolodziej. Among the factors, he said, are the cost of care, emergency-room and inpatient utilization, robust end-of-life programs, and generally agreed-on quality standards, such as following evidence-based guidelines and managing pain.

To create benchmarks, Aetna used a subset of the ones used by the Community Oncology Alliance for the COME HOME project, Kolodziej said. The health plan wanted to start out with a "fairly minimalist" set of outcomes measures and develop them in concert with other groups working on similar projects. "I don't force metrics down people's throats because I don't think anybody knows what the answers are," he said.

He points out that not all practices could adapt as well to the new model. "Those practices were carefully selected because they had both an appetite to pursue this and the aptitude to succeed," he said.

To get an idea how much Aetna can expand this program to other practices, it will watch closely as CMS roles out its Oncology Care Model, Kolodziej said. "I'm pretty good at identifying practices that have a chance of success and practices that have no chance of success," he said. "I think Medicare is going to have practices that are throughout that spectrum."

For example, oncology practices that have not fully implemented electronic medical records cannot participate in the Aetna oncology medical home program.

But Aetna is seeing encouraging signs from the practices that already are part of its oncology medical home program, Kolodziej said. Analyzing data after the first year, Aetna estimates that its oncology medical home project has already saved money for the insurer. And the four participating practices all seem happy with the results as well, he said.

"I would say it offers perhaps the best example of an attempt to use collaboration to achieve the desired result of the optimal shared outcome," Kolodziej said.

And that may be the biggest change in relationships between oncology payers and providers. Despite all the tension over reimbursement rates and preauthorizations, many are talking, working out their differences, and working together. ■