

Payers and providers: a love match?

Can't we all just get along? When two groups, traditionally at odds, come together, some sparks may fly. But at least they're talking and taking tentative steps toward a better understanding.

The relationship between providers and payers is still no love match, but there are ways to bring the two parties closer together. In a panel discussion, representatives from both sides shared their guarded feelings and offered some suggestions for moving toward, if not a love match, at least a civil union.

Bruce A. Cutter, MD, a medical oncologist and the director of Cancer Care Northwest in Spokane, Washington, commented on the overarching problem as he sees it. "There are relationship issues to overcome. There is a lot of distrust to overcome. Providers view payers a certain way, and payers question providers. Some of what each sees is appropriate, and some is not. But I maintain that providers and payers have a lot more in common than we think."

Dave M. Johnson, MD, MBA, CPE, the regional medical director of Premera Blue Cross in Spokane, Washington, agreed. "We've got to get past the historical baggage," he said, "and develop a different kind of relationship or we will all continue to be penalized." Dr. Johnson acknowledged that this lack of trust between the parties is not easily amended. "Trust takes time," he said.

Premera is known locally and nationally for its efforts to reach out to providers in a collaborative way.

Show me the money

From the provider perspective, the chasm exists because many oncologists feel taken advantage of, bilked out of fair compensation, and because they are constantly frustrated about coverage issues such as pro-

tracted precertifications, and delayed reimbursements. Payers are mistrustful because they perceive oncologists as using expensive drugs and service without regard to costs.

"You are a target because you are taking in big money for drugs, radiotherapy, and so forth," Dr. Johnson told attendees. "The payer world is thinking, 'Those oncologists are getting big profits, and if we can reduce this we won't have employers upset with us.' I hear about this tidal wave of biotech agents and I'm wondering how the heck we're going to afford it. How will we do this as a society? Do oncologists even think about the cost?"

The idea that oncologists earn too much money didn't sit well with some attendees. One remarked, to audience applause, "You think oncologists make too much? Some of us think insurance executives make too much!"

Another added, "With Blue Cross, I lose money on every patient and every drug I sell. The insurance companies can well afford oncology fees—which we don't make up. We are given a list of those charges."

Dr. Johnson emphasized that these are *perceptions* only, but there is a widespread belief that oncologists make big profits. He acknowledged, however, that he does not know the cost at which an oncology practice buys its drugs.

An attendee filled him in. "Our list price for Neulasta (pegfilgrastim) from Amgen is \$2,700. We get reimbursed only \$2,400, so we are out \$300 from the start. With a backend rebate of 3%, which we get three weeks later, we have a \$22 profit for the drug, and we are out \$300 for 3 months."

Another attendee added, "Hospitals get paid whatever they charge, but oncologists are cut into the average selling price model. You can't compare these two. You are looking at what you pay hospitals and getting the wrong idea."

Know your stuff

Session moderator Dawn G. Holcombe, FACMPE, MBA, of DGH Consulting and the Connecticut Oncology Association in South Windsor, Connecticut, pointed out that the oncologist doing the math on pegfilgrastim did not factor in the cost of ordering and storing the drug. So the \$22 "profit" actually might have been nil or a loss. "In oncology, doctors are just now beginning to understand their own cost structures," she said. Payers need this kind of information, yet not all practices are able to provide it, she pointed out.

Such information is ammunition for the oncologist, said Dr. Johnson. "By the insurers not knowing your exact costs, they think they can ratchet things downward and they don't know when it's gone too far." But, he added, insurers are "caught in the middle," having to deal with employers on the other end who say that prices are too high and they cannot tolerate more increases.

Be transparent, be responsive

Speaking for payers, Dr. Johnson suggested that the answer is transparency. "We have the perception that you are making boatloads of money. Try to be transparent. Put the numbers side by side for me so that I can take your story to the leadership of

my company,” he told oncologists. “I want to demonstrate that you buy X drug for X amount of money, you administer it for X amount, and so forth. Without these data I cannot get changes made.”

To oncologists, the answer is greater responsiveness from the payer, according to attendees. Several took the opportunity to voice their frustrations over delays in authorizations and payments, and dealing with “the 800 numbers.”

One provider in the audience told the payers on the panel, “We want you to take care of us the way we take care of our patients. We are miles apart!” Regarding the endless and unpredictable authorizations, he added, “We give the drugs and keep our fingers crossed we’ll be compensated. That leads to distrust and dysfunction.”

David H. Henry, MD, clinical professor of medicine at Pennsylvania Hospital in Philadelphia described a typical situation in his office. “I get to exam room 3 and Mrs. Smith is not there. I am told she is in the waiting room, waiting for a referral. I know this could take all day. I say, ‘I’ll just see her free of charge to keep things rolling along.’ Or, I prescribe regimen X for a patient. Then I find out she needs a precert and she cannot get treated today. Then, there are my billers. They are frustrated over things that occur without their knowledge: changes in codes, rules, regulations, and so forth. To remain up to date, they feel they need more education on a basic level.”

Another attendee lamented the routine denials he gets for PET scans, the denial he received for three US Food and Drug Administration-approved breast cancer drugs that the claims personnel considered experimental, and the fact that these workers appear to be unfamiliar with drugs (denying Cytoxan but approving cyclophosphamide). He located the company’s medical director to argue

his case for the breast cancer regimen, “and he was a general practitioner who didn’t know what I was talking about,” he said. “There is truly a big gulf to overcome.”

Another oncologist added that, “If an area of your business is not functioning correctly, you need a designated team of experts. We learned this from our experience with multispecialty groups, when billers and collectors were not specialty-oriented. Our billers have to know oncology. Your people should, too. We need a contact person in the insurer’s office who understands oncology.”

Others expressed annoyance at having to call 800 numbers, enter strings of patient identification numbers, be referred elsewhere, be put on hold, and wait days for a response.

“I call this the ‘spin cycle,’” one attendee said. “I dial up, wait 45 minutes, and get India, where they’ve bundled the chemotherapy codes and have left off a drug. We need an oncology specialist who understands these codes. This costs our office undue time that is not reimbursed. And I won’t even go into the time spent on authorizations!”

Delays in payment of claims also frustrate and mystify providers, as Dr. Henry pointed out. “UnitedHealthcare pays most of its claims within 30 days. Why can’t it happen sooner? It takes seconds for my computer to talk to your computer. We are out this money for a month!”

Ms. Holcombe encouraged providers to engage payers in a discussion of the slow turnaround time. “We know, from the pharmacy benefit side, that a quicker turnaround is possible,” she said.

Models that work

The payer representatives say they have responded to provider frustrations with solutions. Ranae A. Dahlberg, BNS, RN, director of clinical services for UnitedHealthcare’s Oncology Line of Service, said that ef-

forts are under way to improve her company’s relationships with providers, “but it’s a challenge,” she said. Ms. Dahlberg told the providers in attendance, “We want to partner with you to learn more about your practices.” UnitedHealthcare is aiming for timely and accurate payment of claims and for transparency of their own policies, she said.

In response to complaints, her company is putting together an oncology claims payment team to handle concerns from the community. “We heard your complaints, we investigated internally, and we discovered that Herceptin (trastuzumab) claims were not being paid properly. We are correcting this. Our goal is to have 100% of the chemotherapy J codes routed to this specialized team,” Ms. Dahlberg said. She is aiming to have a dedicated oncology call center in the future, and she recognizes the need for the oncology claims payment team to be fully versed in oncology drugs, terminology, and issues.

Premera Blue Cross is also working on solutions, Dr. Johnson said. Premera now has a Provider Network Associate (PNA) for each oncology practice; that person handles claims issues and has direct contact with the provider. One stop higher up is the Provider Network Executive (PNE), who deals with issues other than claims. When issues are not resolved by the PNA or PNE, the medical director (such as Dr. Johnson) is called in to hear the provider’s point of view and to advocate for him or her. All community oncology practices should lobby for such a model with their carriers, “because it works,” Dr. Johnson said.

Initiating the dialogue

“How do you start a dialogue between the frustrated community oncologists and the payers?” Ms. Holcombe asked.

Ms. Dahlberg suggested scheduling sessions with the medical direc-

tors of the carriers and showing hard data. “Bring in examples of your concerns,” she said. When her company realized there were ongoing errors in paying some of the injectable drug claims, they developed specialized claims teams. They also announced that the National Comprehensive Cancer Network compendium would be used as a source for coverage decisions, so providers would understand which situations would be automatically covered and which would have to be negotiated. “We are trying to make changes to make your life, and our life, easier,” she said.

Dr. Johnson further emphasized the point: “I hear the emotion, but I can’t take your concerns forward without hard facts,” he said. He suggested that practices lobby for a “nurse-to-nurse” relationship with their insurers, which

is what Premera has set up for its providers. Additionally, he suggested that practices obtain the medical policies of their major insurers. “You should be reading every policy and knowing what each insurer is looking for.”

When the proper channels, especially a dialogue with the medical director, prove ineffective, providers should complain to a higher authority. “If you don’t get a resolution, the card you should play is the Office of the Insurance Commissioner [OIC]. The OIC does not want to hear from you daily, though, so reserve this recourse for serious cases,” Dr. Johnson advised.

When out-of-state insurers are involved, Ms. Holcombe pointed out that state associations may be useful. For the Connecticut Oncology Association, she hears providers’ complaints, contacts other

practices to look for trends, then takes such information to the medical directors herself. “This way, all practices don’t have to have their own dialogues, and medical directors don’t have 20 doctors yelling at them,” she explained.

Creating a dialogue between payers and providers “is not like magic,” said Dr. Cutter. His practice collaborated with Premera Blue Cross, its largest insurer, to develop a comprehensive quality care initiative that serves both parties well. Much was learned from that process, he said. “We came to an understanding of common goals and commitments. We put patients at the center. This allowed us to start changing our thinking and to have a dialogue. We are a living example that positive, productive relationships can form, but it’s a journey.”
