An Economic Assessment of ANCO Member Practices

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Abstract

An Economic Assessment of ANCO Member Practices reports on a study conducted in late 2009 and early 2010 on a volunteer sample (n=14) of northern California state oncology society member practices to assess key economic factors, diagnose their economic viability, and prescribe changes to their practice management so as to enhance their economic viability. Recommendations for individual member practices as well as for the state oncology society are made as a result of the findings of this study.

ANCO. The *Association of Northern California Oncologists* (ANCO) was organized in 1990 to be an advocate for, educate, and inform the practicing hematologist/oncologist. ANCO currently represents hematologists/oncologists throughout northern California and Oregon. While the majority of ANCO members are community-based physicians, ANCO also represents the hematologists/oncologists of the regional academic cancer centers—*Stanford University, UC Davis*, and *UC San Francisco*—and *The Permanente Medical Group*. ANCO serves the interests of its physician members, their nurses and practice managers, and people living with cancer. ANCO is the state/regional affiliate of the *American Society of Clinical Oncology* (ASCO) for northern California.

ANCO is dedicated to the delivery of the highest quality care to people living with cancer by providing a forum for the exchange of ideas, data, and knowledge and by representing the interests of physicians and people living with cancer. To these ends, ANCO disseminates information via e-mail, FAX broadcast, the *ANCO FAX News*, and its website; sponsors clinical education meetings for physicians and nurses and professional education meetings for physicians, and nurse and practice managers; and, advocates on behalf of physicians and people living with cancer before State and Federal government agencies, regional and national hematology/oncology and medical societies, and insurance and pharmaceutical companies. ANCO's goal is to defend and preserve the autonomy of hematologists/oncologists and to provide the highest quality cancer care to people living with cancer.

ANCO's clearly defined objectives are to:

• Disseminate the latest and best information impacting the practice of hematology/oncology to members.

• Provide clinical education to physicians and nurses and professional education to physicians, nurses, and practice managers.

• Serve as an advocate and liaison for its members before regional and national organizations (i.e., government, private, and corporate).

• Play an active role in the reimbursement environment on behalf of physicians, nurses, managers, and people living with cancer.

Membership Demographics. As of May 1st, 2010, ANCO has 404 total physician members. Of these:

• 3 are government physicians (at *Travis Air Force Base*);

• 83 are with *The Permanente Medical Group* (i.e., Kaiser);

• 141 are at academic cancer centers at *Stanford University*, the *University of California, Davis*, or the *University of California, San Francisco*;

• 61 are physicians affiliated with five (5) separate multi-site, community-based oncology practices (with an average practice size of 12.2 physicians, some of which provide both radiation and medical oncology services);

• 107 are physicians at 70 single-site, community-based oncology practices (with an average practice size of 1.5 physicians, only providing medical oncology services);

• 9 retired physicians.

Member Economic Challenges. In early 2009, ANCO was already keenly aware of the significant economic challenges facing member practices and presented by Medicare payment reform and its adoption by private, third-party payers. However, to our knowledge, only a minor contraction of community-based medical oncology services in northern California had taken place. Some member practices moved from full-time medical oncology services to half-time oncology and half-time internal medicine. Some practices reduced physician staffing but remained full-time oncology practices. And, one practice transitioned from full-time oncology to full-time internal medicine.

In early 2009, however, a prominent, well-informed, and well-managed medical

oncology ANCO member community-based practice failed economically and closed. Was this a "canary in the coal mine" moment or were there unknown internal management issues that closed the practice?

Economic Assessments. In response to its awareness of the growing economic challenges facing member practices and the economic failure of a prominent member practice, ANCO designed a consultation service to assess the economic health of member practices, report results to the participating practices individually and confidentially to the *Association* in the aggregate, and prescribe measures to improve member practice's economic health. Two nationally recognized experts in oncology practice management, Roberta Buell, M.B.A., *OnPoint Oncology LLC*, and Patricia Falconer, M.B.A., *Health Options*, were selected to conduct these economic health assessments. The service was offered to all community-based member practices on a voluntary basis. If a practice decided to participate, then the consultants would visit the practice to collect and analyze data. An individualized reported would be provided to each practice that was assessed.

Economic Parameters. The list of economic parameters for which data was collected, analyzed, and reported include:

- *Gatekeeping*—the process of verifying insurance coverage, reviewing ordered regimens against payer medical policies and compendia, determining patient financial responsibility, and performing financial counseling with the patient in advance of treatment.

- *Evaluation & Management (E/M) Coding*—E/M coding/billing accuracy compared with 2007 CMS profiles for hematology-oncology.

- *Drug Purchasing*—the average and comparative practice acquisition cost for the top 25 drugs.

- *Drug Administration Procedures*—a comparison of direct nursing and supply costs to the net revenue per working hour from drug administration procedure codes.

- *Exposure to Risk/Audit*—coding and procedural predictors of audit or fraud risk.

- *Cash Flow Management—Days from Service Outstanding* (DSO) and cash flow.

- *Impact of Proposed 2010 Medicare Physician Fee Schedule (MPFS)*—the prospective impact of proposed MPFS changes (separate and apart from mandated, but postponed SGR conversion factor reductions).

• *Pay for Performance*—practice participation in Medicare pay for performance/quality initiatives.

Participation. The consultation services were offered to all 75 community-based ANCO member practices via e-mail and FAX broadcast in late September 2009. Enrollment took place during the 4th quarter of 2009. Consultation visits, data collection and analysis, and the preparation and delivery of individual practice reports took place through January 2010.

Fourteen (14, 19%) practices with 38 physicians (of the 168 eligible, or 23%) volunteered for the consultation services. Two (2) practices had more than 3 physicians (i.e., large practices); 12 practices had three (3) or few physicians (i.e., small practices). The largest practice had nine (9) physicians; the smallest practices had one (1) physician.

Results. We report findings for each of the economic parameters assessed below.

Gatekeeping. Financial counseling is an important aspect of cash flow management as it manages patient expectations, makes arrangements for patient payments, and reduces practice reimbursement risk. Almost all of the practices assessed have some sort of financial counseling position performing at various levels of effectiveness. In small practices, staff members usually do an inadequate job of patient screening and pre-collection activity. Collection is rarely performed at the time of service. However, the level of collection sophistication was not uniformly correlated with practice size. A small practice had the best gatekeeping of the practices assessed.

It is important for cash flow to understand all coverage guidelines and policies relative to drugs so as to prevent denials, appeals, and write-offs. Almost all practices seemed vague about payer coverage policies. Major third-party payers (e.g., *Anthem Blue Cross, Blue Shield of California, United Healthcare*) all have published coverage policies that no practice used as a reference. The smallest practices often did not enforce Medicare's *Local Coverage Determinations* (LCDs). With specific respect to ESA coverage, even one of the larger practices did not have adequate screening for the appropriate use of ESAs in chemotherapy-induced anemia.

Cash Flow Management—Days from Service Outstanding (DSO). Cash flow management is the most significant financial issue for practices due to the necessity to pay specialty drug distributors within their defined payment terms. The average days from service until claim payment (DSO) was 44 days and ranged from a minimum of 23 days to a maximum of 87 days. This compares unfavorably with an average DSO of 40 days nationally for 2009. It was expected that ANCO member practices would have a DSO of 30-35 days given that the participating practices have a patient population that is 51.5% Medicare which pays at 14 days for clean claims. A higher that expected DSO for ANCO practices is attributable

to poor gatekeeping procedures, uncollected patient balances, poor coding, and not submitting claims daily (described above).

In addition, a higher DSO for ANCO practices was partially due to third-party payer issues. Only four (4) of the 14 participating practices used a remittance analyzer to manage denials and payments. Use of remittance analyzers can help practices determine third-party payer issues and address them in a timely fashion.

Accounts receivable (A/R) that are over 90 days old are more difficult to collect and can lead to bad debt for practices. On average, 20% of the A/R for the surveyed practices was over 90 days old. A/R aging did not vary significantly by practice size. A minimum of 39% and a maximum of 84% of the A/R greater than 90 days old was patient responsibility. Again, poor financial counseling (resulting in an inability to collect patient deductibles, co-payments, and co-insurance at the time of service) and a lack of adherence to medical coverage policies causing claims denials are key contributors to an A/R aging that will result in bad debt.

In summary, the major impediments to cash flow in order of problem magnitude were:

- arrears to drug distributors causing interest or balloon payments. Four (4) practices closed their infusion centers for some period of time due to an inability to pay drug distributor debt.
- debt service payments due to service expansion and/or building and facility improvements.
- infrequent and/or delayed claims submissions by internal or external billing personnel.
- lack of adherence to third-party payer coverage policies (especially ESA coverage policies).
- poor collection of patient balances.
- third-party payer delays.
- coding accuracy.

Drug Purchasing. The variance in drug acquisition costs between practices for the top 25 drugs utilized in a typical medical oncology practice are shown in Table 1.

Table 1: Variance in Drug Acquisition Costs for the Top 25 Drugs

Drug J-Code & Name	Variance by Drug
J0881 Darbopoetin (Aranesp)	0.372601527
J9310 Rituximab (Rituxan)	79.10362473
J9035 Bevacizumab (Avastin)	0.081754571
J2505 Pegfilgrastim (Neulasta)	21038.41831
J0885 Epo (Procrit)	0.358469824
J9263 Oxaliplatin	1.548005148
J9170 Docetaxel (Taxotere)	19061.62307
J3487 Zoledronic Acid (Zometa)	6.385071016
J9201 Gemcitabine (Gemzar)	2.168967495
J9355 Trastuzumab (Herceptin)	0.487391528
J9055 Cetuximab (Erbitux)	0.255941026
J9305 Pemetrexed (Alimta)	0.22269697
J9206 Irinotecan (Camptosar)	13.71669697
J2469 Palonosetron (Aloxi)	25.97182133
J9041 Borteximib (Velcade)	0.221465267
J1441 Filgrastim	1299.255424
J9264 Paclitaxel Protein (Abraxane)	0.009253264
J9025 Acacitadine (Vidaza)	0.005216364
J9001 Doxorubicin (Doxil)	77.98952545
J9217 Leuprolide Depot (Lupron)	2715.85009
J9350 Topotecan	802.3774233
J9395 Fulvestrant (Faslodex)	1.820189026
J0894 Decitabine (Dacogen)	25.37316429
J2405 Odansetron (Zofran)	0.057741071

On average, small practices paid 106% more than larger practices for the drugs. The variance was highest for docetaxel, filgrastim, leuprolide, and topotecan; it was lowest for acacitadine, bevacizumab, odansetron, and paclitaxel. Irinotecan and pegfilgrastim were most consistently underwater (i.e., drug acquisition cost was greater than Medicare 4Q09 *Average Sales Price* or ASP). The average number of underwater drugs per practice was three (3). Four (4) of the 14 surveyed practices were in arrears to their drug distributor. Eleven (11) of the 14 do not regularly monitor cost versus reimbursement (e.g., quarterly ASP + 6%). Most practices use only one distributor and do not engage in competitive drug purchasing strategies. Direct debit is used by half of the surveyed practices so as to achieve advantageous drug pricing. Direct debit payment terms impeded cash flow and created debt.

Drug Administration Procedures. Results of the drug administration profitability analysis by practice and on average for the small and large practices are presented in Table 2.

The analysis of drug administration profitability only included direct costs (salary and benefits). Overhead costs (such as rent, billing, administration) were not included. Almost every surveyed practice had coding issues that created inflated drug administration revenue. In summary, patient volume enhances drug administration profitability. If a single code is billed in an hour or there is poor chair turn, then profitability from drug administration declines.

In the small practices surveyed, only one (1) practice's drug administration services were unprofitable. The average drug administration costs divided by average revenue for the small practices was 46% (i.e., $172.58 average costs per hour divided by $377.57 average drug administration revenues per hour). However, the average annual working hours for the small practice infusion centers was 1,829 hours per year, less than full-time (2,080 hours per year). Almost half of the small practices had infusion centers open less than full-time.

In the large practices surveyed, the average drug administration costs divided by average revenue for the small practices was 73% (i.e., $661.74 average costs per hour divided by $907.60 average drug administration revenues per hour). All of the large practices infusion centers were open full-time.

Evaluation & Management (E/M) Coding. On average, the ANCO practices see 242 new patients per physician per year (compared to 300 nationally; *Journal of Oncology Practice*, Vol 3, No 1 (January), 2007: pp. 9-12). The number of office visits per physician per year was 3,186 (compared to 3,481 nationally). These statistics did not vary by size of practice.

Table 2: Analysis of Drug Administration Profitability

Practice	*Annual Working Hours*	*Admin Nursing Costs*	*Supply Costs*	*Total Costs*	*Total Costs/Hour*	*Drug Admin Net Revenue*	*Drug Admin Per Hour*	*Profit/Lost Per Hour*
P1	1,664	$168,729.60	$57,277.00	$226,006.60	$135.82	$844,404.60	$507.45	$371.63
P6	2,080	$169,556.25	$9,742.00	$179,298.25	$86.20	$513,138.00	$246.70	$160.50
P7	2,080	$328,416.00	$156,557.00	$484,973.00	$233.16	$569,348.00	$273.73	$40.56
P10	1,248	$84,847.36	$20,000.00	$104,847.36	$84.01	$158,331.26	$126.87	$42.86
P8	2,080	$259,820.00	$53,929.00	$313,749.00	$150.84	$615,610.93	$295.97	$145.13
P9	1,404	$115,904.26	$9,872.96	$125,777.22	$89.58	$264,732.38	$188.56	$98.97
P2	2,080	$171,600.00	$21,500.00	$193,100.00	$92.84	$485,241.86	$233.29	$140.45
P3	2,080	$126,463.35	$59,982.64	$186,445.99	$89.64	$129,017.53	$62.03	-$27.61
P5	2,080	$504,052.64	$268,030.69	$772,083.33	$371.19	$1,129,866.55	$543.21	$172.01
P4	1,846	$432,845.40	$106,482.89	$539,328.29	$292.16	$1,899,481.88	$1,028.97	$736.81
P14	2,080	$621,076.00	$233,768.00	$854,844.00	$410.98	$1,871,912.00	$899.96	$488.98
P12	1,224	$32,500.41	$9,742.00	$42,242.41	$34.51	$151,893.00	$124.10	$89.58
Average	1,829	$251,317.61	$83,907.02	$335,224.62	$172.58	$719,414.83	$377.57	$204.99
P11	2,080	$1,158,151.59	$304,049.48	$1,462,201.07	$702.98	$2,355,820.12	$1,132.61	$429.62
P13	2,080	$1,235,091.00	$53,048.00	$1,288,139.00	$619.30	$1,419,789.32	$682.59	$63.29
Average	2,080	$1,196,621.30	$178,548.74	$1,375,170.04	$661.14	$1,887,804.72	$907.60	$246.46

Note: Analysis = (Annual Drug Reimbursement/Average Working Hours) – [(Drug Administration Nursing Costs + Supply Costs) / Annual Working Hours]

The coding profiles for established patient office visits (99211-99215), hospital admissions (99221-99223), consultations (99241-99245), and hospital follow-up visits (99231-99233) for the ANCO physicians surveyed were compared to the national Medicare profiles. There were very high profiles in comparison to the national Medicare database for nursing visits (99211), consults (99243, 99245), and hospital admissions (992233). Higher than normal profiles often lead to audits by Medicare and third-party payers.

Only one (1) out of the 14 surveyed practices had educated their physicians about the elimination of consultation codes (for 2010) by Medicare. Many of the billers/coders had never been to an ANCO billing/coding professional education program.

Exposure to Risk/Audit. In addition to the profiles mentioned above, several other areas of audit risk were identified, including:

- use of 96368 for more than one drug in a bag.
- use of sequential infusion codes as opposed to additional hours of infusion.
- use of more than one initial code per day.
- billing of fluids to transport drugs.
- billing of 36000 with drug administration.
- billing of 96523 with other services.
- billing 36591-36592 with other services.

Many of the surveyed practices used out-of-date or poorly designed superbills that only included the higher E/M codes, separated bone marrow biopsy/aspiration codes, poorly identified codes, and/or listed old codes.

Impact of Proposed 2010 Medicare Physician Fee Schedule (MPFS). Five (5) of the 14 participating practices may perform positively in 2010 (if the projected 21% MPFS never happens). Most of these practices are small practices. The reasons for their potential positive performance are a high volume of E/M services, abandoning drug administration (closed infusion centers), and fewer consultation services. Average MPFS impact by physician (assuming no change in the conversion factor) is presented in Table 3. In general, the impact of the 2010 MPFS is not overwhelming for most practices and does not vary by size of practice. (Obviously, if the 21% MPFS cut is implemented, many of the practices would have a difficult time surviving economically.) Absent the 21% reduction, drug administration cuts have a greater impact than the elimination of consultation

codes. Practices with high volume infusion centers suffer the worst and this may further change the profitability picture as more third-party payers use Medicare RVUs for their fee schedules.

Table 3: Average MPFS Impact By Physician

	Total	*Average*	*% Change*
MDs	38	2.71	
Total Revenue 2010 (If All Payers Reimburse Like Medicare)	$26,990,812.39	$1,927,915.17	
Total Revenue 2009 (If All Payers Reimburse Like Medicare)	$27,071,967.02	$1,933,711.93	
Total Impact (If All Payers Reimburse Like Medicare)	-$81,154.63	-$5,796.76	-0.30%
Drug Administration Impact (If All Payers Reimburse Like Medicare)	-$458,465.61	-$32,747.54	-1.69%
Consult Impact (If All Payers Reimburse Like Medicare)	-$328,303.14	-$23,450.22	-1.21%
% Medicare Patients		51.12%	
Total Medicare Impact	-$48,196.17	-$3,442.58	-0.35%
Drug Administration Impact Medicare	-$251,074.17	-$17,933.87	-1.81%
Consult Impact Medicare	-$177,953.89	-$12,710.99	-1.29%

Note: Analysis does not include the projected 21.2% decrease in the conversion factor.

The impact of MPFS impact by 2013 is presented in Table 4 by practice and in Table 5 by physician. By 2013, with no change in the SGR, the average practice will lose over $85,000 if all payers adopt the Medicare fee schedule or $46,000 if they

do not. This will have its greatest impact on those practices that are in arrears to their drug distributors (4 of the 14 practices surveyed) or whose debt service payments would be too high to sustain (2 of the 14 practices surveyed).

Table 4: MPFS Impact by 2013

	Total	*Average*	
Total 2009 Revenue (if all payers reimburse like Medicare)	$27,071,967.02	$1,933,711.93	
Total 2013 Financial Impact (if all payers reimburse like Medicare)	-$1,193,687.92	-$85,263.42	-4.41%
Total 2013 Financial Impact (Medicare only)	-$654,769.49	-$46,769.25	-2.42%

Table 5: MPFS Impact by Physician

Medicare 2010 Revenue/MD	$363,092.38
Medicare 2009 Revenue/MD	$364,184.11
Medicare 2010 Drug Administration Impact/MD	-$6,167.48
Medicare 2010 Consultation Impact/MD	-$4,416.48
By 2013 Medicare Financial Impact/MD	-$8,808.25

Pay for Performance. Only two (2) of the 14 surveyed practices participate in Medicare's *e-Prescribing* initiative (eRx) or *Physician Quality Reporting Initiative* (PQRI). One (1) participates in both. As a result of not participating, there is an estimated average loss of $39,500 per practice or $14,600 per physician. Those practices not participating in eRx or PQRI cite a lack of information, confusion, physicians not wanting to implement eRx, or electronic health records that do not have an eRx module as reasons. Participating in eRx and/or PQRI would more than make up for losses from MPFS reductions in 2010.

Conclusions. The biggest challenge facing ANCO member practices in the short term is cash flow. Their inability to collect from patients at the time of service, short payment terms with drug distributors, slow billing in terms of date of service to claim submission, poor adherence to and implementation of coverage guidelines, and lack of systems to evaluate and address reasons for insurance payment delays causes short term unmet cash requirements that are funded by borrowing resulting in additional, burdensome debt. The biggest long term economic challenges facing ANCO member practices are high practice debt caused by short term cash flow issues in addition to service expansion into diversified areas (e.g., imaging, radiation), audit risks due to inaccurate and/or overcoding, lack of participation in Medicare incentive programs (which will lead to future disincentives and discounted fee schedule payments), and higher drug costs. Nonetheless, drug administration services, especially if offered on a full-time schedule, continue to be profitable.

Recommendations. As a result of this study, the following recommendations for practices and ANCO follow:

- Practices must increase the effectiveness of their financial gatekeeping procedures. ANCO should offer member practices a financial counseling workshop that would include information on patient financial counseling, how to access and follow coverage policies, remittance analysis, and how to collect payer and patient balances.

- Small practices need to gain economies of scale and discounted drug pricing to be more profitable. ANCO should offer member practices access to *Group Purchasing Organization(s)*.

- Physicians must use E/M and practices must use other CPT codes accurately. ANCO should offer physicians and practice staff continuing coding education and access to coding assistance.

- Practices must continually evaluate their costs of doing business, especially drug administration, and reduce costs where possible. ANCO should offer education and tools to enable member practices to analyze their costs.

- Practices must participate in pay for performance programs starting with eRx and PQRI. ANCO should make it easier for member practices to participate in these (and other) pay for performance programs.