The Oncology Social Worker's Role in the Reimbursement Process

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Today's oncology social workers play a critical role in reimbursement, assisting with pre-authorizations, coverage denials, and patient assistance programs. The oncology social workers at St. Luke's Mountain States Tumor Institute see their "chemotherapy pause" as the best way to meet the needs of cancer patients *and* ensure the cancer program's financial viability.

Why Social Workers?

A key component of healthcare social work is to help patients navigate a very complex system. Cancer patients are usually fatigued, in pain, and/or coping with high levels of anxiety. At a time when they should focus solely on getting better, many patients are worried about how they will pay for their cancer treatment. In fact, our experience has been that many patients and their family members present with nearly as much stress about their financial situation during six months or a year of treatment, as they do about the cancer diagnosis itself.

During this tumultuous time, the oncology social worker helps patients and family members cope with the complex interplay of stressors, developing a unique bond with patients and families. As the literature has shown, the bond and rapport between oncology social workers, patients, and families often results in increased patient satisfaction. If treatment goes well, the oncology social worker assists patients and families in adjusting to their "new normal." If treatment does not result in a cure, oncology social workers help patients and family transition to palliative care.

The Oncology Social Worker's Role in the "Chemotherapy Pause"

Money is *always* a sensitive subject, and patients dealing with a cancer diagnosis and treatment require delicate handling. The bond the oncology social worker has forged with the family can make the sensitive process of applying for medication assistance more successful and increase the likelihood for patient follow through. We help patients and families understand that the cancer center's goal in applying for medication assistance is to prevent the burden of medical costs—for the cancer center *and* the patients and families.

Insurance companies are often unconvinced of the efficacy of newer, more expensive chemotherapy drugs, establishing prescreening processes to deny payment for these drugs. In our program, while the financial advocate focuses on the preauthorization and pre-approval process, the oncology social worker works in tandem with this team member to help patients and families cope with the stress of waiting for their medication. In the worst case scenario—when medication is unavailable—oncology social workers help patients and families with anger and grief issues.

In several cases, I have had to complete the patient assistance application process with a surviving spouse. I was able to draw upon my trained skills in dealing with bereavement and grief to make this difficult process easier on the surviving family members. In addition to educating surviving families about grief and coping mechanisms, I provide tangible help paying for the cost of medications.

Patient Assistance Programs: The Good, the Bad, and the Ugly

With the current reimbursement climate, community cancer centers should look at dedicating staff to work directly with patient assistance programs. Pharmaceutical patient assistance programs, in particular, have helped thousands of Americans who could not afford their anti-cancer medication. And it is not only uninsured patients who benefit; some patient assistance programs help insured patients by providing medications that have been denied payment by insurers.

Patient assistance programs offer clear benefits to community cancer centers, including:

- The ability to offer the same level of care for all patients—regardless of the individual's ability to pay for the treatment.
- The freedom to prescribe the highest standard of patient care suggested by the treating physician.
- The ability to treat patients without incurring an overwhelming financial burden.

The patient assistance process varies tremendously from manufacturer to manufacturer and from drug to drug. Access to patient assistance programs also runs the gamut from easy to extremely difficult. ACCC's online list of reimbursement assistance hotlines is a good resource: *www.accc-cancer.org.*

GlaxoSmithKline, for example, has a phone approval process that can put medication in the patient's hand an hour later. AstraZeneca's and Genentech's SPOC (single point of contact) programs are taking the lead to cover the Medicare Part D "donut hole" deficit by providing pre-approval assistance and expanding income eligibility.

Of course patient assistance programs also fall on the other end of the spectrum. Roche, for example, has a stringent program that requires that attorneys and accountants verify (in writing) income for patients who clearly live on the margin of the working poor.

Some patient assistance programs are generous with whom they help, others restrict their outreach to less than 200 percent of the federal poverty limit, approximately $1,600 a month for a single person. Think about the hard choices cancer patients are forced to make trying to afford $200 in pain medication on that income. Could *you* afford 10 percent of your monthly income for medication every month?

When our patients hit a difficult program, they are prone to just give up. Remember, these individuals are dealing with pain and fatigue—in addition to all of the other stressors of treatment—that make it difficult to complete onerous applications. Patients may or may not tell us when they are stymied by the application process. Many of our patients are private in nature. They grew up during the Depression or in a social milieu where giving out financial information was just not socially acceptable. Unfortunately, any reluctance on their part to provide the necessary financial information can halt or even derail the patient assistance process. At this point, a skilled and empathetic oncology social worker can make all the difference.

Applying for Assistance

Each patient assistance program is unique. Tracking all of these programs requires a dedicated staff member to ensure that patients apply for the correct programs in the correct time frames.

Careful monitoring of application submissions and patient follow-up with financial documentation is required to make sure the replacement drug will be provided. And if the oncology social worker coordinating patient assistance applications is not a dedicated specialist in this area, your cancer center may face financial losses far greater than the amount spent to fund the oncology social worker's salary. The financial advocate and the oncology social worker must work seamlessly together to ensure drug reimbursement and to recover medications. This time-consuming process includes several challenges:

Different applications, different criteria. Each manufacturer uses a specific application form and requires different documentation of financial need. This situation is very confusing to many cancer patients. They don't understand why they must submit (and resubmit) different information to several different companies.

Even worse, patient assistance programs often change criteria and forms. One cancer patient completed and submitted a form only *one* day after such a change; the manufacturer would not accept the old application.

Unfortunately, this challenge is not easily addressed. Online services and automatic form-generating programs are insufficient because they don't necessarily modify their forms as quickly as the manufacturers do. Even a one-day time lapse can mean a loss of thousands of dollars, particularly with the newer oral chemotherapy agents. These programs have several other drawbacks. First, they offer no assistance getting patients to provide the necessary documentation. Second, these programs cannot address the variability of all the different patient assistance programs. Some manufacturers require that patient data be phoned in for the initial application, or a new application be generated each time.

Communication glitches. Some programs notify the clinic (by fax or mail) that a patient has been accepted into a program; others do not. If the patient assistance program is a "direct ship" program where the medication is sent directly to the patient, the cancer center can be left out of the loop. In some cases, we have believed that patients were taking medication for a month or more before we learned that they were not.

Drug replacement. Some patient assistance programs replace stocks of medication already given to patients. Other programs only replace the drug that was given after the application was submitted. Some manufacturers require providers send in copies of the treatment record after the patient has received the dose. Still other programs backfill only a limited number of treatments or a limited number of vials of medication.

Payer denials and appeals. Some patient assistance programs offer help with the denial and appeal process, providing copies of clinical research studies and putting together appeal letters that fulfill payer requirements for reversing a denial and paying for a drug. Unfortunately, such assistance can sometimes bring about a false sense of security that the drug will be replaced, resulting in a costly mistake for provider and patient.

The Future is Today

There are some indications that pharmaceutical companies are attempting to streamline their patient assistance programs. In 2006, several manufacturers at ACCC's two annual meetings committed to making the patient assistance forms more uniform and easier to access. While coming to consensus and modifying the initial application process is a first step in improving the patient assistance process, it is our opinion that a bigger overhaul is required in order to break down all the systemic barriers to patients accessing medication.

As cancer care providers, we need to advocate to pharmaceutical manufacturers and legislators to continue to improve patient assistance programs. We must also educate them as to how proper utilization of patient assistance programs provides a safety net for patients, families, *and* providers.

When, and if, such improvements are made, cancer patients will still need local help navigating our complex healthcare system. In addition, community cancer centers will still need experienced staff to oversee these patient assistance and drug replacement programs to ensure that the program is adequately reimbursed for the care it provides to patients.

As we all know, the landscape of chemotherapy reimbursement is complex and constantly changing. New internal processes will be required to cope with these changes. Community cancer centers will need to establish and continue to fund patient financial advocate and oncology social work positions whose primary responsibility is assistance with cost recovery. Not only is the future solvency of the cancer program at risk, so too is patient access to the most appropriate and best quality care.

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