

FROM THE EDITOR...

Without Severity-Adjusted DRGs, Prospective Payment May Severely Impair State-Of-The-Art Cancer Care



In this issue of *The Journal of Cancer Program Management*, we have three major articles on cancer DRGs and their implications for cancer treatment, cancer programs, and cancer patient care. In a landmark article, Dr. Susan Horn, of the Johns Hopkins Center for Hospital Finance and Management, demonstrates that organized cancer programs are already seeing sicker patients requiring more complicated and expensive care than hospitals without organized programs. Horn's data suggests that prospective payment mechanisms require adjustment for the severity of illness for the patients treated or more advanced programs

will be unable to pay for the resources they need to care for the sicker patients they are treating. Hospitals may soon have significant incentives to cut back on staffing, to discourage certain types of patient care (whether or not it is effective) and, in some cases, eliminate their cancer program entirely.

We have already seen shifts in the kinds of patients that are being referred to other institutions and to outpatient care. Certainly, Horn's case is compelling and backed by the everyday experiences of people in the field. It is also a refutation of the initial inclinations of senior HCFA staff that the regionalization of cancer care will lead to lower costs.

When John Yarbrow and I expressed concerns over DRGs (*JAMA*, February 1985), Dr. Carolyn Davis, then Administrator of the Health Care Financing Administration, told us that HCFA expected that cancer care would eventually be driven toward regionalized centers where it would be delivered "cheaper in bulk" -- sort of the grocery store approach. Evidently, the idea was that if you pump a lot of chemotherapy, you can line up patients, buy drugs in quantity, and succeed by making an adequate margin on quantity.

While, no doubt, there is some truth to the "cheaper by the dozen" philosophy, several intrinsic flaws with the basic concept remain: Cancer is too prevalent a disease for care to be limited to a few geographic locations. Cancer care is delivered wherever care is provided, big hospitals and small hospitals. What is regionalized (i.e., referred to secondary and tertiary care institutions) is more complex care of sicker patients. This is one of the lessons of Horn's data.

So rather than getting "bulk quantity" revenues, more sophisticated cancer programs are seeing patients that require more resources and more costs. On average, then, the smaller institution may see fewer cancer patients than the organized cancer program, incurring less cost and make greater margins. At the same time, the institutions we expect to treat patients with more advanced therapies have lower margins, or significant losses, which will lead them to cut back on the resources available to deliver adequate care.

This is a perfect "Catch-22" situation, and one that does not bide well for cancer treatment under a capitated system. Here we come to the crux of the problem: HCFA and other payers are excited by the prospects of capitated care. How easy it will be to monitor and cap! The complexity of severity-adjusted DRGs is a "step" they wish to skip.

Yet, from the patient's perspective, and from the perspective of cancer program providers, capitation without severity-adjustment is bound to doom our ability to meet complex cancer care with adequate resources. For cancer care, severity-adjustment is not a step to be skipped. It is likely to be the only way we can assure the future of quality patient care.

In this issue, you will read about oncology's "winners" and "losers" and about the breadth of the oncology product line. Without a doubt, as a specialty, we have just begun to understand the complexity of managing cancer program finances. In future issues of *The Journal*, we will look at other aspects of cancer financing.



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