

FROM THE EDITOR...

ON THE BRIDGE OR IN THE SWAMP?



As Associate Editor Eileen Cahill said the other day when she began to prepare this issue's feature article on freestanding cancer centers: "It's hard to find anyone with an existing center to say something negative!" Reactions of attendees at our recent jointly sponsored FCC conference with the AHA were similar. But, a little rock turning does uncover problems. Some feasibility studies regularly overstate the chances of success. Planning committees fight over locations and profits. Some consulting firms start out asking for money to do a feasibility study and end up trying to be joint venture partners. In some areas, licensure is unclear. Some FCCs have failed; others have had a coup d'etat. Still others are apparently offering sub-standard care in rural areas with newly installed older machines, inadequate supportive care, and occasional physician site visits.

Yet, without a doubt, some places are spectacular -- real additions to cancer resources in their region, and showcases for better care.

Regardless of how you see FCCs, regardless of their location and value, you do have to wonder about whether they will survive the significant changes in the reimbursement system just ahead. For example, if capitation continues to grow, the FCC without a connection to a hospital, HMO, or PPO may suddenly find patients diverted back into its hospital competition.

Another scenario of concern relates to reimbursement schemes like the Ambulatory Visit Groups (AVGs). My interpretation of the Brandeis study (published in the Spring 1987 issue of JCPM) is that there are two basic AVGs for radiation therapy: "Get Set" and "Go." If these two AVGs are weighted high (i.e., well reimbursed), then radiation therapy in hospitals and FCCs will do well. If they are weighted in a mid-range, FCCs may remain very competitive while hospitals lose money. However, if they are weighted too low, FCCs that rely heavily on radiation therapy revenues may close, while inpatient departments may be able to survive through that old hospital stand-by, cost shifting.

Which way should you bet? Well, that depends on how you view the "Fed." AVGs, relative value scales (RVS), and capitation are all on the current federal research and policy agenda. So is catastrophic insurance and the high cost of AIDS. My bet is that in two or three years (right around the time we will either have lame ducks or new Congressmen) catastrophic insurance, AIDS, and the aging population will drive Congress to make a dramatic move. They did it with DRGs, and I believe they will be just as desperate again. Whatever they legislate will take at least three years to become a reality (circa 1991), and so my guess is that FCC planners should look at a short term (5 - 7 years) payout. If your FCCs payout is 10 years and heavy and you expect competition, I'd look again. If you are being conservative, and it breaks even in five years, you might want to go for it.

Isn't this fun? Probably not, but it is reality we need to review whenever we confront a new challenge. FCCs may be a bridge over the troubled waters of inpatient DRGs. On the other hand, with the wrong roll of the reimbursement dice, limited access to the rest of the health care system or inadequate attention to quality, the road could lead into a veritable swamp land. Clearly, planners have to think of both options as they consider some of their relationships and fundings plans. In this issue, we'll look at what some of the leaders in the field suggest.

Lee E. Mortenson, M.S., M.P.A.  
Senior Editor  
ACCC Executive Director

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