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APCs: What They Mean to Your Hospital or Practice

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Hospital and Physician Reimbursement

APCs, RBRVS, and DRGs

Ambulatory Payment Classifications (APCs), the Resource-Based Relative Value Scale (RBRVS), Diagnostic Related Groupings (DRGs)—three massive and complicated models developed under the aegis of the Health Care Financing Administration to control Medicare costs. In 1985, the first year of DRG implementation, hospital administrators were wondering if cancer programs were a product line with a future. They raised concerns that HCFA data lagged behind actual treatment patterns in oncology and saw potential damage to clinical research under the new cost reimbursement system. There was a furor about the underweighting of chemotherapy, one of the highest volume cancer DRGs.

Thirteen years later, much the same story…Challenges to oncology programs continue from HCFA through its new proposals for APCs and revisions to the practice expense component of physician reimbursement. HCFA is again being accused of lack of foresight, using data that do not reflect current patterns of practice, and coordinating threats to cancer patients and the entire oncology health care profession. The following three articles examine HCFA's newest proposals for cutting outpatient hospital expenditures and physician (namely, medical and radiation oncology) reimbursement. A fourth article looks at what DRGs can reveal about the financial health of a hospital cancer program.

APCs: What They Mean to Your Hospital or Practice

by David K. King, M.D., F.A.C.P.

As a prospective method for reducing Medicare Part A outpatient hospital expenditures, the Health Care Financing Administration (HCFA) is proposing to implement Ambulatory Payment Classifications (APCs). HCFA's prepublication drafts use 1996 claims data and put all drugs into one of four categories for which the agency is computing collective prices. New drugs for which there is no 1996 information have been automatically placed in the lowest cost category. The categories do not reflect changes in the patterns of care subsequent to 1996, namely, that the introduction of new drugs (estimated to be at least ten drugs) or new indications (estimated to be more than a dozen new indications) have altered the regimen of oncology drugs that physicians use. The fact that HCFA has chosen to place new drugs in the lowest cost category and ignore changes in the patterns of care will have serious and long-term consequences, given the many new drugs and biological agents in the clinical trials pipeline. The maximum available reimbursement for such relatively new oncology drugs as gemcitabine or rituximab, for example, would be inadequate, whether the lowest priced category is $57 or $150. Moreover, since hospitals would be reimbursed on an average price, they might well feel pressured to choose more moderately priced, older drugs than more expensive, newer agents.

As for supportive care drugs, they will not even have an APC category; they are to be "bundled" into the cost of other APCs (presumably chemotherapy or nursing administration). This bundling will put significant pressure on oncologists to choose between the newest chemotherapy or older drugs with supportive care drugs...assuming that the costs of the chemotherapy will even be covered.

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A LOOK TO THE FUTURE

Any set of APC categories for chemotherapy will be difficult for hospitals and threatens to make these agents immediately unavailable to hospital-based oncologists (including university cancer centers). Assuming APCs are implemented in the fashion currently under discussion, university hospitals (where there is a significant outpatient component) likely will rapidly consider divesting their outpatient cancer programs. At the other end of the spectrum, hospital-based cancer clinics in rural areas (where physicians run satellite clinics and the hospital bills for the chemotherapy) could close. Hospitals (where physicians now route their infusion therapies) are unlikely to desire this traffic anymore.

Of equal concern, if HCFA sees "results" with APCs in an outpatient hospital setting, it will certainly wish to apply the results to physician offices. Such a move would likely block *both* settings from using new agents.

HCFA is attempting to delay the release of the APC regulations until it has a definite time horizon for implementation, figuring (rightly) that an early release will give opponents more time to analyze and pick the proposal apart. The good news is that HCFA has alerted Congress that it is planning to delay implementation of APC changes until it has its Year 2000 issues under control. No timeline has been given for actually addressing this problem. In fact, many HCFA resources are now focused on how to keep hospital and physician doors open when the system goes down in the Year 2000! HCFA is considering pre-payment based on rates paid during the first months of 1999 and other options. Both the American Society of Clinical Oncology (ASCO) and ACCC have jointly urged Congress to pressure HCFA not to delay release of the proposed regulations in order for the actual price of the categories to be made public.

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