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Worse than we Thought

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FACT ACCC provides information about approaches for the effective management, delivery, and financing of comprehensive cancer care through its national meetings, regional symposia, and publication of oncology patient management guidelines, standards for cancer programs, critical pathways, oncology-related drugs and indications, and *Oncology Issues*.

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FROM THE EDITOR

Worse Than We Thought

by Lee E. Mortenson, D.P.A.

The most telling exclamation came from Bart McCann, former HCFA senior staffer. Upon seeing the radiation oncology data from our study of APCs, I was told that Bart's words were: "It's even worse than I thought."

That sums it up. When we look at the analyses completed by The Lewin Group and ACCC in preparation for our comments to HCFA, the news about APCs is pretty gloomy. And that's an understatement!

As you will see from our article in this issue, the news is that hospital outpatient cancer programs are DOA. The problem likely stems from a combination of methodological issues and a fundamental core issue relating to this system of prospective payment. The data sample is old, warped, and inappropriate. No matter how HCFA manipulates its data sample, the end result will be old, warped, and inappropriate.

Can APCs be fixed? Frankly, I'm stumped. Every member of the oncology community working with the Hill has been asked this question repeatedly in the last few weeks. Yet HCFA staff have made it quite clear that they intend to keep drugs within this APC framework, no matter what.

Let's examine the possibilities. First, there's AWP minus 5 percent, the same reimbursement that our office practices receive, which would create a "level playing field" and reflect current pricing. But medical oncologists are losing money on this proposition, and hospitals have at least a few obligations that offices don't have to meet, such as charity care. While AWP minus 5 percent has some attractive aspects, it underpays hospitals just as it underpays offices.

Second, there is the question of keeping the current system of reimbursement for drugs. This system obligates hospitals to maintain the cost report, but it appears that they will be doing so anyway. This solution makes the most sense; it works now and will continue to reflect changes in the patterns of care as they happen. HCFA hates this idea, because it fundamentally challenges the entire APC concept. For the rest of the hospital community, the more we look at APCs, the more we realize they are not going to have the same benefit as DRGs...and it might be good to challenge the APC concept.

Radiation oncology is a good example. Its innovation and equipment costs will keep it from being profitable under APCs. HCFA's entire scheme for allocating costs to hospital outpatient services looks bad in terms of what it has done to radiation oncology. HCFA's proposed reimbursement is just shy of $200 million below costs...a big bad number!

For the moment, HCFA believes it can't exempt anything from APCs. We are going to have to ask Congress to recognize the problem and to figure out how the APC system might actually work without killing off cancer programs. The Clinton administration is going to moan. HCFA staffers are going to complain.

But Congress has some experience with HCFA's reassurances. We'll have to count on the Hill to tell HCFA what takes precedence: an unworkable methodology or patient needs.

Let's hope they know.