

N O V E M B E R 2 0 0 0

R E P O R T T O T H E C O N G R E S S

Medicare Payment
for Post-surgical
Recovery Care Centers

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for Post-surgical
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MEDPAC Medicare
Payment Advisory
Commission

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Executive summary

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In the Balanced Budget Refinement Act of 1999, the Congress instructed the Medicare Payment Advisory Commission (MedPAC) to examine the efficacy and cost-effectiveness of post-surgical recovery care centers (PSRCCs), review data from state demonstration projects, and report its findings by December 1, 2000. Currently, Medicare does not pay for stays in PSRCCs and limits payment for ambulatory surgery to procedures that are expected to require less than a four-hour post-operative observation period. This report reviews the characteristics of PSRCCs, discusses the policy questions raised by Medicare beneficiaries' stays in these facilities, and presents the Commission's conclusions and recommendation regarding payment for care delivered by PSRCCs.

PSRCCs represent a distinct class of health care facilities that provide limited medical and nursing care to patients who require short-term observation after surgery in an ambulatory surgical center (ASC). More complex procedures can be performed in ASCs that have the capacity to provide longer periods of post-operative care than in those without it. Over the past two decades, these facilities have increased in number and in private-sector use as technological advances have allowed more types of surgeries to be safely performed in an ambulatory setting.

Despite growing enthusiasm for PSRCCs in the private sector, no studies have comprehensively examined the quality of care and the cost implications of these facilities. Two states, California and Illinois, have recently sponsored demonstration projects to evaluate PSRCCs as sources of post-surgical care, but evaluations of these projects were not available in time for this report.

MedPAC examined several critical policy issues relating to PSRCCs, including quality of care, access to services, cost and economic implications, and the potential impact on medical education. Although the industry contends that PSRCCs will improve the quality of care by matching specialized resources to patient needs, there is little evidence to support or discount this assertion. In addition, while PSRCCs may offer a more comfortable post-operative environment, we were unable to identify any essential need fulfilled by these facilities that is not also provided by hospitals. Although PSRCCs may prove convenient for beneficiaries, we do not believe these facilities would substantially increase access to care. The impact of PSRCCs on medical and nursing education has not been measured.

Although PSRCCs have been espoused as a cost-saving measure for post-operative care, their impact on system-wide costs has not been comprehensively examined. In general, studies suggesting significant cost savings for PSRCCs base their conclusions on lower negotiated insurer payments and not on actual analysis of providers' costs. Thus, we remain unconvinced that Medicare coverage of PSRCC services would significantly reduce the provider cost of surgical care for beneficiaries. If Medicare were to cover services provided by PSRCCs, the Health Care Financing Administration (HCFA) would need to expand the list of procedures appropriate for ASCs, develop a new set of payment rates that reflects the below-average-complexity of patients treated in these facilities, and remove restrictions that currently govern ambulatory surgery for Medicare beneficiaries.

In conclusion, available data do not support a change in Medicare payment policy for post-operative care. In the future, evidence demonstrating that PSRCCs provide high-quality, convenient post-operative care at a cost no greater than that incurred by current providers for similar levels of care may warrant reconsideration of Medicare policy.

**Medicare Payment
for Post-surgical
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R E C O M M E N D A T I O N

At this time, there is insufficient evidence to support a change in Medicare payment policy for post-operative care. If, in the future, data from two ongoing demonstration projects or other sources support coverage of post-surgical recovery care centers, Medicare policy for these facilities should be reexamined.

Recovery care centers make up a distinct class of health care facilities that provide limited medical and nursing care to people who require short-term inpatient observation or overnight lodging for services that include pain control, drug administration and fluid maintenance. Post-surgical recovery care centers (PSRCCs) represent one type of recovery care center that offers care to relatively healthy patients without significant co-morbidities who have undergone a surgical procedure.

Models for PSRCCs are defined primarily by the location of the facility. In concept, PSRCCs can either be operated by a hospital or ambulatory surgical center (ASC) or be freestanding. Currently, the predominant type of PSRCC is ASC-based.

PSRCCs came into vogue in the 1980s as more surgical procedures were performed in an outpatient setting, particularly in ASCs. Two factors account for the increase in outpatient surgeries over the last two decades. First, advances in technology (such as laparoscopic procedures and improvements in anesthesia) decreased the need for prolonged post-operative hospital stays. Second, the federal government approved Medicare payments for ambulatory surgery in freestanding centers in 1982.

With the advent of and growth in the numbers of ASCs, private-sector ambulatory surgical practice patterns evolved to encompass more complex procedures and patients. PSRCCs were developed to provide care to patients requiring longer post-operative observation than the usual recovery room period for outpatient surgery. Presently, many private payers pay for ambulatory surgery followed by a stay in a PSRCC; often, a single payment covers both.

In contrast to the private sector, the Medicare program currently restricts ambulatory surgeries to those not generally exceeding 90 minutes of surgery or 4 hours of recovery room time. Any required anesthesia must last no longer than 90 minutes. A procedure is excluded from the Medicare-approved ASC list if it:

- generally results in extensive blood loss;
- requires major or prolonged invasion of body cavities;
- directly involves major blood vessels; or
- is generally emergent or life-threatening in nature.

On June 12, 1998, HCFA issued a proposed rule to update the ratesetting methodology, the payment rates, and the list of covered surgical procedures for ASCs (HCFA 1998). Implementation of this rule has been delayed, however. The rule proposes to remove the operating, anesthesia, and recovery time limits but to retain the specific clinical standards (including the exclusion criteria listed above) when determining whether a procedure may be safely performed in an ambulatory setting. MedPAC supports eliminating arbitrary operating, anesthesia and recovery time limitations from the criteria used to designate procedures as appropriate for the ambulatory environment and agrees that such designation should be based on clinical standards.

The current Medicare requirements and restrictions have two consequences. First, they limit the kinds of surgeries that can be performed on Medicare beneficiaries in an ASC. In fact, Medicare has designated procedures that can be performed in an ASC. Second, as a result of the Medicare rules, the patient loads of ASCs tend to be of lower complexity than those treated in hospitals.

Proponents assert that because PSRCCs provide appropriate care and use resources in a cost-efficient manner that increases patient and physician satisfaction, Medicare should cover the cost of stays in these facilities. Consequently, in the Balanced Budget Refinement Act of 1999, Congress directed MedPAC to study and report on the cost effectiveness and feasibility of covering the services of PSRCCs under the Medicare program.

This report describes the characteristics of PSRCCs and states' experiences with these facilities. It also discusses policy questions raised by the operation of these centers for the Medicare program. Finally, the Commission offers its conclusions and recommendation regarding PSRCCs and Medicare payment policy.

Characteristics of PSRCCs

PSRCCs exist in several constructions. Some are physically attached to, or constitute a distinct part of, a hospital or ASC. Others are freestanding and have contractual relationships with providers, including hospitals or ASCs. In theory, a patient could be admitted as an inpatient, have surgery in a hospital's regular operating suite, and then be transferred to a PSRCC after an appropriate period in the recovery room. We have found little evidence of this approach occurring, however. In reality, patients who use a PSRCC almost always have their surgery in an ASC, with the ASC operating the PSRCC on site or transporting the patient to a freestanding PSRCC. Although the predominant model for PSRCCs is a facility that is part of an ASC, an ASC (with the accompanying PSRCC) can be operated by a hospital and located on or near the hospital campus.

Although information on PSRCCs is at best incomplete, the general characteristics of these facilities and the non-Medicare patients currently served by them can be gleaned from a 1999 survey of ASCs performed by the Federated Ambulatory Surgery Association (FASA) (FASA 2000, Bryant 2000). This survey found that 240 of these facilities—nearly 9 percent of ASCs nationwide—were providing post-surgical recovery care (Table 1). In addition, 34 states had PSRCCs. Although some PSRCCs are owned solely by hospitals, most are independently owned or part of a multi-facility chain.

In general, state laws and regulations govern the operations of PSRCCs, including staffing requirements and credentials and the maximum length of stay. The FASA survey reported that although many states limit recovery care to fewer than 24 hours, a trend toward permitting longer stays is occurring and, currently, 18 states permit patients to stay more than 24 hours (Table 1). In these cases, the maximum length of stay is usually 72 hours. At least one state, Arizona, does not limit the number of days that a patient may recuperate in a PSRCC (Caine 2000).

Many observers believe that the patients served by PSRCCs are relatively healthy, with few complicating medical problems or conditions, compared with the average inpatient undergoing the same procedure. In the 1999 FASA survey, patients having orthopedic procedures accounted for the largest volume of PSRCC stays. Plastic surgery; general surgery; ear, nose, and throat (ENT) procedures; and gynecologic operations also accounted for significant percentages of PSRCC business. The specific procedures that most frequently led to recovery care services were abdominoplasty, anterior cruciate ligament reconstruction, facelift, laparoscopic cholecystectomy, and breast reduction. In certain locations, PSRCCs care for patients recovering from more invasive, complex surgeries, such as thyroidectomies, mastectomies, hysterectomies, total joint replacements, and laminectomies (Mayo 2000, Steinman 2000, Turney 2000).

**TABLE
1****Number of post-surgical recovery care centers affiliated
with ambulatory surgery centers, 1999**

State	Number of PSRCCs	Number by maximum stay		Percent of ASCs with recovery care
		23 or less hours	24 or more hours	
Alabama	5	5	0	17.2%
Alaska	1	1	0	20.0
Arizona	9	3	6	17.6
Arkansas	0	0	0	N/A
California	54	50	4	13.8
Colorado	16	6	10	63.4
Connecticut	0	0	0	N/A
Delaware	0	0	0	N/A
Florida	2	0	2	1.6
Georgia	10	8	2	9.2
Hawaii	1	1	0	9.1
Idaho	1	1	0	4.4
Illinois	3	1	2	5.6
Indiana	17	14	3	24.1
Iowa	2	2	0	16.7
Kansas	3	3	0	8.8
Kentucky	1	1	0	4.4
Louisiana	0	0	0	N/A
Maine	0	0	0	N/A
Maryland	2	2	0	1.3
Massachusetts	0	0	0	N/A
Michigan	3	3	0	5.4
Minnesota	2	2	0	12.5
Mississippi	2	1	1	17.6
Missouri	6	5	1	15.9
Montana	0	0	0	N/A
Nebraska	0	0	0	N/A
Nevada	6	5	1	20.6
New Hampshire	0	0	0	N/A
New Jersey	3	3	0	3.5
New Mexico	0	0	0	N/A
New York	3	3	0	8.6
North Carolina	10	10	0	15.9
North Dakota	0	0	0	N/A
Ohio	6	4	2	8.5
Oklahoma	10	9	1	29.7
Oregon	1	1	0	3.8
Pennsylvania	0	0	0	N/A
Rhode Island	0	0	0	N/A
South Carolina	0	0	0	N/A
South Dakota	2	1	1	14.3
Tennessee	10	9	1	13.8
Texas	35	29	6	24.6
Utah	2	2	0	10.5
Vermont	0	0	0	N/A
Virginia	1	1	0	2.4
Washington	4	3	1	5.1
West Virginia	0	0	0	N/A
Wisconsin	4	2	2	16.2
Wyoming	1	1	0	14.3
District of Columbia	0	0	0	N/A
Puerto Rico	3	0	3	46.2

Note: N/A (not applicable). Freestanding post-surgical recovery care centers were not included in the survey.

Source: Federated Ambulatory Surgery Association, *Post-Surgical Recovery Care, 2000*.

According to the 1999 FASA survey, managed care plans, including preferred provider organizations and health maintenance organizations, provided about 41 percent of payments to PSRCCs. Self-pay was also a major source of payment for these facilities, accounting for roughly 29 percent of revenue, while indemnity plans accounted for 16 percent and workers' compensation for 9 percent.

State demonstrations or experience with PSRCCs

Although PSRCCs have existed for more than two decades, no comprehensive studies have been conducted that compare the cost and quality of care at these facilities with that of other providers. One study of payments was conducted in 1990 and is summarized below. Two states have conducted or are currently conducting demonstration projects designed to evaluate PSRCCs as alternate providers of post-surgical care (see text box). California recently completed a 12-year demonstration project, and Illinois initiated a five-year demonstration study of PSRCCs in 1997.

Analysis of payments to PSRCCs in Arizona and California

A study of PSRCC payments in Arizona and California was prepared for the National Recovery Care Association in 1990 by the Lewin Group/ICF (Lewin 1990). This study reviewed the medical records of 371 and 142 patients treated in one Arizona and one California PSRCC, respectively. Only 3 percent of the Arizona patients and 7 percent of the California patients were over the age of 65. Orthopedic, gynecologic, and ENT procedures, plus general surgeries (for example, laparoscopic cholecystectomies) accounted for the majority of admissions to the study PSRCCs.

The Lewin report compared actual outpatient surgical facility charges and PSRCC charges with an estimate of the inpatient payments by diagnostic category (CPT-4 or ICD-9-CM code) that would have been made using Medicare payment rates in the absence of the PSRCCs. Using this formula, Lewin estimated that use of PSRCCs for surgical encounters of Medicare beneficiaries would produce a cost savings of up to 35 percent. This report may have exaggerated the potential savings, however, because the authors used Medicare diagnosis related group (DRG) payment rates to estimate what would have been paid for the non-aged patients who predominated in the study. These patients almost undoubtedly received less complex services than Medicare patients receiving the same surgery would have required. The study also failed to consider the impact of PSRCCs on provider costs (in contrast to insurer payments), as discussed further in the next section.

California and Illinois demonstrations

The California demonstration project began in 1987 and ended in September 2000. Of the six participating PSRCCs, two were hospital-based, two were associated with freestanding ASCs, and two were freestanding (Robertson 2000). One site was in a rural area. Five of the six sites withdrew before the demonstration period ended. The reasons for withdrawal could not be obtained in time for this report. The final evaluation report for the six California demonstration sites is not yet available but is currently under review by state officials.

Illinois also recently authorized the establishment of a Post-surgical Recovery Care Center Model Demonstration Program under its Alternative Health Care Delivery Act. This program is designed to evaluate the effectiveness and appropriateness of this model of care, as well as its effect upon the existing health care system. The program allows hospitals and freestanding ambulatory surgery centers to provide overnight post-surgical care, including nursing care, pain control, and observation, to generally healthy patients who would otherwise require care in an inpatient setting. To date, the demonstration project has five centers participating; three are based in hospitals and two are part of freestanding ASCs. Definitive evaluation of this demonstration project is at least two years away and no preliminary assessment is available.

Description of California and Illinois demonstration projects

California law and regulations outlined the specifics of the demonstration, providing for a maximum of 12 sites with up to 20 beds each that met state standards for skilled nursing facilities. Each site was required to have a medical director who was a physician and who assumed responsibility for the operation of the facility and for reviewing, evaluating, and approving patient care policies and procedures. State regulations mandated that each PSRCC have at least two licensed nurses, with one being a registered nurse certified for advanced cardiopulmonary life support, any time a patient was in the facility. Each facility also had to retain a consultant pharmacist and registered dietitian.

Admission to these PSRCCs was limited to people who needed post-surgical care following an outpatient surgical procedure and who needed to stay at least overnight but not more than 48 hours at the facility. A PSRCC could extend the stay to 72 hours if the attending surgeon certified that an additional period of recovery care was medically necessary and the medical director concurred.

As in California, the regulations governing the Illinois demonstration require that PSRCCs only accept patients whose expected length of stay is less than 48 hours. A patient's length of stay can be extended to a maximum of 72 hours, at which time the patient must be discharged or transferred to a hospital. Up to 12 facilities can participate in the demonstration and each facility may have up to 20 beds. Each facility must obtain a certificate of need from the state's health facilities planning board and must be licensed by the Illinois Department of Public Health as a PSRCC.

The participating PSRCCs must comply with state regulations and rules regarding professional staffing and credentials and patient eligibility. These centers must have at least one registered nurse and one licensed practical nurse on duty for each shift. At all times, a physician must be on call and able to respond within 15 minutes. The sites are required to undergo regular inspections and to collect and report patient data on a timely basis. ■

Policy questions/pros and cons

Continued progress and advancements in surgical science and technology have expanded the number and types of procedures that proponents believe can be safely performed in ASCs. As a result, an increasing number of patients are being treated in this setting. The evolution of ambulatory surgical practice to include more complicated procedures and patients has created a demand for a type of facility in which patients can be observed for a somewhat longer post-operative period than that provided in an ASC recovery room. Moreover, the continued growth in ambulatory surgery and in facilities of this type has prompted some to question Medicare's payment policy in this area. However, only limited data exist on the impact of PSRCCs on the cost and quality of post-operative care in general, and, more specifically, for Medicare beneficiaries. The following section discusses key policy issues raised by PSRCCs and presents the arguments for and against Medicare support of these facilities.

Do PSRCCs meet special or unique needs for post-operative patients that are not currently met by traditional hospitals? If so, do Medicare beneficiaries have similar needs?

PSRCCs were created as an alternative to inpatient hospital care for patients needing relatively short periods of post-operative observation or sub-acute care. Proponents assert that these facilities permit patients who require post-operative observation to recover from a surgical procedure in a non-hospital, less-intensive setting that provides "home-like" amenities. As such, PSRCC nurses may provide more personalized care than that received on a general medical/surgical hospital unit, where more critical patients demand more of the professional staff's time.

In addition, the availability of PSRCCs allows surgeons to perform more procedures in the outpatient setting, which they may find convenient. Proponents argue that PSRCCs facilitate timely performance of elective procedures by eliminating scheduling competition for operating room time with emergency or more complex surgeries and by allowing surgeons to schedule similar cases back-to-back.

Although PSRCCs may provide a more comfortable environment for recovery from low-complexity surgical procedures, no special medical needs are uniquely met by these facilities. Hospital post-operative units provide the same spectrum of medical services, and may be better equipped to handle unexpected complications or emergencies.

Would PSRCCs improve access to surgical services for Medicare beneficiaries?

Proponents claim that PSRCCs would increase access to certain surgical procedures for some Medicare beneficiaries. As noted above, PSRCCs may reduce the waiting time for surgeries that can be effectively performed in an ASC because patients scheduled for elective procedures do not have to compete with acutely ill patients for surgical suite time and post-operative beds.

In theory, ASCs with PSRCCs located in rural communities that cannot support a full-service hospital could increase access for beneficiaries residing in these areas. To our knowledge, however, few PSRCCs are in rural areas. Moreover, some states require that PSRCCs be located within a certain travel time of a hospital (for example, 15 minutes) in case patients who develop complications need to be transferred to that facility. Thus, ASCs with PSRCCs may not be a viable option for increasing access to surgery in isolated rural communities.

As previously noted, patients served by PSRCCs tend to be relatively healthy, with few co-morbid conditions. Because Medicare patients are older than the general population and may have more complicated medical conditions, the number who might qualify for ambulatory surgery with observation in a PSRCC is less than in the general population. Moreover, some of the specific procedures suitable for PSRCC care are not frequently performed in the Medicare age group. Therefore, PSRCCs may not significantly increase access for Medicare patients.

Do PSRCCs improve the quality of care for post-operative patients? If so, how?

Quality of medical care is an important focus of the Medicare program. Advocates of PSRCCs claim that these facilities improve the quality of care rendered to patients by matching resources more closely to the needs of patients. They assert that highly specialized and focused professional staff are more familiar with the expected post-operative course of treatment and likely problems of patients served by PSRCCs. In addition, the nurse to patient ratio may be better in a PSRCC than in a hospital. Finally, by moving the post-operative stay from the acute care facility to a PSRCC, patients may avoid complications engendered by the hospital environment, such as nosocomial infections.

One measure of quality is patient satisfaction with medical care and services. To this end, in the 1999 FASA survey, PSRCCs collecting satisfaction data reported that they scored an average of 97 percent satisfaction among their patients. Satisfaction data for similar patients treated in acute care hospitals are not available.

PSRCCs are a relatively new provider of health care services and are regulated by state law. Not surprisingly, state requirements vary. The Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, and the Joint Commission for Accreditation of Healthcare Organizations have recently developed general accreditation guidelines for overnight stays in ASCs.

The quality of care delivered by PSRCCs has not been rigorously evaluated and compared with that provided by acute care hospitals. In addition, some are concerned that these facilities may not have the emergency personnel and equipment to respond adequately to serious, life-threatening complications. Yet, to be fair, these facilities must comply with state licensing laws, which usually specify requirements for emergency personnel and equipment.

What are the potential economic effects of PSRCCs?

PSRCCs have been advocated as a cost-saving measure for post-operative care; the most commonly cited reason is that ASCs and PSRCCs have lower overhead costs than do full-service hospitals. However, proponents describe these savings in terms of lower payments (that is, costs to the insurer) rather than lower provider costs. In this context, savings are more likely attributable to payment rates that are not well matched to providers' costs for the specific types of surgery and patient acuity levels involved than to any real difference in production costs. To our knowledge, no study has attempted to demonstrate that PSRCCs lower provider costs.

Provider costs might be compared using either dynamic or static methods. Although we currently lack the data needed to analyze providers' costs empirically, we believe it is unlikely that either of these approaches would provide evidence that Medicare coverage of PSRCC services would reduce the provider costs of surgical care for beneficiaries.

A dynamic cost analysis would compare the aggregate costs of surgical care for Medicare beneficiaries before and after the introduction of PSRCCs. If the services of ASC/PSRCCs were substituted for those of hospitals, the additional costs of the ASC/PSRCCs would reflect these facilities' full unit costs while any differences in hospitals' costs would reflect only changes in their variable costs. Hospitals' fixed costs—building, equipment, and possibly certain key personnel—would not be affected in the short term, and additional capacity would be added to a system that already has substantial excess capacity. System-wide costs would probably increase.

Moreover, costs to the Medicare program could increase if services provided by PSRCCs were substituted for follow-up home care or physician outpatient visits for Medicare beneficiaries who would have been discharged to home after having ambulatory surgery under the current benefit. In this case, the stay in PSRCCs would constitute more of a convenience for the beneficiary than a medically-justified admission for post-operative care and, in essence, would be a new Medicare benefit. The Medicare program would obviously require medical necessity for stays in PSRCCs, but in practice, coverage decisions often defer to clinical judgement.

A static cost analysis would compare the average unit costs of ASC/PSRCCs and hospitals for comparable patient loads. Some elements of hospitals' overhead costs may be higher, particularly for costs related to standby capacity and teaching that ASCs and PSRCCs do not incur, but other elements may only appear higher due to shortcomings in cost allocation methodology. For example, hospitals' per diem costs of routine inpatient care (covering nursing staff, medical supplies, and so on) are undoubtedly higher than those of PSRCCs.¹ But the hospital figures result from averaging costs incurred in treating expensive cases (pediatric or cardiology patients, for example) with the costs of the relatively low-complexity patients that PSRCCs typically handle. If all low-complexity patients were treated on one unit and a separate per diem cost calculated for that unit, then the per diem costs of hospitals and PSRCCs might be similar.

¹ The Medicare Cost Report uses such a hospital-wide per diem cost for determining the routine costs of Medicare patients.

The one quantitative analysis of hospitals and PSRCCs, conducted by the Lewin Group/ICF, constructed a comparison based on payments rather than provider costs. The Medicare prospective payment system (PPS) rates used to estimate what would have been paid if PSRCC patients had been treated in a hospital are designed to cover the average costs of all patients in the applicable DRG. It should not be surprising that these rates are higher than those that the PSRCCs in the study reported, because PSRCCs negotiated with private insurers for a patient load that was limited to low-complexity patients. The measured difference should not be interpreted as evidence that PSRCCs have lower production costs.²

Medicare could take short-term advantage of the fact that its DRG rates were not designed to be applied to a subset of low-acuity patients by covering care provided in ASC/PSRCCs and developing a set of lower rates to pay for that care. Removing the least complex cases from hospitals' patient loads would raise the average complexity level of the remaining cases, however, thus increasing hospitals' average unit costs. MedPAC's framework for updating PPS payments recognizes the cost-increasing impact of an increase in intra-DRG case complexity. The Commission believes that if there were evidence of such an increase resulting from widespread use of PSRCCs, the Congress should raise the payment update for the following year to compensate for hospitals' added costs. That response could reduce Medicare's savings significantly.

In the longer run, however, expanded use of ASCs and PSRCCs may have at least a modest cost-reducing effect by better matching resources to specific patient needs. This may ultimately reduce overall costs, but only after the extended period of time required to restructure the current health care system and eliminate excess capacity. Innovation of health care delivery systems in an attempt to increase patient satisfaction and quality of care is an important objective of the Medicare program and may justify the additional costs to the system generated by PSRCCs.

What are the payment implications of PSRCCs?

Care for Medicare patients who could be treated by PSRCCs is probably paid for under the inpatient PPS in most cases, but using these rates to pay for the care provided by ASCs and PSRCCs would probably result in a windfall for these facilities because of below-average patient complexity. Therefore, a decision to cover the services of PSRCCs under Medicare would require HCFA to develop a new set of payment rates.

Both the relative weights and the conversion factor needed for a prospective payment system would ideally be based on providers' experience in treating Medicare patients. One way to obtain the necessary data would be to include aged patients with somewhat longer stays in the survey of ASCs that Medicare administers every five years to develop the ASC fee schedule. However, the aged patient loads of ASCs offering post-surgical care are limited to a small number of Medicare+Choice enrollees and aged patients lacking Medicare coverage. An alternate approach would be for Medicare to sponsor a demonstration project to create a more representative sample of Medicare patients upon which to base rate setting; it would also provide HCFA with greater control over the data collection process. In addition, the demonstration could be designed to determine whether there are systematic differences between patients using ASC/PSRCCs and those receiving the same surgery in hospitals.

² As noted earlier, the authors' use of Medicare PPS rates may also exaggerate the potential for savings to the Medicare program for a second reason—that these rates are designed for application to aged patients rather than the predominantly non-aged population of the study PSRCCs.

The all-patient refined diagnosis-related group (APR-DRG) system, which MedPAC recommended this year that Medicare adopt for its inpatient PPS, could be useful in developing an appropriate set of rates for ASC/PSRCCs (MedPAC 2000). The APR-DRG system accounts more accurately for severity differences by assigning patients to one of four severity classes—minor, moderate, major, and extreme—based on combinations of secondary diagnoses, age, procedures, and other factors. The system not only differentiates by the presence or absence of co-morbidities and complications (CCs), but on the level of particular CCs. Ideally, this more sophisticated patient classification approach would be implemented for all surgical patients requiring an overnight stay, so as to have appropriately lower rates for the cases ASC/PSRCCs would likely treat and higher rates for the more complex patients that would continue to go to hospitals. Even testing this system for ASC/PSRCCs would require patient abstract and cost data, however, which could only be generated through a demonstration project.

A separate question that would arise if Medicare were to consider covering PSRCC services is whether the program would develop an all-inclusive rate or separate rates for the surgical and post-surgical components of care. A bundled rate would appear more appropriate and consistent with present practice for both inpatient and outpatient surgery; it would establish the organization providing the surgery as responsible for arranging post-surgical care and at risk for the additional costs it would incur to transport patients if it chooses to contract with an independent PSRCC rather than provide the care itself. As noted earlier, the vast majority of PSRCCs are operated by an ASC anyway.

Finally, to cover PSRCC services, HCFA would need to remove the four-hour post-surgical observation time limit for beneficiaries treated in ASCs (as in HCFA's June 12, 1998 proposed rule) and expand the list of surgeries that Medicare allows ASCs to perform. This list identifies procedures that can safely be performed in an ambulatory setting that lacks the full spectrum of ancillary services and back-up medical personnel available at most full-service hospitals.

What impact (if any) would PSRCCs have on medical education?

The extent to which patients treated in PSRCCs are available for medical education is uncertain. As the number of procedures performed in the ambulatory setting with post-operative care delivered in PSRCCs continues to increase, the least complicated and most stable patients, which are often the most suitable for training of new physicians and nurses, will be treated in these facilities. Continued expansion of surgical and medical services into alternate care sites will pose a challenge to medical educators in the future.

RECOMMENDATION

At this time, there is insufficient evidence to support a change in Medicare payment policy for post-operative care. If, in the future, data from two ongoing demonstration projects or other sources support coverage of post-surgical recovery care centers, Medicare policy for these facilities should be reexamined.

Although PSRCCs may offer an attractive alternative to acute care hospitals for certain patients who require a relatively short period of post-operative observation, data on the quality of care provided by these facilities are limited. To our knowledge, the economic impact of PSRCCs has not been rigorously examined, and consequently no evidence exists that the services of these facilities are less costly than those of hospitals. In the future, Medicare's decision to cover services provided by PSRCCs should be based on evidence demonstrating that these facilities deliver high-quality and convenient post-operative care at a cost no greater than that incurred by current providers for similar levels of care. ■

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