AMERICAN HOSPITAL ASSOCIATION
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TRENDWATCH

The Migration of Care to Non-hospital Settings: Have Regulatory Structures Kept Pace with Changes in Care Delivery?

A growing number of increasingly complex procedures are moving from the inpatient to the outpatient environment, and out of hospital settings into physicians' offices and free-standing ambulatory surgery or diagnostic facilities. Many of these care settings involve physician ownership and self-referral. This edition of TrendWatch explores the impact these trends have on health care utilization and costs, quality of care and patient safety, access to care, and the health care system overall. It also addresses whether oversight of these facilities to ensure quality and safety has, or has not, responded to the shift in care from the hospital outpatient department (HOPD) to non-hospital settings.

Services Provided Outside the Hospital Have Grown and Become More Complex

The number of surgeries, imaging studies and diagnostic tests performed away from HOPDs is growing rapidly. These procedures and services are primarily moving to ambulatory surgery centers (ASCs) which provide outpatient surgical services not requiring an overnight stay, independent diagnostic and testing facilities, and physician offices. From 1997 to 2004, the volume of ASC procedures provided to Medicare beneficiaries rose 145 percent while the number of ASCs climbed 67 percent – on average, 240 additional ASCs per year between 1998 and 2004. The most common ASC procedures include those in ophthalmology, gastroenterology and orthopedics.[1]

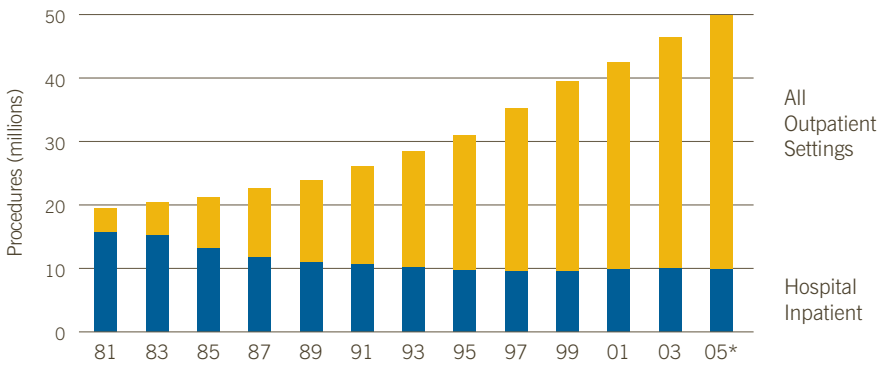
The number of procedures and tests performed in physician offices also has been increasing – particularly imaging services. In 2004, physician offices provided about 60 percent more imaging services than in 1996.[2] And since the early 1980s, the share of outpatient surgeries performed in hospitals has fallen from over 90 percent to 45 percent, while the share performed in ASCs and physician offices has grown from less than 5 percent to 38 and 17 percent, respectively.[3]

Not only is the number of procedures performed outside of HOPDs rising, so too is their complexity. When ASCs first opened in the 1970s, procedures were limited – simple breast biopsies, cataract removals, etc. ASCs now handle complex orthopedic, gastroenterological and gynecological surgeries.[4]

Innovation in medical techniques and technology, along with the preferences of multiple players in the health

Increasing numbers of surgical procedures are moving from the inpatient to the outpatient setting.

Chart 1: Inpatient vs. Outpatient Surgery Volume, 1981-2005



Source: Avalere Health analysis of Verispan's Diagnostic Imaging Center Profiling Solution, 2004, and American Hospital Association Annual Survey data for community hospitals, 1981-2004. *2005 values are estimates.

American Hospital Association

care system, have driven the migration of care to non-hospital settings. Less invasive surgical techniques and advances in anesthesia have made it possible for more procedures to be performed in outpatient settings where recovery time is limited.

Physicians value the reliability of scheduling procedures in non-hospital settings where operating room schedules are not interrupted by emergency patient needs. In addition, many physicians have ownership in ASCs which offers them added income along with a role in managerial decision-making. And some patients prefer the convenience and aesthetics of non-hospital settings.

Vendors of medical equipment and technology have encouraged physician investment as a part of their marketing strategy. Companies such as General Electric (GE) have increased their marketing to physician offices and tailored promotional messages to focus on the return on investment in imaging equipment, noting that physicians see imaging as a new and potent source of revenue. GE also helps physicians with financial concerns, and recently acquired a company that specializes in financing for physicians and dentists, helping to ease purchase of in-office equipment.[5]

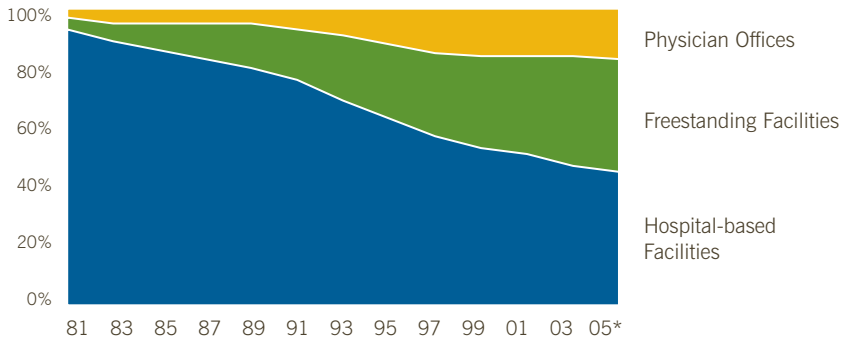
Finally, payers – both private and public – want to pay the least amount

55%

Percentage of outpatient surgeries done in physicians' offices or freestanding surgery centers, 2005

Outpatient surgery is quickly migrating to non-hospital settings…

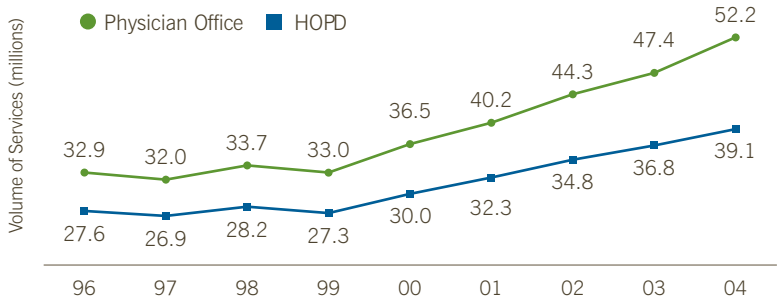
Chart 2: Percent of Outpatient Surgeries by Facility Type, 1981-2005



Source: Verispan's Diagnostic Imaging Center Profiling Solution, 2004. *2005 values are estimates.

…while imaging is growing faster in office-based settings than in HOPDs.

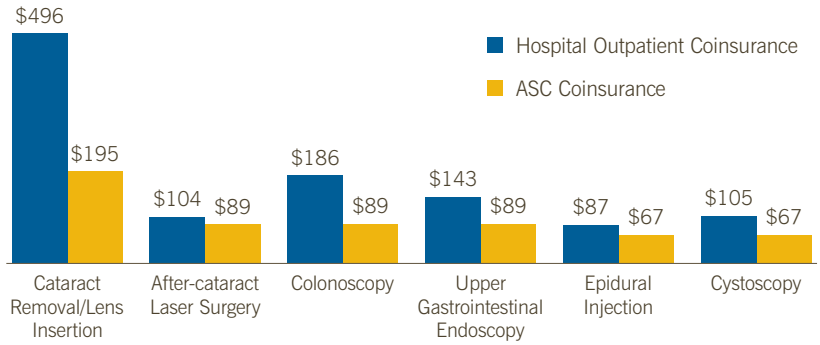
Chart 3: Volume of Medicare Imaging Services Delivered, 1996-2004



Source: Avalere Health analysis of Part B Physician/Supplier Procedure Summary Master Record.

Lower copayments may make ASCs more attractive to Medicare beneficiaries.

Chart 4: Medicare Required Procedure Coinsurance Rates for ASCs and Hospital Outpatient Departments, 2006



Source: Federal Register, *Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures; Interim Final Rule,* May 4, 2005, and Centers for Medicare & Medicaid Services, CMS-1501-FC, *Changes to Hospital Outpatient PPS for Calendar Year 2006, Addendum B.*

possible for each service and these settings often, though not always, have lower per-service rates.

The Centers for Medicare & Medicaid Services (CMS) has long allowed ASCs to serve Medicare patients, hoping to save money on each episode of care. Since 1990, CMS has approved more than 1,100 procedures for ASCs and set payment rates that in some cases exceed the rates paid to hospitals. Due to the different payment systems for the HOPD and ASC, beneficiaries often pay lower coinsurance at an ASC than at an HOPD. Beneficiaries pay 20 percent of the Medicare payment for care at an ASC, but Medicare requires beneficiaries pay as much as 45 percent of the total payment for care received at an HOPD.

However, the potential for increased service use due to supply-induced and/or physician-induced demand – particularly in self-referral situations – has some payers concerned that the shift in care is driving overall costs for outpatient services *up*, not down.[6] In addition, as the procedures performed in these settings have become more complex, patient safety and quality have come into question.

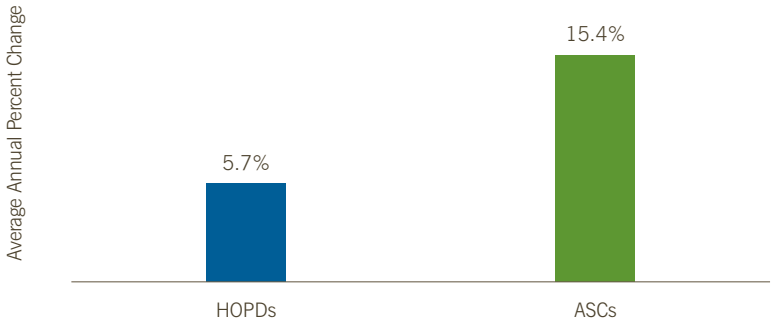
Rapidly Rising Utilization Raises Concerns

The Medicare Payment Advisory Commission (MedPAC), the independent federal body that advises Congress on issues affecting the Medicare program, has expressed concern about rising Medicare utilization and costs for both ASCs and outpatient imaging. Growth in the volume of services provided in non-hospital settings has outstripped growth in services performed in hospital outpatient departments. From 2001 to 2004, the number of ambulatory surgeries delivered to Medicare beneficiaries grew by only 5.7 percent annually for HOPDs while increasing 15.4 percent annually for ASCs.[7]

Medicare payments for services done outside the hospital also have grown at an extraordinary pace. Medicare expenditures directed to ASCs nearly tripled from 1995 to 2004 – from $849 million to $2.5 billion. Additionally, payments for physician office imaging more than doubled between 1996 and 2004.[9]

The growth in Medicare spending for outpatient surgery in ASCs has raised concerns about excess utilization…

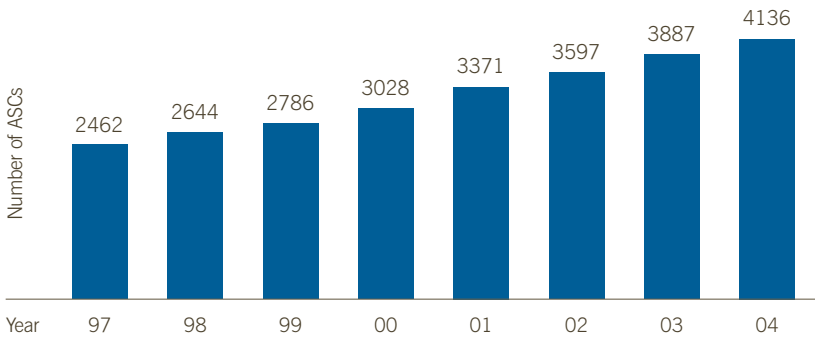
Chart 5: Average Annual Percent Change in Medicare Outpatient Surgical Volume, ASC vs. Hospital, 2001-2004



Source: The Moran Company analysis of Part B Physician/Supplier Procedure Summary Master Record and Hospital Outpatient PPS Files.

…as the number of ASCs has increased rapidly.

Chart 6: Number of Medicare-approved ASCs, 1997-2004



Source: MedPAC, *A Data Book: Healthcare Spending and the Medicare Program*, June 2005.

Capacity Growth Linked to Regulatory Policies

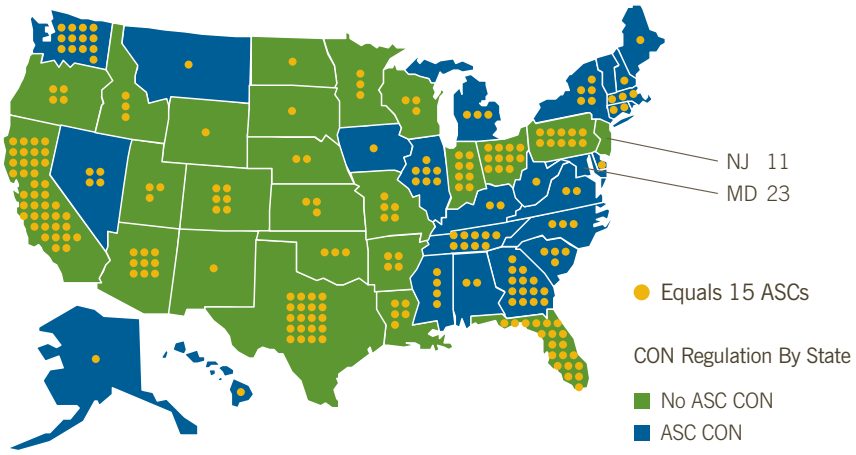
Differential regulation across care settings at both the state and federal levels has fostered the growth of procedures in ASCs and physician offices.

The relaxation or outright elimination of certificate of need (CON) laws at the state level has allowed imaging and surgical capacity growth, which in turn has helped drive the migration of care out of hospitals. CON laws require hospitals that wish to add beds, services or capital equipment, or entities seeking to build new facilities, to demonstrate that doing so would address an unmet health care need. Today, 37 states have some CON oversight in place.[10] But often those same restrictions are not placed on other ambulatory settings. In New York, for example, hospitals and licensed centers must receive approval under the state's CON laws to purchase imaging equipment while physicians do not face the same requirements when purchasing equipment for their offices.[11] ASCs are more prevalent in states having minimal or no applicable CON rules.

The regulation of self-referral varies across care settings, providing opportunities for physician investment in ASCs and office-based surgery and diagnostics that are precluded in many other settings. At the federal level, the Ethics in Patient Referrals Act (physician self-referral law) prohibits physicians from referring Medicare patients for designated health services to entities with which they have financial relationships. Designated health services include clinical laboratory, radiology, physical therapy, and inpatient and outpatient hospital services. ASCs, however, are not designated health services

ASCs are more prevalent in states lacking CON requirements…

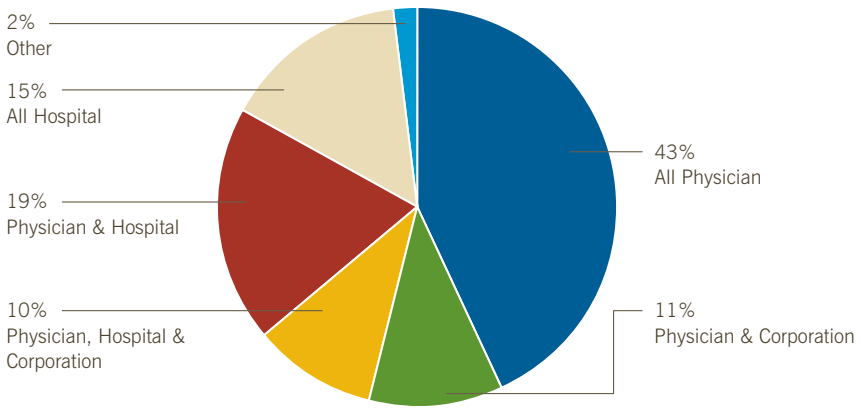
Chart 7: Number of ASCs Relative to CON Laws Governing ASCs, by State, 2005



Source: Federated Ambulatory Surgery Association (FASA), *Medicare Certified ASCs 2005,* available at www.fasa.org, and American Health Planning Association (AHPA), *2005 Relative Scope and Review Thresholds: CON Regulated Services by State,* updated January 19, 2005.

…and 83 percent of ASCs are wholly- or partly-owned by physicians.

Chart 8: Ownership Structures of ASCs, 2004



Source: American Association of Ambulatory Surgery Centers, *ASC Ownership Survey,* February 2004.

from the field

"What concerns us most is whether doctors are keeping to the appropriate kinds of surgery," said Richard McGarvey, a spokesman for the Pennsylvania Health Department, "And whether only the most appropriate people are being treated."[12]

under this law. To the extent that one of the designated services is provided in an ASC owned by the referring physician, the physician self-referral statute does not prohibit the referral as long as there is no separate payment for the designated service (i.e., it is part of the bundled ASC Medicare payment). In addition, there are a variety of exceptions under the physician self-referral law which allow self-referral for services offered in a physician's office or group practice. Exceptions also permit self-referral in rural areas and in the "whole hospital" setting.

As of February 2004, physicians had ownership interests in 83 percent of ASCs, and they owned 43 percent outright.[13] The number of physicians offering in-office diagnostic and surgical services is rising.

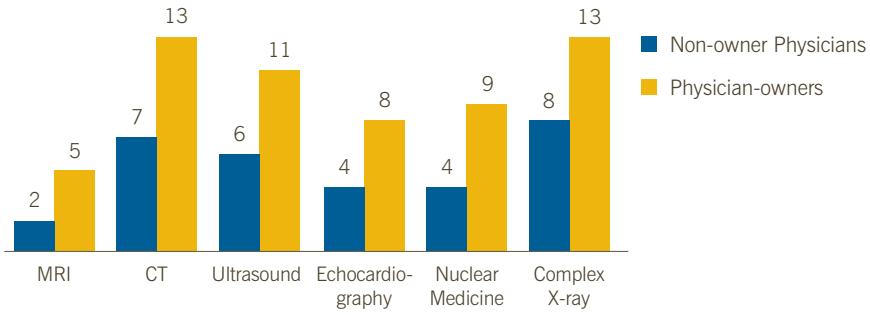
Past research reveals that physician self-referral contributes to higher usage and total overall costs. One study found that physicians who performed imaging services in their own offices were 1.7 to 7.7 times more likely to utilize imaging than physicians who referred patients to radiologists. Average imaging charges per episode of care were 1.6 to 6.2 times greater for the self-referring physicians.[14]

Financial incentives also influence where physicians direct referrals. Two case studies in which ASCs entered markets to compete with community hospitals found that physician investors moved their patient caseloads from HOPDs to the new ASCs but non-owners did not. In both instances, the number of surgeries that physician investors performed at the hospital dropped drastically – by 50 to 75 percent.[15]

More recent research has found increased utilization rates for inpatient cardiac surgery associated with the opening of physician-owned cardiac hospitals, but limited data exist on self-referral in the ASC setting.[16] Only a handful of states collect data on procedures performed in ASCs and/or require financial disclosure of physician ownership interests.

Self-referral has been linked to increased utilization of diagnostic services…

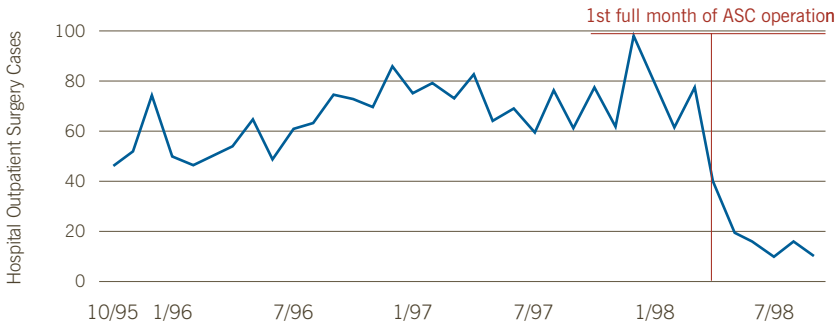
Chart 9: Number of Imaging Services Ordered per Physician-owner vs. Non-owner, 1990



Source: United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, October 1994.

…and financial incentives influence where physician-owners direct and treat patients.

Chart 10: Orthopedic Surgeries Performed by Physician-owners at a Full-service Hospital System Before and After ASC Opening, October 1995 - September 1998



Source: Lynk WJ and Longley CS. (2002), "The Effect of Physician-owned Surgicenters on Hospital Outpatient Surgery," *Health Affairs* 21: 218.

83%

Percentage of ASCs owned at least in part by physicians, 2004

States Consider Legislative and Regulatory Action on CON and Self-referral

Some state legislatures and regulatory agencies have taken action in response to what is believed to be supplier and/or physician-induced demand.

In Pennsylvania, a state with no CON requirements for ASCs, 48 new ASCs opened between July 2003 and May 2004, and patient visits during that period jumped 83 percent, from 279,000 to more than 510,000.[17] As a result, Pennsylvania is considering reinstating CON laws.

More states have considered reinstating or enhancing CON laws and others, such as Indiana and Texas, have tried to pass laws to restrict or prohibit physician referral of patients to facilities in which they have ownership or investment interests. At least two states also proposed laws to require disclosure to patients of physicians' financial interests in entities to which they refer patients.

Recent state measures aim to curb supply-induced and physician-induced demand and growth in ASCs.

Chart 11: Proposed State Legislative Efforts to Restrict Growth of ASCs

Massachusetts	Massachusetts legislators are debating HB 2711 which would ban physicians and physician groups from referring patients to non-hospital-based facilities in which they have an investment or ownership interest for MRI studies, PET scans, or linear accelerator treatment.
Indiana	Legislation effective July 1, 2005, requires that physicians make written disclosure to patients of their investments in health care entities, including diagnostic and surgical services, before referring a patient to that entity. The individual must be informed that he/she can request another referral. This notice must be signed by the patient except in emergencies.
Pennsylvania	Legislation is expected to be introduced in the senate that would prohibit virtually all physician self-referrals.
Texas	Several bills were introduced in 2005, but not passed, that would have limited physician self-referral to ASCs. HB 3281 would have prohibited physician referral for designated health care services, including ASC and imaging services to facilities in which the provider has an interest. HB 3316 would have required limited-service hospitals, ASCs, and imaging centers to disclose the names of physicians with ownership interests via signs, notifications to patients prior to receipt of services, advertising, and other similar materials.

Source: *FASA, State Update,* July/August 2005, and Choudhry, S, Choudhry, NK, and Brennan TA, "Specialty Versus Community Hospitals: What Role for the Law?" *Health Affairs*, August 9, 2005, Web Exclusive.

Quality and Patient Safety Standards Have Not Kept Up with Shift in Care

Hospitals and HOPDs are subject to more quality and safety regulation than are ASCs or physician offices. Though comparable surgical procedures may be performed in an HOPD, ASC or physician office, Medicare standards are less stringent for ASCs than for HOPDs, and are non-existent for office-based surgery. State licensing requirements vary in the degree to which they fill these gaps.

The majority of ASCs also seek private accreditation. However, an estimated 500 ASCs are not accredited. The standards for accreditation by these private organizations also vary in the degree to which they address gaps in the Medicare standards for ASCs as compared to hospitals. Three accrediting bodies share most of the ASC segment: the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) accredits approximately 2,000 ASCs; the Accreditation Association for Ambulatory Health Care (AAAHC) accredits more than 1,000 ASCs; and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits more than 500 ASCs.[18]

State licensure is required for hospitals everywhere and, in 43 states, for ASCs. Few states require licensure of physician offices, just of physicians themselves – and that licensure is not procedure-specific. In states that regulate office surgery, safety and personnel standards are highly variable. In the area of imaging, HOPDs are held to hospital-level Medicare standards for patient and staff safety, equipment maintenance and staff qualifications. With

from the field

"If you run into complications, you don't have a diverse group of doctors right there for backup," said James Lyons, M.D., a plastic surgeon in Connecticut and member of a panel for the Connecticut State Medical Society to define standards in free-standing ASCs.[19]

Medicare's standards for ASCs and physicians' offices fall short of those required for hospitals…

Chart 12: Medicare Standards for Hospitals, ASCs and Physician Offices

Hospital Standard*	ASC Standard**	Physician Office†
Must have an infection control officer who develops and implements policies governing infections and communicable disease	No standard	No standard
Hospital must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel	Must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting results to the appropriate authorities	No standard
Hospital CEO, medical staff, and director of nursing must ensure that there is a hospital-wide quality assurance and training program	No standard	No standard
Operating room must be supervised by an experienced nurse or physician	No standard	No standard
There must be a complete history and physical workup in the chart of every patient prior to surgery, except in emergencies	No standard	No standard
An individual qualified to administer anesthesia must perform a pre-anesthesia evaluation within 48 hours prior to surgery, and provide an intra-operative anesthesia record	A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed	No standard
A hospital must inform each patient or, when appropriate, the patient's representative, of the patient's rights in advance of furnishing care	No standard	No standard

* 42 CFR 482.42, 482.51, 482.52, 482.13 ** 42 CFR 416.44, 416.65 † No federal standards govern surgery performed in physician offices.

…while states' licensing requirements vary in filling in the gaps…

Chart 13: Federal and State Requirements for Hospitals and ASCs

	State Requirement of ASC (Selected States)									
Medicare Requirement of Hospital But Not ASC	AZ	CO	FL	IL	MD	MI	PA	RI	SC	TX
OR supervised by experienced nurse or physician			✓							
Roster of practitioners specifying surgical privileges of each	✓	✓				✓			✓	
Complete history and physical workup in patient's chart pre-surgery, except emergencies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Designated infection control officer develops, implements policies	✓		✓					✓	✓	
Facility-wide quality assurance and training program	✓	✓	✓		✓	✓	✓	✓	✓	✓

Source: 42 CFR 482.42, 482.51, 482.52, 482.13, 42 CFR 416.44, 416.65; Avalere Health analysis of state regulation and administrative code.

...as do accreditation requirements.

Chart 14: Accreditation Requirements for ASCs

Medicare Requirement of Hospital But Not ASC	ASC Accreditation Requirements of Accrediting Organizations*		
	AAAASF (# ASCs ~2,000)	AAAHC (# ASCs ~1,000+)	JCAHO (# ASCs ~500+)
OR supervised by experienced nurse or physician	✓	Recommended supervision by anesthesiologist, physician, or dentist	No requirement
Roster of practitioners specifying surgical privileges of each	No requirement	No requirement	No requirement
Complete history and physical workup in patient's chart pre-surgery, except emergencies	Only required for patients undergoing major surgery or minor surgery with risk factors	✓	✓
Designated infection control officer develops, implements policies	No requirement	✓	✓
Facility-wide quality assurance and training program	✓	✓	✓

Source: Avalere Health analysis of accreditation standards for ambulatory care. ASC accreditation numbers from phone conversations with representatives of each organization; April 2006.
* Note: American Osteopathic Association (AOA) also accredits ASCs; currently fewer than 10 ASCs are accredited by AOA.

the exception of mammography, there are no federal standards governing physician office imaging services. In response to concerns about safety and technical quality, some private insurers have instituted their own inspections of freestanding outpatient imaging facilities.[20]

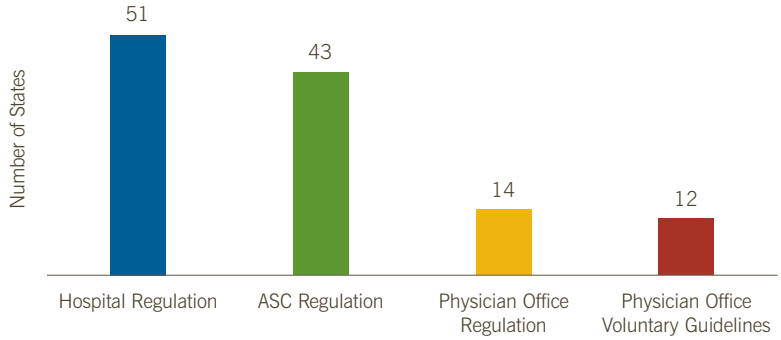
MedPAC has recognized this variation in oversight and recommended implementing quality standards for physicians who receive payment for performing and interpreting imaging studies. MedPAC notes that this policy recommendation is justified by the rapid growth in use of imaging studies, the migration of imaging from the HOPD to the physician office and freestanding centers, and evidence of variation in the quality of physician interpretations.[21] Further, MedPAC also recommends strengthening rules that restrict physician investment in imaging centers to which they refer patients.

A U.S. Department of Health and Human Services Office of the Inspector General (OIG) study on quality oversight of ASCs found that states' ability to oversee ASCs on behalf of Medicare is eroding because of the growth in ASCs and states' limited resources. Of state-surveyed ASCs, one-third (872) had not undergone a recertification survey in over five years. The OIG also found that CMS gives little oversight to ASC surveys and accreditation, and CMS does not make findings readily available to the public as it does for hospitals and other types of providers.[22]

Despite the lack of oversight, recent proposals by MedPAC and in Congress

Few states regulate surgeries performed in physician offices...

Chart 15: Number of States Regulating Hospitals, ASCs, and Physician Offices



Sources: Accreditation Association for Ambulatory Health Care, *Ambulatory Regulations*; Franko, FP, "State Laws and Regulations for Office-based Surgery;" FASA, "The Regulation of Ambulatory Surgery Centers;" Hochstadt, A, "How States Regulate Office Surgery – A Primer;" and Avalere Health analysis of state regulations.

...and for those that do, regulation is variable.

Chart 16: Comparison of State Regulations of Physician Office-based Surgery

	CA	FL	NJ	RI	TX
Reporting of adverse events	✓	✓	✓		
Training and qualification of surgeon, nurse and other personnel			✓		✓
Personnel requirements	✓	✓	✓	✓	✓
Quality assessment/improvement systems	✓	✓			
Restrictions on procedures performed				✓	
Emergency protocols	✓	✓			✓
Infection control practices			✓		
Equipment requirements			✓	✓	✓
Record keeping	✓			✓	

Sources: Franko, FP, "State Laws and Regulations for Office-based Surgery;" Hochstadt, A, "How States Regulate Office Surgery – A Primer;" Sutton, JH, "Office-based Surgery Regulation: Improving Patient Safety and Quality Care;" and Avalere Health analysis of state regulations.

would eliminate the current approach of approving ASC procedures on a procedure-by-procedure basis and replace it with a list of excluded procedures.[23] Without an explicit process to determine what is safe, a list of excluded procedures is likely to be based on where problems occur. This change could put patients at risk of undergoing procedures in ASCs before those procedures are deemed safe specifically for ASCs.

1/3

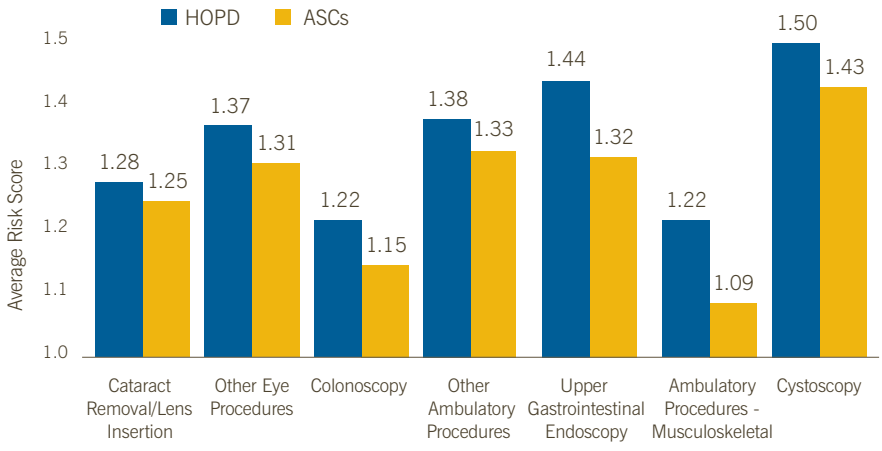
Medicare-certified ASCs not undergoing recertification survey in over five years

The Migration of Care May Weaken the Overall Delivery System

Patients and payers like aspects of ASC and physician office care, but the migration out of HOPDs may hurt the health care system as a whole. Physician ownership of ASCs and in-office imaging equipment not only sets up financial incentives for physicians to increase utilization but also encourages the steering of patients by acuity and payer, directing the more complex, costly and less well-insured patients to hospitals. A study of procedures with the highest share of Medicare payments to ASCs found that patients treated in ASCs had lower average risk scores than those treated in HOPDs.[24] Findings from an industry survey of ASCs illustrate their small share of Medicaid and charity care patients.[25]

ASCs treat a less complex mix of Medicare patients...

Chart 17: Average Risk Score for Medicare Patients in HOPDs vs. ASCs, 1999



Source: Winter, A, (2003), "Comparing the Mix of Patients in Various Outpatient Surgery Settings," *Health Affairs*, 22: 68-75.

The loss of elective cases for healthier insured patients creates a financial challenge for full-service hospitals. Full-service hospitals need adequate volumes of patients to support a wide range of services and technologies for all patients – inpatient and outpatient, elective and emergency. They also depend on well-paid services and patients to subsidize care for low-income patients, 24-hour access to care, disaster readiness, and high-intensity standby resources such as trauma centers and burn units.

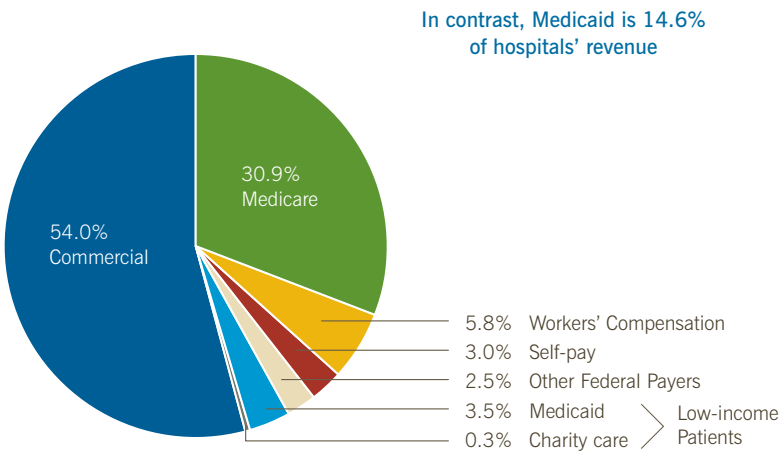
Many hospitals also are facing declining physician engagement as the migration of care out of the hospital setting has made physicians less dependent on hospitals as a practice site. This trend is weakening the ability of full-service hospitals to maintain access to care for their communities. Hospitals struggle to hang onto specialists to provide on-call support, staff clinics and teach medical students.

In a recent survey by the American College of Emergency Physicians, 51 percent of emergency department (ED) directors reported deficiencies in on-call coverage because specialists left their hospital to practice elsewhere.[26] The top five specialties cited were orthopedics; plastic surgery; neurosurgery; ear, nose, and throat; and hand surgery. More than one-third of hospitals report paying for coverage in some specialty areas.[27]

Ironically, ASCs rely on but generally don't support the emergency standby capabilities of hospitals. ASCs do not typically maintain the complement of resources to respond to the full range of complications that can occur during a procedure or post-discharge. When their patients become unstable and require

...and ASCs treat a smaller portion of low-income patients.

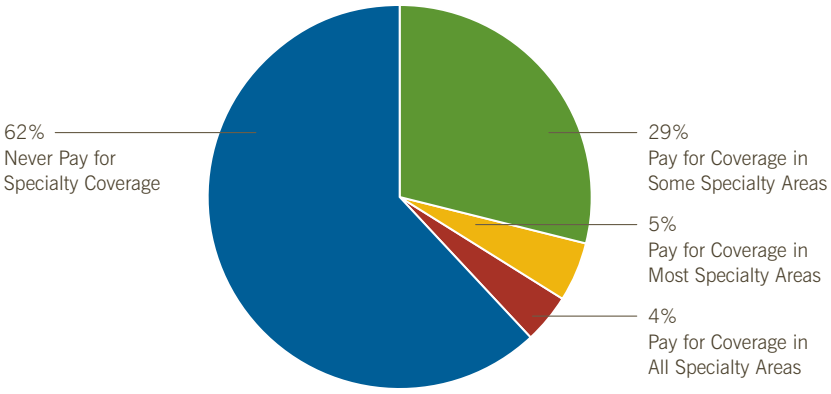
Chart 18: Percent of ASC Patients by Payer



Source: Medical Group Management Association (MGMA), *Ambulatory Surgery Center Performance Survey,* 2005 Report, and AHA Annual Survey.

More than one-third of hospitals now pay for on-call coverage in some specialty areas.

Chart 19: Percent of Hospitals Paying for Specialty On-call Emergency Department Coverage, 2006



Source: American Hospital Association, *The State of America's Hospitals: Taking the Pulse*, 2006.

from the field

"There are two community hospitals in my district, and one is really struggling," said Massachusetts State Rep. Paul Kujawski, author of HB 2711, which would restrict physician self-referral for imaging, "Hospitals rely on the ability to perform diagnostic services for their community."[28]

emergency care they send them to a hospital for stabilization. Hospitals have obligations under EMTALA to screen and stabilize patients presenting to their EDs. That means that they must provide back-up services to ASCs whose patients develop complications, even though ASCs have no obligation to support the hospitals' emergency capacity. Further, under EMTALA a hospital must follow a rigorous protocol when transferring an unstabilized patient from the ED to another hospital for services that they can't provide, but ASCs are not required to follow any similar transfer protocols to protect their patients' safety when transferring them to a hospital. ASC patients suffering from complications can appear in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used, and often no ability to reach the ASC's surgeon for consultation.

Post-Surgical Recovery Care Centers

Post-Surgical Recovery Care Centers (PSRCCs) provide medical and nursing services for patients requiring short-term supervision following surgery. These facilities predominantly serve individuals who have received care in an ASC. A survey found PSRCCs in 34 states.[29] Many states limit PSRCC stays to less than 24 hours, though more than one-third of states permit patients to stay longer. The maximum length of stay is typically 72 hours, or three days.[30] The patients served by a combination of ASCs and PSRCCs – especially PSRCCs allowed to keep patients up to three days – may look increasingly like hospital inpatients whose average length of stay is not much longer. If PSRCCs are, in essence, providing hospital-type inpatient care, should they also meet hospital-level standards for inpatient care?

As more complex procedures are performed in ASCs, there is growing demand for the longer duration of post-operative care delivered by PSRCCs. Some patients may prefer the amenities of PSRCCs but hospital post-operative units are more likely to be better equipped to handle complications from surgical procedures.

Many private payers cover treatment in PSRCCs; Medicare does not. MedPAC found insufficient evidence that Medicare coverage of PSRCC services would reduce the cost or elevate the quality of surgical care.[31]

POLICY QUESTIONS

- In what ways, and to what degree, does the migration of care to non-hospital settings affect patient safety, quality of care and patient outcomes?
- Is the public aware of differences in certification and quality standards across settings of care including hospitals, ASCs and physician offices?
- Is the public aware of the risk associated with frequent radiological imaging or of the standard safety procedures for which they should watch?
- Should ASCs be required to disclose the limitations of their service capabilities to patients?
- What changes are required – in federal or state statute, in regulation or policy, and in accreditation protocols – to ensure comparable patient safeguards across all settings of care for like procedures?
- What is the cost to the health care system as a whole of the migration of services out of the hospital setting?
- How has the shift in care out of hospitals affected access to care for all patients and the health care safety net for patients of limited means?
- Should the provisions of the federal laws that allow physicians to profit from self-referral in non-hospital facilities be revisited, given new data showing higher frequency of use by physician-owners?
- In what ways should payment policy be realigned to appropriately recognize the varying roles of each of these settings of care and the resources required to provide care, particularly taking into account patient risk factors?
- How might state and federal regulation of the creation and operation of health care facilities help to level the playing field for hospitals and non-hospital providers of ambulatory services?

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