Hospital outpatient services under Medicare, 1987

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Presented in this article are data related to hospital outpatient services provided for aged and disabled Medicare beneficiaries during calendar year 1987. Trend data are also presented for selected calendar years 1974-87. Hospital outpatient covered charges and Medicare program payments (in total and per enrollee) are the statistics employed to measure the use of hospital outpatient services. The data contained in this article should provide information to help identify trends and patterns of care for monitoring the Medicare hospital outpatient services.

Introduction

The implementation (effective October 1, 1983) of the Medicare prospective payment system (PPS) for inpatient care provided to Medicare beneficiaries in participating short-stay hospitals has resulted in large increases in the utilization of hospital outpatient (HOP) services. As shown by Medicare program data in this article, there appears to be a shift from hospital inpatient to HOP care.

From 1984 through 1987, program payments for Medicare HOP services increased from $3.4 billion to $5.6 billion, an average annual rate of growth (AARG) of 18.2 percent. During the same period, program payments for Medicare hospital inpatient services increased from $38.5 billion to $44.1 billion, an AARG of only 4.6 percent. Since the implementation of PPS, the HOP rate of growth (18.2 percent) is actually lower than for the pre-PPS years 1974-83 (26.4 percent), but the HOP rate is quadruple the rate of increase for hospital inpatient services for the period 1984-87.

In 1983, HOP program payments represented about 5.0 percent of all Medicare expenditures; by 1987, the proportion had increased to 7.4 percent. During the period 1984-87, total Medicare payments grew at an AARG of 8.6 percent, compared with 19.0 percent during the period 1974-83.

Medicare is authorized to pay for ambulatory surgical procedures performed in ambulatory surgical centers (ASCs), HOP departments, and physician offices. In 1982, Medicare began paying the ASCs on the basis of prospective rates for four groups of surgical procedures. In ASCs, Medicare pays 100 percent of the prospective rates, waiving the usual Part B 20-percent coinsurance and deductible requirements. The HOP departments were reimbursed for surgical procedures, including those on the ASC list, on a reasonable cost basis, with beneficiaries paying a 20-percent coinsurance.

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In an effort to control the rapid growth in HOP program payments, Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509), which revised the Medicare reimbursement methodology for ambulatory surgery performed in HOP facilities. Instead of paying hospitals on a reasonable cost basis, OBRA mandated that the surgical procedures covered in participating ASCs were to be paid a blend of HOP costs and the ASC prospective payment rates. Surgical procedures not approved for ASCs continue to be paid on the traditional reasonable cost basis.

OBRA 1986 also directed the Secretary of Health and Human Services to develop by April 1989 a PPS for all ambulatory surgery performed in HOP departments. A PPS for all other types of HOP care was to be developed by January 1991. To support the development of these new systems, hospitals are required by OBRA to use the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) to report claims for surgery and other designated outpatient services. The HCPCS is based on codes found in *Physicians' Current Procedural Terminology, 4th Edition;* it is intended to standardize the reporting of outpatient services by hospitals for development of a PPS and to enable comparisons of services among hospitals and other ambulatory settings.

Medicare's initiation of prospective payment for inpatient hospital services probably explains a significant portion of the continued rise in the use of outpatient hospital services. The incentives embedded in PPS encouraged hospitals to re-examine traditional modes of patient care. The ability of hospitals to treat more patients on an outpatient basis was facilitated by recent advances in medical technology; procedures such as cataract extraction, insertion of a pacemaker, and cardiac catheterization can now be performed efficiently and appropriately on an outpatient basis.

Utilization review policies have also influenced the Medicare patient case-mix in hospitals. For example, preadmission review for medical necessity, appropriateness, and quality of care encourage treatment in the most cost-effective setting consistent with the patient's safety. Public and private insurers have also encouraged the use of outpatient care as a means of containing the growth of health expenditures; that is, some insurers pay 100 percent of the charge for procedures that are performed on an outpatient basis, but require a coinsurance payment for those procedures requiring a hospital inpatient stay.

HCFA's goals and objectives related to the development and implementation of a PPS for ambulatory surgery and medical care may be summarized as follows:

- To control growth in Medicare expenditures.
- To select and use a patient classification system that is efficient, equitable, and responsive to changes in medical technology.
- To maintain and improve beneficiary access to quality care.

- To give providers of care incentives for the efficient delivery of services.
- To use payment rates that reflect identifiable and justifiable differences in resource costs.

The data are arrayed by: selected calendar years 1974-87 (Tables 1 and 2); sex, race, type of entitlement, and selected types of hospital outpatient services (Tables 3 and 4); beneficiary area of residence (Table 5); selected leading principal diagnoses (Table 6); and selected leading principal surgical procedures (Table 7).

Selected data highlights

Trend data shown in Table 1, for selected years 1974-87, compare the amounts of Medicare program payments for all Medicare services, total hospital services, and inpatient and outpatient hospital services. The relative growth in program payments during the period is presented through the use of indexes, with 1974 representing the base year (Figure 1). To illustrate the growth in the proportion of HOP program payments during the 1974-87 study period, HOP payments are presented as a percent of all Medicare payments, total hospital payments, and hospital inpatient payments. AARGs are also shown.

- From 1974 to 1983, program payments for all Medicare services increased from $11.2 billion to $53.4 billion, an AARG of 19.0 percent.
- Following the implementation of PPS, the escalation of program payments (from $59.1 billion in 1984 to $75.8 billion in 1987) for all Medicare services slowed to an AARG of 8.6 percent, an indication of the influence of the PPS.
- For hospital inpatient services during the 1974-83 period, program payments climbed from $7.8 billion to $34.3 billion, an AARG of 17.8 percent.
- The AARG for hospital inpatient payments decreased to 4.6 percent in the post-PPS years (1984-87).
- Program payments for HOP services increased from $323 million in 1974 to $2.7 billion in 1983, an AARG of 26.4 percent.
- Although the AARG in HOP payments increased at a slower rate (18.2 percent) during the post-PPS years 1984-87, the rate of increase was considerably higher than that for all Medicare services (8.6 percent) and hospital inpatient services (4.6 percent).
- The relative rate of growth in program payments (as measured by the index presented in Table 1) shows the HOP payments jumped from an index of 100 in 1974 to 1,734 in 1987, or by a factor of more than 17. In contrast, total Medicare payments increased by a factor of only 7 and total hospital payments by a factor of only 6.
- HOP program payments accounted for 2.9 percent of all Medicare program payments in 1974; the proportion had increased to 7.4 percent by 1987.
- As a proportion of the total hospital payments, HOP program payments accounted for 4.0 percent in 1974 and 11.3 percent in 1987.
- As a proportion of hospital inpatient payments, HOP payments rose from 4.1 percent in 1974 to 12.7 percent in 1987.

Trends in the number of supplementary medical insurance (SMI) enrollees, type of enrollment, the amounts of HOP covered charges, and HOP program payments for the years 1974 through 1987 are shown in Table 2.

- The total number of SMI enrollees increased from 23.2 million in 1974 to 31.2 million in 1987, an AARG of 2.3 percent.
- Among the disabled—including persons under 65 years of age with end stage renal disease (ESRD)—the rate of growth (3.7 percent) was 68 percent greater than the rate among the aged (2.2 percent) during the period 1974-87.

Table 1

Medicare program payments and average annual rate of growth for all Medicare services, total hospital services, inpatient and outpatient hospital services, and hospital outpatient payments as a percent of payments: Selected calendar years 1974-87

	Program payments for services								Hospital outpatient payments as a percent of payments		
	Total Medicare		Total hospital		Hospital inpatient		Hospital outpatient				
Year	Amount in millions	Relative index[1]	Amount in millions	Relative index[1]	Amount in millions	Relative index[1]	Amount in millions	1Relative index[1]	Total Medicare	Total hospital	Hospital inpatient
1974	$11,179	100	$8,160	100	$7,837	100	$323	100	2.9	4.0	4.1
1980	33,613	301	23,541	288	22,099	282	1,442	446	4.3	6.1	6.5
1983	53,438	478	36,999	453	34,338	438	2,661	824	5.0	7.2	7.7
1984	59,146	529	41,887	513	38,500	491	3,387	1,049	5.7	8.1	8.8
1985	63,694	570	44,282	543	40,200	513	4,082	1,264	6.4	9.2	10.2
1987	75,816	678	49,668	609	44,068	562	5,600	1,734	7.4	11.3	12.7
					Average annual rate of growth						
1974-87	15.9	—	14.9	—	14.2	—	24.5	—	—	—	—
1974-83	19.0	—	18.3	—	17.8	—	26.4	—	—	—	—
1984-87	8.6	—	5.8	—	4.6	—	18.2	—	—	—	—

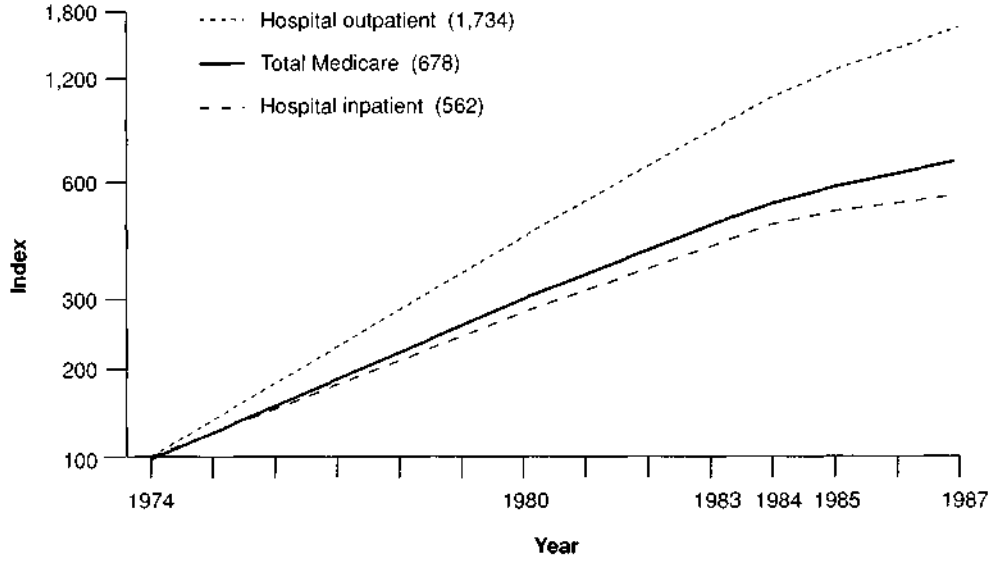
[1]1974 represents the base year with an index of 100.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Figure 1

Relative growth in total Medicare payments, hospital inpatient payments, and hospital outpatient payments: Selected years 1974-87

(Semi-logarithmic scale, 1974=100)



NOTE: The numbers in parentheses represent 1987 value of index.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

- From 1974 to 1987, covered charges for HOP services to Medicare beneficiaries increased from $535 million to $9.6 billion, an AARG of 24.9 percent.
- During the same period, program payments for HOP services increased from $323 million to $5.6 billion, an AARG of 24.5 percent.
- The average HOP program payment per enrollee increased from $14 in 1974 to $180 in 1987, an AARG of 21.7 percent.
- In 1987, the average HOP payment per enrollee was $417 for the disabled compared with $156 for the aged. This reflects the higher proportion of disabled ESRD enrollees who use outpatient renal dialysis.

In Table 3, the use of Medicare HOP services during 1987 is shown by types of service. The types of service are presented by sex, race, and type of enrollment. The pattern of use is measured by the amounts of covered charges, percent distribution of covered charges, and average charge per enrollee.

- Nearly 52 percent of all Medicare HOP charges ($9.6 billion) were for three services—radiology ($2.3 billion or 24.2 percent), renal dialysis ($1.4 billion or 14.2 percent), and laboratory ($1.3 billion or 13.0 percent) (Figure 2).
- HOP charges for operating room services ($936 million) accounted for about 10 percent of all HOP charges for Medicare beneficiaries, reflecting the significance of surgical procedures performed in an outpatient setting.
- By race and type of enrollment, substantial differences exist in the use of HOP services as measured by the average charge per enrollee. The total charge per enrollee for persons of races other than white ($465) was 60 percent higher than that for persons of the white race ($290). The total charge per disabled enrollee ($633) was 129 percent higher than that for the aged ($277). For the most part, these differences in the average charge per enrollee reflect the use of renal dialysis services by ESRD enrollees, who constitute a larger proportion of the disabled population than do the ESRD enrollees in the aged population.
- Renal dialysis accounted for about 47 percent of all HOP charges among the disabled, but only 7 percent among the aged. Similarly, charges for renal dialysis services represented 37 percent of all charges for persons of races other than white, compared with only 10 percent for white persons.

Hospital outpatient clinic and emergency room visits and charges under Medicare for 1987 are shown in Table 4, by sex, race, and type of enrollment.

- Users of HOP services in 1987 made 6.4 million visits to clinics and 8.7 million visits to emergency rooms, an average of 207 and 280 visits per 1,000 enrollees, respectively.
- Although data for 1983 are not shown in the table, the rate of use of clinic services by Medicare beneficiaries increased about 2 percent from 1983 (204 visits per 1,000 enrollees) to 1987 (207 visits per 1,000 enrollees).

Table 2

Supplementary medical insurance (SMI) enrollees, hospital outpatient charges, and program payments under Medicare, by type of enrollment and year service incurred: Selected calendar years 1974-87

Type of enrollee and year service incurred	Number of SMI enrollees	Covered charges in thousands	Program payments		
			Amount in thousands	Per enrollee	As percent of charges
All SMI					
1974[1]	23,166,570	$ 535,296	$ 323,383	$ 14	60.4
1976	24,614,402	974,708	630,323	26	64.7
1978	26,074,085	1,384,067	923,658	35	66.7
1980	27,399,658	2,076,396	1,441,986	52	69.4
1982	28,412,282	3,164,530	2,203,260	78	69.6
1983	28,974,535	3,813,118	2,661,394	92	69.8
1984	29,415,397	5,129,210	3,387,146	115	66.0
1985	29,988,763	6,480,777	4,082,303	136	63.0
1986	30,589,728	8,115,976	4,881,605	160	60.1
1987	31,169,960	9,623,763	5,600,094	180	58.2
			Average annual rate of growth		
1974-87	2.3	24.9	24.5	21.7	-0.3
1974-83	2.5	24.4	26.4	23.3	1.6
1984-87	1.9	23.3	18.2	16.0	-4.1
Aged					
1974[1]	21,421,545	394,680	220,742	10	55.9
1976	22,445,911	704,569	432,971	19	61.5
1978	23,530,893	1,005,467	648,249	28	64.5
1980	24,680,432	1,517,183	1,030,896	42	69.9
1982	25,706,792	2,402,462	1,645,064	64	68.5
1983	26,292,124	2,995,784	2,066,207	79	69.0
1984	26,764,150	4,122,859	2,679,571	100	65.0
1985	27,310,894	5,210,762	3,211,744	118	61.6
1986	27,862,737	6,529,273	3,809,992	137	58.4
1987	28,382,203	7,859,038	4,436,787	156	56.5
			Average annual rate of growth		
1974-87	2.2	25.9	26.0	23.3	0.1
1974-83	2.3	25.3	28.2	25.4	2.4
1984-87	2.0	24.0	18.3	16.0	-4.6
Disabled					
1974[1]	1,745,019	140,617	102,641	57	70.8
1976	2,168,467	270,139	197,352	91	73.1
1978	2,543,162	378,600	275,409	108	72.7
1980	2,719,226	559,213	411,090	152	73.5
1982	2,705,490	762,068	558,195	206	73.2
1983	2,682,411	817,335	595,187	222	72.8
1984	2,651,247	1,006,351	707,575	267	70.3
1985	2,677,869	1,270,015	870,560	325	68.5
1986	2,726,991	1,586,703	1,071,613	393	67.5
1987	2,787,757	1,764,726	1,163,307	417	65.9
			Average annual rate of growth		
1974-87	3.7	21.5	20.5	16.5	-0.6
1974-83	4.9	21.6	21.6	16.3	0.3
1984-87	1.7	20.6	18.0	16.1	-2.1

[1]1974 is the first full year of coverage for disabled beneficiaries under Medicare.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

- The rate of emergency room visits, however, showed an increase of about 36 percent from 1983 (206 visits per 1,000 enrollees) to 1987 (280 visits per 1,000 enrollees).
- The average HOP charge per visit for clinic services was $44, and the average charge per visit for emergency room services was $47.
- Substantial differences exist in the rate of use (visits per 1,000 enrollees) of clinic and emergency room services by race and type of entitlement. Persons of races other than white used clinic and emergency room services 4.2 times and 1.4 times more, respectively, than did white persons. This suggests that persons of races other than white in urban areas may be using HOP settings for primary care services to a greater extent than white persons. Disabled beneficiaries used clinic and emergency room services 2.7 times and 2.2 times more, respectively, than did aged beneficiaries.

HOP covered charges, program payments, and program payments per enrollee are shown in Table 5 by area of residence and type of enrollee. Calculations of rates per 1,000 enrollees are based on hospital insurance (HI) and/or SMI enrollment for 1987.

Table 3

Covered charges, percent distribution, and average charge per enrollee for hospital outpatient services under Medicare, by type of service, sex, race, and type of supplementary medical insurance enrollment: Calendar year 1987

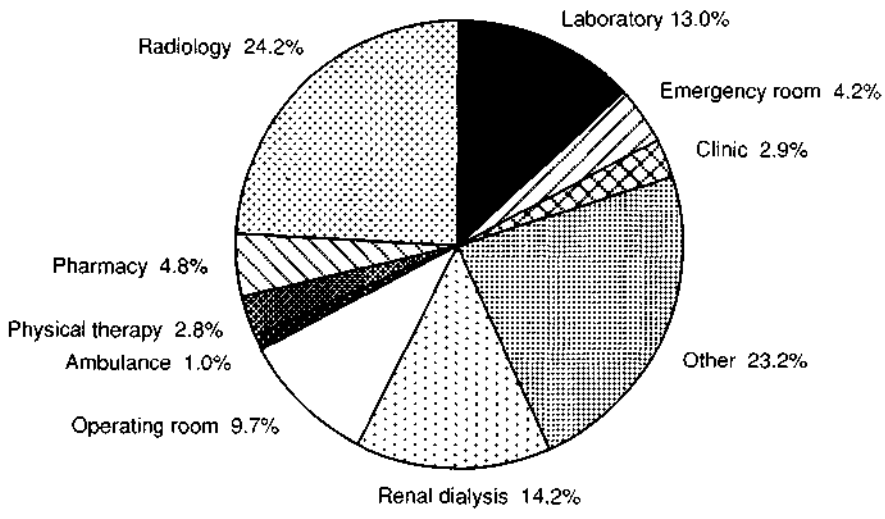
Sex, race, and type of enrollment	Total	Type of service									
		Clinic	Emergency room	Laboratory	Radiology	Pharmacy	Physical therapy	Ambulance	Operating room	Renal dialysis	Other[1]
						Covered charges in thousands					
Total	$9,623,763	$280,886	$405,612	$1,252,407	$2,324,673	$464,951	$268,884	$93,830	$936,199	$1,369,439	$2,226,882
Sex											
Male	4,202,163	110,552	176,931	523,635	1,006,753	202,006	95,511	43,416	375,700	694,771	972,888
Female	5,421,600	170,333	228,681	728,771	1,317,919	262,945	173,372	50,414	560,498	674,668	1,253,999
Race											
White	7,868,797	172,068	332,333	1,054,511	2,036,611	404,969	236,790	81,876	835,119	770,266	1,944,254
Other	1,468,336	102,326	62,674	161,883	219,965	47,254	24,370	9,405	73,694	547,151	219,614
Unknown	286,629	6,492	10,604	36,012	68,097	12,728	7,722	2,548	27,385	52,021	63,020
Type of enrollment											
Aged	7,859,037	218,549	334,488	1,067,015	2,121,618	405,971	237,279	83,986	879,479	535,355	1,975,297
Disabled	1,764,725	62,337	71,124	185,392	203,055	58,980	31,605	9,844	56,719	834,084	251,585
						Percent distribution					
Total	100.0	2.9	4.2	13.0	24.2	4.8	2.8	1.0	9.7	14.2	23.2
Sex											
Male	100.0	2.6	4.2	12.5	24.0	4.8	2.3	1.0	8.9	16.5	23.2
Female	100.0	3.1	4.2	13.4	24.3	4.8	3.2	0.9	10.3	12.4	23.4
Race											
White	100.0	2.2	4.2	13.4	25.9	5.1	3.0	1.0	10.6	9.8	24.8
Other	100.0	7.0	4.3	11.0	15.0	3.2	1.7	0.6	5.0	37.3	14.9
Unknown	100.0	2.3	3.7	12.6	23.8	4.4	2.7	0.9	9.6	18.1	21.9
Type of enrollment											
Aged	100.0	2.8	4.3	13.6	27.0	5.2	3.0	1.1	11.2	6.8	25.0
Disabled	100.0	3.5	4.0	10.5	11.5	3.3	1.8	0.6	3.2	47.3	14.3
						Charges per enrollee					
Total	$308.76	$9.01	$13.01	$40.18	$74.58	$14.92	$8.63	$3.01	$30.04	$43.94	$71.44
Sex											
Male	323.04	8.50	13.60	40.25	77.39	15.53	7.34	3.34	28.88	53.41	74.80
Female	298.53	9.38	12.59	40.13	72.57	14.48	9.55	2.78	30.86	37.15	69.04
Race											
White	290.49	6.35	12.27	38.93	75.18	14.95	8.74	3.02	30.83	28.44	71.78
Other	464.66	32.38	19.83	51.23	69.61	14.95	7.71	2.98	23.32	173.15	69.50
Unknown	311.55	7.06	11.53	39.14	74.02	13.83	8.39	2.77	29.77	56.54	68.50
Type of enrollment											
Aged	276.90	7.70	11.79	37.59	74.75	14.30	8.36	2.96	30.99	18.86	69.60
Disabled	633.20	22.37	25.52	66.52	72.86	21.16	11.34	3.53	20.35	299.28	90.27

[1]Includes charges for computerized axial tomography, durable medical equipment, blood, etc.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Figure 2

Percent distribution of hospital outpatient charges under Medicare, by type of service: 1987



Total charges = $9.6 billion

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

- In 1987, total HOP program payments in the United States were $5.6 billion; by region, the HOP program payments were highest in the South ($1.8 million) and lowest in the West ($1.0 billion).
- By State, California had the highest program payments ($603.5 million), and Alaska ($5.3 million) had the lowest.
- The average program payment per enrollee ranged from a low of $112 in Arkansas to a high of $277 in the District of Columbia (Figure 3).
- Although this is not shown in the table, ESRD enrollees (150,000) represented only about 0.05 percent of all Medicare HI and/or SMI enrollees (31.2 million), but they accounted for more than 20 percent ($1.1 billion) of all Medicare HOP program payments ($5.6 billion).
- The average HOP program payment per ESRD enrollee ($8,468) was nearly 50 times greater than the average HOP payment per enrollee ($173) for all Medicare enrollees.

Table 4

Hospital outpatient clinic and emergency room visits and charges under Medicare, by sex, race, and type of supplementary medical insurance enrollment: Calendar year 1987

	Clinic				Emergency room			
	Visits		Charges		Visits		Charges	
Sex, race, and type of enrollment	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit
Total	6,447	207	$280,886	$43.57	8,718	280	$405,612	$46.53
Sex								
Male	2,565	197	110,552	43.10	3,764	289	176,931	47.01
Female	3,883	214	170,333	43.87	4,954	273	228,681	46.16
Race								
White	4,231	156	172,068	40.67	7,319	270	332,333	45.41
Other	2,051	649	102,326	49.89	1,170	370	62,674	53.57
Unknown	166	180	6,492	39.11	229	249	10,604	46.31
Type of enrollment								
Aged	5,117	180	218,549	42.71	7,181	253	334,488	46.58
Disabled	1,330	477	62,337	46.87	1,537	551	71,124	46.27

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Table 5

Covered charges, program payments, and average program payments per enrollee for hospital outpatient services under Medicare, by type of enrollment and area of residence: Calendar year 1987

Area of residence	Covered charges				Program payments				Average program payments per enrollee			
	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]
	Amount in thousands								Amount per enrollee[1]			
All areas	$9,623,763	$7,338,696	$807,317	$1,477,750	$5,600,094	$4,045,404	$445,880	$1,108,811	$173	$138	$152	$8,468
United States[5]	9,580,710	7,317,512	803,251	1,459,947	5,571,079	4,032,700	443,379	1,095,000	176	140	156	8,526
Northeast	2,243,370	1,715,703	195,799	331,868	1,277,822	918,519	108,488	250,815	177	139	183	9,079
North Central	2,461,185	1,950,270	186,188	324,727	1,487,080	1,134,520	107,185	245,375	184	154	154	8,418
South	3,057,247	2,279,860	261,045	516,343	1,768,827	1,238,312	141,572	388,943	165	129	132	8,123
West	1,818,909	1,371,681	160,219	287,010	1,037,350	741,349	86,135	209,866	183	144	183	8,827
New England division	587,745	471,368	52,649	63,728	358,081	277,423	32,301	48,357	196	166	225	7,990
Connecticut	124,354	93,686	14,163	16,505	85,716	63,788	9,354	12,575	190	153	302	7,286
Maine	59,464	49,898	5,078	4,488	31,589	25,481	2,689	3,418	180	161	159	7,751
Massachusetts	309,745	254,269	26,236	29,240	180,638	142,826	15,748	22,064	214	184	243	7,791
New Hampshire	37,497	31,073	2,835	3,589	22,451	18,210	1,653	2,589	173	153	161	7,035
Rhode Island	38,258	28,254	3,062	6,942	26,100	18,534	2,078	5,489	169	133	150	11,022
Vermont	18,427	14,187	1,274	2,965	11,586	8,585	778	2,223	162	133	118	11,888
Middle Atlantic	1,655,625	1,244,335	143,151	268,140	919,741	641,096	76,187	202,458	170	130	169	9,384
New Jersey	222,025	155,609	15,694	50,722	141,812	93,691	9,584	38,536	134	97	116	8,027
New York	664,901	469,133	72,523	123,245	389,841	254,732	40,722	94,387	158	114	189	9,322
Pennsylvania	768,699	619,593	54,934	94,172	388,089	292,674	25,881	69,535	207	170	170	10,460
East North Central	1,778,671	1,407,068	134,700	236,902	1,078,962	821,513	78,190	179,259	195	164	153	8,469
Illinois	477,259	364,606	32,373	80,281	295,943	216,200	19,085	60,657	199	159	162	9,450
Indiana	201,573	156,796	16,824	27,953	123,079	91,798	9,827	21,453	170	141	141	8,204
Michigan	499,051	401,911	41,175	55,966	296,244	230,378	23,487	42,379	253	221	192	9,098
Ohio	434,121	346,326	31,811	55,984	256,989	197,280	17,878	41,831	175	150	125	7,755
Wisconsin	166,667	137,430	12,518	16,718	106,707	85,857	7,911	12,939	156	137	140	6,218
West North Central	682,514	543,201	51,488	87,825	408,118	313,007	28,995	66,116	160	133	154	8,283
Iowa	124,715	100,683	8,275	15,756	73,984	57,276	4,839	11,868	166	139	158	9,229
Kansas	103,023	86,936	5,721	10,365	70,427	58,881	3,733	7,813	200	179	163	7,392
Minnesota	112,156	82,607	7,895	21,653	67,138	45,862	4,694	16,583	119	87	123	8,901
Missouri	235,842	182,877	24,273	28,691	136,704	102,077	12,884	21,743	181	149	190	8,467
Nebraska	57,603	47,109	3,408	7,086	33,080	25,976	1,863	5,241	143	120	128	8,215
North Dakota	26,832	24,388	1,070	1,374	13,769	12,552	527	690	144	141	84	2,695
South Dakota	22,344	18,601	845	2,898	13,016	10,383	455	2,178	122	105	62	6,936
South Atlantic	1,623,576	1,215,759	135,368	272,449	968,084	690,137	74,767	203,180	170	135	137	8,082
Delaware	27,567	22,182	2,491	2,893	14,717	11,310	1,266	2,141	181	154	163	5,504
District of Columbia	33,683	21,817	2,282	9,584	21,909	13,380	1,307	7,221	277	186	205	9,060
Florida	590,254	483,357	35,301	71,596	394,599	315,075	23,582	55,942	185	159	160	7,849
Georgia	222,354	160,185	25,754	36,415	115,354	75,323	12,476	27,556	168	127	144	7,200
Maryland	145,501	103,342	11,240	30,919	95,120	64,990	6,863	23,267	188	141	165	9,164
North Carolina	218,643	143,862	19,683	55,098	121,760	74,458	10,608	36,694	148	103	114	9,684
South Carolina	123,302	83,173	13,093	27,036	72,010	44,616	6,599	20,795	178	127	126	9,105
Virginia	179,832	130,114	16,728	32,990	96,131	62,603	8,347	25,181	144	105	120	7,180
West Virginia	82,439	67,726	8,796	5,918	36,484	28,382	3,718	4,384	123	111	91	4,976

See footnotes at end of table.

Table 5—Continued

Covered charges, program payments, and average program payments per enrollee for hospital outpatient services under Medicare, by type of enrollment and area of residence: Calendar year 1987

Area of residence	Covered charges				Program payments				Average program payments per enrollee			
	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]
	Amount in thousands								Amount per enrollee[1]			
East South Central	$573,913	$422,301	$62,389	$89,223	$314,918	$213,979	$33,142	$67,798	$152	$118	$130	$7,767
Alabama	183,254	138,693	17,788	26,774	87,544	59,004	8,102	20,437	158	122	123	7,050
Kentucky	116,244	88,457	12,850	14,937	76,832	57,275	8,023	11,534	151	130	121	7,085
Mississippi	92,108	64,819	9,557	17,732	46,482	29,036	4,156	13,290	132	95	88	8,199
Tennessee	182,307	130,332	22,194	29,781	104,061	68,663	12,861	22,536	159	119	171	8,731
West South Central	859,758	641,800	63,288	154,670	485,824	334,197	33,663	117,964	162	123	123	8,418
Arkansas	78,977	60,411	6,829	11,737	42,341	30,142	3,359	8,840	112	91	78	7,330
Louisiana	175,856	123,649	15,591	36,616	103,376	66,532	8,550	28,293	205	151	138	10,514
Oklahoma	98,140	79,028	6,621	12,491	56,095	43,156	3,717	9,222	130	109	106	7,083
Texas	506,784	378,711	34,247	93,826	284,013	194,366	18,037	71,610	168	126	136	8,124
Mountain	384,342	303,000	30,379	50,962	250,249	192,403	19,127	38,718	170	143	157	7,149
Arizona	110,719	84,704	9,572	17,073	81,083	60,952	6,764	13,366	182	150	185	8,125
Colorado	101,625	80,551	8,375	12,698	59,359	45,038	4,955	9,366	183	152	185	7,690
Idaho	36,562	29,839	2,335	4,388	22,582	17,851	1,387	3,344	183	157	151	10,289
Montana	22,694	18,660	1,609	2,425	17,318	14,220	1,169	1,929	157	141	121	6,163
Nevada	28,455	21,910	2,699	3,846	14,674	10,678	1,253	2,743	129	104	123	5,442
New Mexico	42,739	31,941	3,708	7,090	24,121	16,772	2,054	5,296	149	116	128	7,731
Utah	30,929	27,239	1,505	2,185	23,263	20,469	1,121	1,673	161	153	113	2,784
Wyoming	10,618	8,786	576	1,257	7,848	6,424	424	1,001	166	146	129	8,008
Pacific	1,434,567	1,068,681	129,839	236,047	787,101	548,945	67,008	171,148	188	144	192	9,322
Alaska	8,196	6,853	753	590	5,257	4,343	462	452	258	241	204	4,305
California	1,131,028	843,846	107,464	179,718	603,536	415,313	53,666	134,557	195	148	204	9,165
Hawaii	39,412	15,597	1,930	21,884	19,174	7,531	1,051	10,591	170	72	132	16,919
Oregon	99,613	79,230	8,513	11,869	60,203	46,466	4,904	8,833	153	128	162	8,201
Washington	156,319	123,155	11,179	21,985	98,932	75,292	6,924	16,715	174	145	151	8,934
Outlying areas[6]	43,053	21,183	4,067	17,803	29,016	12,704	2,500	13,811	66	37	27	5,700

[1]Based on hospital insurance and/or supplementary medical insurance enrollment as of July 1, 1987.
[2]Aged beneficiaries with end stage renal disease (Medicare status code 11) excluded from the data; includes Medicare status code 10 (all other aged beneficiaries) only.
[3]Disabled beneficiaries with end stage renal disease (Medicare status code 21) excluded from the data; includes Medicare status code 20 (all other disabled beneficiaries) only.
[4]ESRD enrollees have end stage renal disease; these data include ESRD beneficiaries entitled to Medicare because of age, disability, or ESRD (Medicare status codes 11, 21, and 31).
[5]Consists of 50 States and the District of Columbia.
[6]Consists of Puerto Rico, Virgin Islands, Guam, other areas, and residence unknown.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System: data development by the Office of Research and Demonstrations.

- By region, the South had the lowest average program payment per enrollee ($165) for all types of enrollees, about 5 percent lower than the national average ($173). Whereas, the North Central displayed the highest average program payment per enrollee ($184), about 6 percent higher than the national average.
- The average program payment per aged enrollee ranged from a low of $72 in Hawaii to a high of $241 in Alaska, a difference of 235 percent.
- The average program payment per disabled enrollee ranged from a low of $62 in South Dakota to a high of $302 in Connecticut, a difference of 387 percent.
- By State, North Dakota had the lowest program payment per ESRD enrollee ($2,695), and Hawaii had the highest program payment per enrollee ($16,919), a difference of 528 percent.

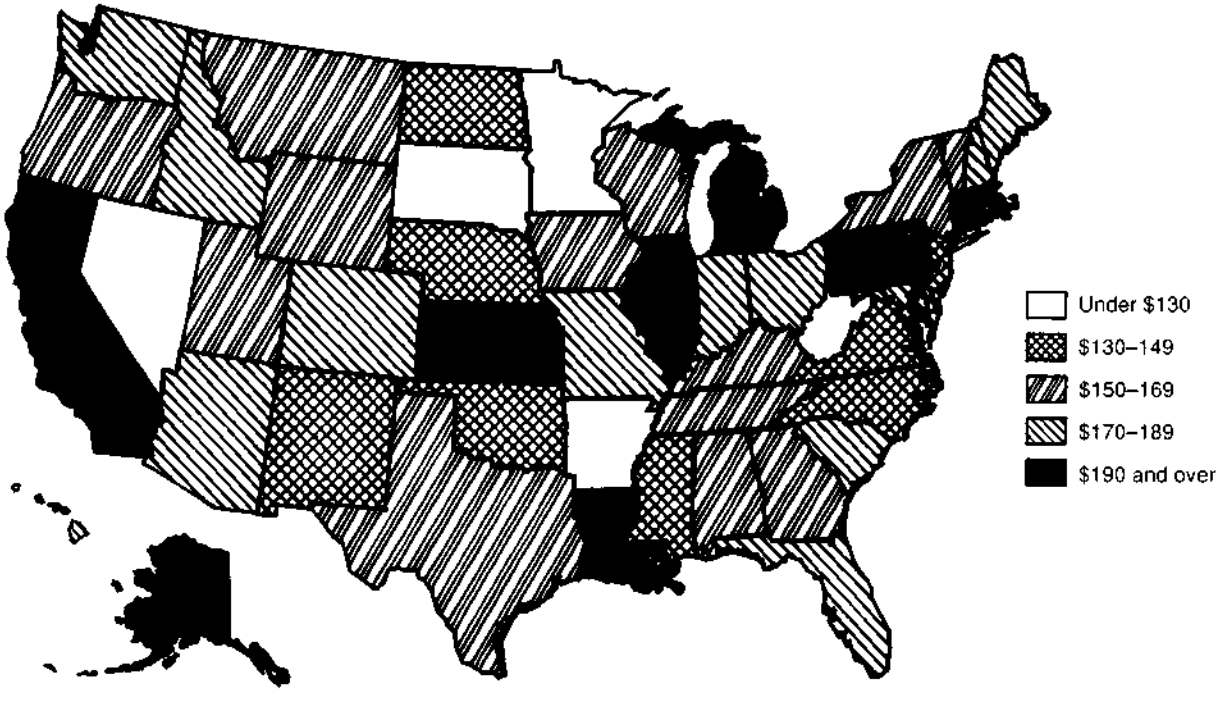
For Medicare beneficiaries receiving HOP services in 1987, the 10 leading (most frequently reported) principal diagnoses are shown in Table 6. Data include the number of bills, amounts of covered charges and program payments, and average charges and program payments per bill.

- Among all Medicare beneficiaries using HOP services, the 10 leading principal diagnoses accounted for 29 percent (12.0 million) of all HOP billings (40.8 million) and 42 percent ($2.4 billion) of all HOP program payments ($5.6 billion).
- For the 10 leading principal diagnoses, the average program payment per bill ($198) was 45 percent higher than the average payment for all diagnoses ($137).
- Diabetes was the most frequently reported principal diagnosis (Figure 4), comprising 5 percent ($1.9 billion) of all billings and 1 percent ($61.7 million) of all program payments for HOP services. The average program payment per bill for beneficiaries with diabetes was $33, or about one-fourth that for all diagnoses ($137).
- Chronic renal failure (CRF) was the most costly leading principal diagnosis, accounting for 18 percent ($1.0 billion) of all HOP program payments. The average program payment per bill for CRF was $822, or six times higher than the average HOP payment for all diagnoses.

For 1987, Table 7 presents the leading (most frequently reported) principal surgical procedures performed on Medicare beneficiaries in HOP departments.

- HOP program payments for all surgical procedures amounted to $1.4 billion, an average of $324 per procedure.
- The 10 leading surgical procedures accounted for about 42 percent (1.8 million) of all HOP surgical procedures (4.2 million); however, these procedures accounted for more than three-fifths ($831 million) of all Medicare program payments for HOP surgery ($1.4 billion).

Figure 3
Average program payment for hospital outpatient services per Medicare enrollee, by area of residence: 1987



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Table 6

Number of hospital outpatient bills, covered charges, and program payments under Medicare, by the 10 leading principal diagnoses: Calendar year 1987

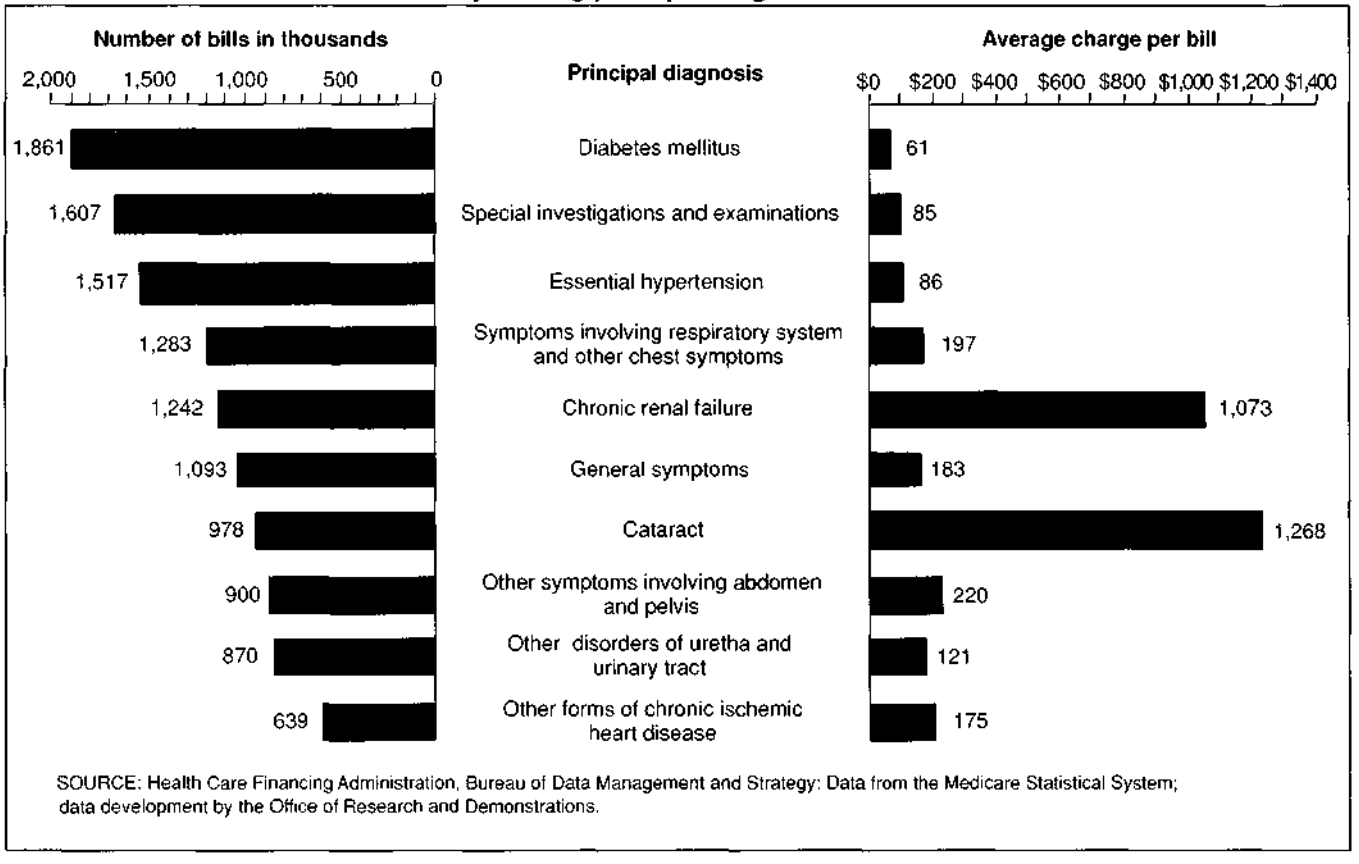
Principal diagnosis	ICD-9-CM Code[1]	Number of bills	Covered charges in thousands	Program payments in thousands	Average charge per bill	Average program payment per bill
Total, all diagnoses	—	40,799,700	$9,623,763	$5,600,094	$236	$137
Leading diagnoses	—	11,989,320	3,820,214	2,375,670	319	198
Diabetes mellitus	250	1,861,420	112,995	61,732	61	33
Special investigations and examinations	V72	1,607,340	135,834	74,506	85	46
Essential hypertension	401	1,516,720	131,051	69,271	86	46
Symptoms involving respiratory-system and other chest symptoms	786	1,282,560	253,211	131,107	197	102
Chronic renal failure	585	1,241,900	1,332,968	1,021,446	1,073	822
General symptoms	780	1,092,900	199,534	103,437	183	95
Cataract	366	977,540	1,239,381	692,148	1,268	708
Other symptoms involving abdomen and pelvis	789	900,360	198,275	104,557	220	116
Other disorders of urethra and urinary tract	599	869,760	105,460	54,949	121	63
Other forms of chronic ischemic heart disease	414	638,820	111,506	62,518	175	98
All other diagnoses	—	28,810,380	5,803,549	3,224,424	201	112

[1]Principal diagnosis from the *International Classification of Diseases, 9th Revision, Clinical Modification,* Volume 1.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Figure 4

Number of bills and average charge for hospital outpatient services under Medicare, by leading principal diagnosis: 1987



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

Table 7

Number of hospital outpatient surgical procedures, covered charges, and program payments under Medicare, by the 10 leading principal surgical procedures: Calendar year 1987

Principal surgical procedure	ICD-9-CM Code[1]	Number of procedures	Covered charges in thousands	Program payments in thousands	Average charge per procedure	Average program payment per procedure
Total, all procedures	—	4,216,560	$2,421,136	$1,365,102	$574	$324
Leading procedures	—	1,781,060	1,478,287	830,689	830	466
Operations on lens	13	588,760	965,234	542,230	1,639	921
Incision, excision, and anastomosis of intestine	45	424,200	160,939	90,628	379	214
Operations on skin and subcutaneous tissue	86	263,800	81,874	44,070	310	167
Operations on urinary bladder	57	192,400	107,090	60,887	557	316
Operations on the breast	85	70,320	60,356	34,676	858	493
Operations on retina, choroid, vitreous, and posterior chamber	14	55,780	17,794	10,080	319	181
Other operations on stomach	44	53,640	19,538	10,918	364	204
Operations on iris, ciliary body, sclera, and anterior chamber	12	45,620	19,700	11,032	432	242
Operations on cranial and peripheral nerves	4	45,160	31,647	18,217	701	403
Operations on esophagus	42	41,360	14,114	7,953	341	192
All other procedures	—	2,435,500	942,849	534,413	387	219

[1]Principal surgical procedure from the *International Classification of Diseases, 9th Revision, Clinical Modification,* Volume 3.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

- The average program payment per procedure for the 10 leading surgical procedures ($466) was 44 percent higher than the average program payment for all surgical procedures ($324).
- The most frequent HOP surgical procedure was operation on lens (Figure 5), which accounted for 14 percent (589,000) of all procedures and 40 percent ($542 million) of all HOP program payments for surgical procedures ($1.4 billion).
- The average HOP program payment per procedure was highest for operations on lens ($921), almost three times higher than the average for all surgical procedures.
- The next highest average program payment per procedure was for operations on the breast ($493).

Definition of terms

Hospital outpatient services—Major hospital outpatient services covered by SMI include services in an emergency room or outpatient clinic, laboratory tests billed by the hospital, X-rays and other radiology services billed by the hospital, renal dialysis, medical supplies such as splints and casts, drugs and biologicals that cannot be self-administered, and blood transfusions. Surgical and anesthesiology services are also covered. Physical therapy services must be furnished under a plan set up and reviewed periodically by a physician. For outpatient speech pathology services, a speech pathologist can establish the plan of treatment.

Principal surgical procedure—The first-listed operative procedure recorded on the patient's bill (HCFA Form 1453) and defined as surgery in the Health Care Financing Administration Common Procedure Coding System. Principal surgical procedures include incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, or manipulation.

Aged beneficiaries—Persons 65 years of age or over entitled to monthly benefits or payments from the Social Security Administration (SSA) or the Railroad Retirement Board (RRB), persons uninsured for SSA or RRB benefits but transitionally insured for Medicare, and persons 65 years of age or over not included in the above groups who purchase HI and SMI coverage. Also included are persons dually entitled because they are 65 years of age or over and have ESRD.

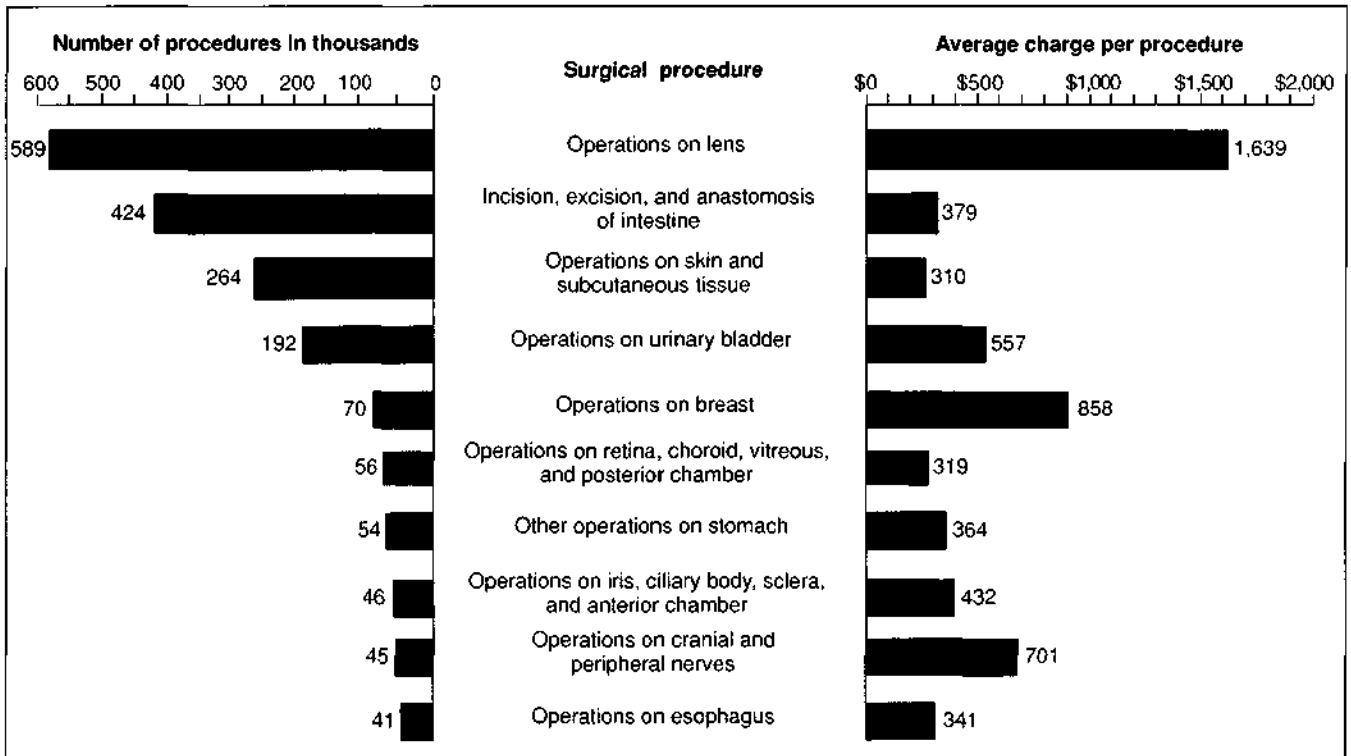
Disabled beneficiaries—Persons under 65 years of age entitled to SSA disability benefits for at least 24 months, those who are dually entitled because they receive SSA disability benefits and have ESRD, and those deemed disabled solely because of ESRD.

Source and limitations of data

The HOP data in this article are derived from a 5-percent sample of bills for services performed in HOP departments during 1987. The bills were posted and tabulated by HCFA's central records as of December 1988. It is estimated that these bills represent about

Figure 5

Number of procedures and average charge for hospital outpatient services under Medicare, by leading surgical procedure: 1987



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; data development by the Office of Research and Demonstrations.

98 percent of the eventual program payments for HOP services in 1987. Data for the years 1974-84 are based on bills recorded 12 months following the year of service. Sample counts are multiplied by a factor of 20 to estimate population totals. Therefore, the data are subject to sampling variability.

Payments for HOP services are based on interim rates that may be adjusted after the end of the hospital's accounting year, calculated on reasonable costs of operation. The HOP figures in this article reflect bills for covered services whether or not a reimbursement was made by the Medicare program.

Charges for outpatient services include the use of the hospitals' resources and staff, such as interns and resident physicians who are employed by the hospitals. Not included in these charges are the fees that may be charged by private physicians for services furnished to Medicare patients in the hospital outpatient department; such fees are billed separately to Medicare by the private physicians.

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Reference

Department of Health and Human Services; Office of Research and Demonstrations, *Report to Congress: Development of Prospective Payment Methodology for Ambulatory Surgical Services*, Health Care Financing Administration. Washington, D.C., April 1989.