Supplemental eAppendix

Removing Medicare’s Outpatient Ban and Medicare and Private Surgical Trends

1 Introduction

This supplemental appendix is intended to operate as an additional resource for interested readers and includes more granular analysis as well as some extended discussion to help frame the analyses. In the main analyses, we tracked the physicians’ allocation of treatment settings (inpatient vs. outpatient) for TKAs by the two key payer groups (commercial and Medicare). We examined whether physicians allocated Medicare patients to outpatient settings in 2018 and to what extent these allocations spilled over onto the privately insured market. We also examined the cross-payer concordance in 2018 outpatient use for TKAs within the same hospital.

To supplement these findings and flesh out the market context, we conducted three separate supplementary analyses. We examined the differences in vertical integration status (i.e., whether a physician was employed by a hospital/health system or not) on the orthopedic surgeons’ setting allocation for TKAs vs. all other orthopedic surgeons. In a second analysis, we examined trends in site of care for all non-TKA procedures over our study period to ensure that 2018 was not remarkable in other ways. Our third supplementary exercise examined changes in the inpatient case mix for Medicare and privately insured TKAs in 2018.
2 Data

The administrative dataset was obtained from the Florida Agency for Health Care Administration (AHCA) and comprises the universe of inpatient and outpatient (ambulatory) procedure discharge records from the state of Florida over the 2012-2018 period. The AHCA data are at the quarterly level; however, we annualize the trends data to smooth out within-year seasonality in care delivery in the main paper. For the reader interested in increased granularity, we have also included the quarterly versions of the main paper’s figures at the end of this appendix (see Figures A1-A3). Each discharge record contains rich information on the medical procedures being performed, the providers involved (e.g., surgeons and hospitals), and patient characteristics – including the primary payer for the received care (e.g., Medicare or private insurance). TKA cases were identified using the corresponding ICD-9 and ICD-10 procedure codes for the inpatient discharge records and the corresponding Current Procedural Terminology (CPT) codes for the outpatient discharge records.\(^1\)

In keeping with several recent studies, we linked the discharge data to the SK&A annual physician office survey by National Provider Identification (NPI) numbers to determine the physicians’ vertical integration status (e.g., see Baker, Bundorf, and Kessler 2016; Richards, Nikpay, and Graves 2016; Koch et al. 2017, 2018; Nikpay, Richards, and Penson 2018). The SK&A database specifically catalogues whether a practice is independently owned, part of a larger physician group (i.e., horizontally integrated), or owned by a hospital or health system (i.e., vertically integrated).

\(^1\) Note, the data collectors and administrators use different coding strategies when it comes to procedures within the inpatient (ICD) and outpatient (CPT) discharge records. This is true of all procedures, not just TKAs. Also, in the fourth quarter of 2015, AHCA transitioned from ICD-9 to ICD-10 coding.
3 Methods

In order to estimate the policy effects on patient selection characteristics (thereby estimating risk characteristics as well), we employed difference-in-differences methodology and event studies. The IPO list prior to January 1, 2018 virtually ruled out TKA procedures from being performed in the outpatient setting for Medicare beneficiaries thereby forcing full allocation of TKA Medicare patients to the inpatient setting. Following the policy change, the Medicare beneficiaries were suddenly covered in the outpatient setting as well. In other words, the outpatient setting went from zero price to a positive price in the Medicare market for TKAs while no such rule existed for the private market. During our time period, privately-insured patients were free to have inpatient or outpatient procedures.

We utilize the two-way fixed effects difference-in-differences (DD) model as shown in Equation (1) to uncover any policy effects on patient selection – and hence risk – characteristics.

\[ Y_{ijt} = \alpha_i + \beta_t + \delta D_{ijt} + \gamma_j + \epsilon_{ijt} \]  

(1)

In this model, \( Y_{ijt} \) represents the various case characteristics as described below (e.g. age, sex, etc.). The \( \alpha_i \) parameter represents the fixed group characteristics (e.g., physician or hospital), \( \beta_t \) represents the fixed time characteristics, \( \gamma_j \) represents fixed procedure effects.\(^2\) Finally, the \( D_{ijt} \) is the DD parameter of interest.\(^3\) This model makes it easy to estimate treatment effects under the common trend assumption.

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\(^2\) The fixed procedure effects are only relevant to the hospital-level regressions.

\(^3\) Note, \( \epsilon_{ijt} \) represents the error term.
For the event studies, we slightly modified specification displayed by Equation (1). This allows us to vary the comparison time period and analyze the effects of each individual (quarterly) time period by interacting the treatment group indicator with each year-quarter time dummy in our analytic data. We can then observe any differential trends in outcomes prior to the policy change (which would invalidate the difference-in-differences research design) as well as any dynamics in the changes post-policy. With the exception of the full vector of quarter fixed effects and accompanying interactions with the treatment group (i.e., TKA cases), the model is otherwise the same as that in Equation (1).

4 Results

4.1 Baseline Characteristics

Over the 2012 to 2018 period, the number of TKAs performed in Florida remains similar throughout the IPO list change, as shown in Figure A1. This figure gives the quarterly trends in TKA procedures by payer from 2012-2018 across both (inpatient and outpatient) settings. We observe approximately 4,000-5,000 Medicare TKAs and 2,000-4,000 privately insured TKAs quarterly. This corresponds to about 17,000-20,000 Medicare TKAs and 10,000-14,000 privately insured TKAs annually. 15% of Medicare TKA cases are reallocated from the inpatient to the outpatient setting in the same year as the IPO decision as shown in the main paper (Figure 1), and uptake is observed across a variety of hospitals in terms of TKA procedure volumes during the first deregulation year (Figure 4). The balance across settings may adjust further as providers and patients have more time to adapt, but interacting regulations could also be the source of some inertia.
For example, orthopedic surgeons have expressed confusion as to how the inpatient versus outpatient classification for TKAs conforms with the pre-existing “Two Midnight Rule” for Medicare inpatient reimbursement. All Medicare TKAs were previously designated as inpatient care, irrespective of length of stay. However, from 2018 and onward, a TKA performed as an inpatient but with a length of stay shorter than two midnights necessarily falls into a billing gray zone. Same-day or next-day discharges were relatively common while the TKA was under the IPO list regulation, but it is now unclear how to categorize these inpatient cases (Edwards et al. 2019; Schwartz et al. 2020; White 2014). Additionally, not every patient that would spend one midnight as an inpatient would be appropriate for the outpatient setting, and others have lamented the dearth of formalized selection criteria for determining outpatient TKA candidacy (Edwards 2019). CMS does not presently offer specific guidelines for this administrative complication and maintains that the inpatient/outpatient decision should rest with physicians (82 FR 59216).4 The deference to provider autonomy is likely appreciated by affected surgeons, but explicit payment rule guidance may also be necessary.

One possible concern with our main results is the potential that the composition of Florida TKA patients may have changed during our time period so we calculated the characteristics of Florida patients who receive TKA procedures during the relevant time period. Table A2 shows the summary statistics for the TKA inpatient case characteristics in 2017 and 2018 for both private and public payers; these include age, sex, length of stay (LOS), total diagnoses, and whether or not the patient spent time in the intensive care unit (ICU). Due to the differences in patient composition in age, we chose to use an indicator for 75 and older in the

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4 The Two Midnight rule is a guideline first implemented late in 2013 by CMS that states if a physician expects the patient to need to midnights to accompany a procedure, then it should be performed and reimbursed as inpatient care (see 82 FR 59216).
Medicare analyses because over 75 was identified as a risk factor in the literature (Edwards et al. 2019). Similarly, for the private payer analyses, we chose to use an indicator for 60 and older due to the eligibility for Medicare at age 65. The patient’s sex was coded as one if male, zero otherwise. LOS is an indicator representing a long length of stay (LOS) and takes the value of one if the patient stayed more than three midnights and zero otherwise. Given that one or two midnights was typical for a TKA and that there have been overall downward trends on LOS (see Iorio et al. 2020; Schwartz et al. 2020; Edwards et al. 2019), more than three midnights should capture some patient heterogeneity.

The age distribution is younger for the private payers, which is expected given the age requirements on Medicare enrollment and is consistent with the literature. There is a higher percentage of males in the private payer group, although in both groups, females comprise the majority of patients (approximately 60%). It is interesting to note that the LOS and ICU stays are slightly higher for Medicare patients than commercial patients, but it is not clear that they are significantly higher. LOS over three days comprise 9.8% vs. 10.9% of Medicare and commercial patients, respectively. Similarly, people who had an ICU stay comprise about 4.5% vs. 5.4% of Medicare and commercial patients, respectively.

4.2 Vertical Integration Characteristics

Edwards et al. (2019) note that there are other factors salient to the decision. They remark that most (as of 2016) outpatient surgical departments aren’t setup to handle outpatient TKA and that shifting healthy candidates to outpatient TKA will make performance on inpatient bundled payments more challenging. Additionally, the availability and willingness to participate in an outpatient program post-operation is key for health outcomes (Edwards et al. 2019). This
statement implies that their patient heterogeneity influences how physicians allocate their cases. Examples of this heterogeneity would be how far away from the hospital/outpatient program the patient lives, and whether they have convenient transportation for follow-up.

Therefore, we examined the baseline inpatient characteristics across 2017 and 2018 stratified by whether the physician is vertically integrated in Table A1 and the trends for private outpatient TKAs by vertical integration in Figure A2. It appears as though there are not large discrepancies between the case characteristics of vertically- versus non-vertically-integrated physicians except for rurality as discussed below. To create a rural indicator for the patients, we merged Florida’s population density by county from 2010 US Census with the patients’ county of residence data (U.S. Census Bureau 2010). We then classified any county smaller than 100 people per square mile as rural. Table A1 shows the baseline characteristics of the TKA patients stratified by payer and whether the physician is vertically integrated. There are no characteristics that vastly vary between the vertically- and non-vertically-integrated physicians case mix except for the rurality of patients. In both the Medicare and private markets, the vertically-integrated physicians see a higher percentage of patients from rural counties.

Figure A2 shows the vertical integration of physicians performing private outpatient TKAs from 2012-2018 and demonstrates that the massive increase in private outpatient cases is almost entirely due to physicians that are not vertically integrated. This figure provides suggestive evidence that hospitals may keep some fraction of patients on the inpatient side that would have otherwise shifted to outpatient with the IPO list change.

Although the patients of vertically-integrated physicians are not observably riskier pre-operation, their ability to participate in same-day surgery is perhaps inhibited. The difference in rurality in the Medicare market is much smaller than in the private market. The private market
shows about 54% of the patients of vertically-integrated physicians come from rural counties whereas about 32% of the patients of non-vertically-integrated physicians come from rural counties. The difference between vertically- and non-vertically integrated physician groups equates to approximately a difference of 22%. On the other hand, the Medicare market shows about 47% of the patients of vertically-integrated physicians come from rural counties whereas about 38% of the patients of non-vertically-integrated physicians come from rural counties. The difference between vertically- and non-vertically integrated physician groups equates to approximately a difference of 9%. Therefore, it is not obvious that a higher share of patients living in more rural areas fully explains the limited take-up of outpatient TKA delivery among vertically integrated surgeons.

4.3 Non-TKA Trends

Figure A3 shows the quarterly trends in site of care for all non-TKA procedures over our study period and corresponds to Figure 3 in the main paper. In theory, there is substantive physician and patient discretion for elective procedures, and some adjustment frictions on the part of physicians, hospitals, and patients are expected as they adapt to new and/or more extensive use of the outpatient setting for a major surgery. There are no distinct large trends in the inpatient or outpatient care delivery settings in any year (as confirmed in Figure 3 in the main paper). The trends appear to fluctuate fairly consistently with seasonality rather than indicating any clear, sharp changes in 2018 (or any other year for that matter). Figure A3 suggests that the doubling of TKAs in outpatient delivery for privately insured beneficiaries shown in Figure A2 was likely due to factors specific to TKA procedures.
4.4 Inpatient Case Mix

Our third supplementary exercise examined changes in the inpatient case mix for Medicare and privately insured TKAs in 2018. We relied on difference-in-differences regression analyses coupled with corresponding event studies to uncover any policy effects on patient selection – and hence risk – characteristics. We limited the panel to only those hospitals who perform procedures in all quarters from 2015Q4-2018Q4, in part to maintain consistency in coding of procedures as the dataset shifted to ICD-10 in 2015Q4. This requirement ensures that the hospital panel does not have hospitals entering and/or exiting and ensures a more balanced panel. It is also important to consider the appropriate procedures to include in the control group. It is possible (and probable) that there are procedures that could enter or exit the panel. If this entry or exit is correlated with the Medicare policy change, our results could be confounded. Therefore, we limit the panel to include only procedures that are present for all quarters in the study. The treatment group is then constructed as any TKA procedure, and the control group is constructed as any non-TKA procedure from the aforementioned reduced panel.

4.4.1 Difference-in-Differences

As shown in Table A3, we see limited changes in the health risk profile and case characteristics for inpatient TKAs following the Medicare IPO policy change. The one exception is that there seems to be some selection against the oldest (i.e., age 75 and up) Medicare beneficiaries receiving a TKA as an outpatient, which is not surprising when considering the elevated risks of complications as well as greater post-operative needs these patients are likely to have. Inpatient privately insured TKA case characteristics appear unaffected by the 2018 shift toward outpatient delivery as shown in Table A4.
4.4.2 Event Studies

The event studies that correspond to Tables A3 and A4 are given in the following two sections by payer (Medicare and private). The Medicare event studies are shown in Figures A5 through A9, and the private payer event studies are shown in Figures A10 through A14.

The pre-treatment trends and post-policy changes at the individual provider level are most compelling for Medicare beneficiaries who are 75 and over and female as the pre-trends oscillate around zero nor are they typically statistically different from zero. The percent of patients 75 and over and the percent of female patients in the inpatient setting begin to rise immediately after implementation of the IPO list change.

However, the patterns and inferences for total diagnoses are a bit more speculative in nature. The treatment and control groups show some differential trending early in our study period, which encourages a cautious interpretation for the DD estimate in Table 3. Total diagnoses show generally declining pre-treatment trends and then flatten out to be statistically no different from zero post-policy change. In other words, the IPO list change resulted in less-complicated Medicare beneficiaries being shifted to the outpatient setting, but overall the trends in total-diagnoses was declining. Thus, the inpatient setting appears to be left with a slightly higher concentration of more-complicated patients than the outpatient setting, but the total diagnoses even for the more-complicated patients are declining. However, it is important to note that the estimates post-policy change are not tightly estimated.

The private payer event studies that correspond to Table A4 demonstrate that the pre-policy change trends are not well-behaved. Additionally, the post-policy periods are approximately not statistically different from zero. These results show that there was no
discernible change in the case characteristics among inpatient privately insured beneficiaries. Overall, the payer-stratified facility-level analysis demonstrated that cases are being allocated according to patient risk to some extent (among Medicare beneficiaries), and there is a large opportunity to move patients to the outpatient setting thereby reducing health care costs.

Appendix Table A5 shows the average total charges for inpatient versus outpatient TKAs among the privately insured during 2017 and 2018. While not transaction prices, the outpatient TKAs among the privately insured have roughly 20% lower total charges in each year, which is consistent with the aforementioned studies estimating considerable cost-savings opportunities from outpatient TKA delivery.

5 References


### Table A1: Vertical Integration: Means and Standard Deviations for 2017 TKA Inpatient Cases by Payer

<table>
<thead>
<tr>
<th></th>
<th>Private</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vertical</td>
<td>Non-Vertical</td>
</tr>
<tr>
<td>Age</td>
<td>59.94</td>
<td>59.23</td>
</tr>
<tr>
<td>Male</td>
<td>0.421</td>
<td>0.424</td>
</tr>
<tr>
<td></td>
<td>(0.494)</td>
<td>(0.494)</td>
</tr>
<tr>
<td>White</td>
<td>0.786</td>
<td>0.834</td>
</tr>
<tr>
<td></td>
<td>(0.411)</td>
<td>(0.373)</td>
</tr>
<tr>
<td>LOS over 3</td>
<td>0.0879</td>
<td>0.0980</td>
</tr>
<tr>
<td></td>
<td>(0.283)</td>
<td>(0.297)</td>
</tr>
<tr>
<td>ICU</td>
<td>0.0188</td>
<td>0.0489</td>
</tr>
<tr>
<td></td>
<td>(0.136)</td>
<td>(0.216)</td>
</tr>
<tr>
<td>Total Diagnoses</td>
<td>5.873</td>
<td>6.592</td>
</tr>
<tr>
<td></td>
<td>(4.159)</td>
<td>(4.512)</td>
</tr>
<tr>
<td>Rural</td>
<td>0.537</td>
<td>0.322</td>
</tr>
<tr>
<td></td>
<td>(0.499)</td>
<td>(0.467)</td>
</tr>
<tr>
<td>Procedures (N)</td>
<td>160,564</td>
<td>637,739</td>
</tr>
</tbody>
</table>

Note: Standard deviations in parentheses.
### Table A2: Means and Standard Deviations for 2017 and 2018 TKA Inpatient Cases by Payer

<table>
<thead>
<tr>
<th></th>
<th>Private 2017</th>
<th>Private 2018</th>
<th>Medicare 2017</th>
<th>Medicare 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 plus</td>
<td>0.0160</td>
<td>0.0187</td>
<td>0.375</td>
<td>0.398</td>
</tr>
<tr>
<td></td>
<td>(0.126)</td>
<td>(0.135)</td>
<td>(0.484)</td>
<td>(0.490)</td>
</tr>
<tr>
<td>60 plus</td>
<td>0.529</td>
<td>0.542</td>
<td>0.970</td>
<td>0.971</td>
</tr>
<tr>
<td></td>
<td>(0.499)</td>
<td>(0.498)</td>
<td>(0.170)</td>
<td>(0.167)</td>
</tr>
<tr>
<td>Male</td>
<td>0.421</td>
<td>0.424</td>
<td>0.386</td>
<td>0.371</td>
</tr>
<tr>
<td></td>
<td>(0.494)</td>
<td>(0.494)</td>
<td>(0.487)</td>
<td>(0.483)</td>
</tr>
<tr>
<td>LOS over 3</td>
<td>0.0978</td>
<td>0.0824</td>
<td>0.109</td>
<td>0.106</td>
</tr>
<tr>
<td></td>
<td>(0.297)</td>
<td>(0.275)</td>
<td>(0.311)</td>
<td>(0.308)</td>
</tr>
<tr>
<td>ICU</td>
<td>0.0458</td>
<td>0.0407</td>
<td>0.0535</td>
<td>0.0544</td>
</tr>
<tr>
<td></td>
<td>(0.209)</td>
<td>(0.198)</td>
<td>(0.225)</td>
<td>(0.227)</td>
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<tr>
<td>Total Diagnoses</td>
<td>6.570</td>
<td>6.670</td>
<td>8.222</td>
<td>8.747</td>
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<tr>
<td></td>
<td>(4.495)</td>
<td>(4.523)</td>
<td>(5.045)</td>
<td>(5.432)</td>
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<tr>
<td>Rural</td>
<td>0.336</td>
<td>0.325</td>
<td>0.378</td>
<td>0.364</td>
</tr>
<tr>
<td></td>
<td>(0.472)</td>
<td>(0.468)</td>
<td>(0.485)</td>
<td>(0.481)</td>
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<td>Procedures (N)</td>
<td>357,076</td>
<td>352,423</td>
<td>356,502</td>
<td>348,231</td>
</tr>
</tbody>
</table>

Note: Standard deviations in parentheses.
Table A3: Medicare FFS Difference-in-Differences Regressions for IPO List Change (2015Q4 - 2018Q4)

<table>
<thead>
<tr>
<th></th>
<th>75 plus</th>
<th>Male</th>
<th>LOS over 3</th>
<th>ICU</th>
<th>Total Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1[TKA IPO Change]</td>
<td>0.0214***</td>
<td>-0.0224***</td>
<td>0.00137</td>
<td>0.00903</td>
<td>-0.378*</td>
</tr>
<tr>
<td></td>
<td>(0.00565)</td>
<td>(0.00571)</td>
<td>(0.00598)</td>
<td>(0.00982)</td>
<td>(0.183)</td>
</tr>
<tr>
<td>F-stat</td>
<td>14.33</td>
<td>15.43</td>
<td>0.0528</td>
<td>0.847</td>
<td>4.263</td>
</tr>
<tr>
<td>R-squared</td>
<td>0.102</td>
<td>0.0583</td>
<td>0.239</td>
<td>0.342</td>
<td>0.302</td>
</tr>
<tr>
<td>N</td>
<td>1154698</td>
<td>1154698</td>
<td>1154698</td>
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</tr>
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</table>

Notes: Standard errors in parentheses. All regressions include time, hospital, and procedure fixed effects and are clustered at the hospital level. The column headings are the outcome variables.

75 plus is an indicator variable taking the value of one if the patient’s age is 75 or older and zero otherwise. Male is an indicator variable taking the value of one if the patient is male and zero otherwise. LOS over 3 is in indicator variable taking the value of one if the patient’s length of stay over three midnights. ICU is an indicator taking the value of one if the patient incurred any ICU charges and zero otherwise. Total diagnoses is the number of diagnoses a patient has listed per procedure.

* p < 0.05, ** p < 0.01, *** p < 0.001
Table A4: Private Payers Difference-in-Differences Regressions for IPO List Change (2015Q4 - 2018Q4)

<table>
<thead>
<tr>
<th></th>
<th>60 plus</th>
<th>Male</th>
<th>LOS over 3</th>
<th>ICU</th>
<th>Total Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1[TKA IPO Change]</td>
<td>0.0142*</td>
<td>0.00231</td>
<td>-0.0236***</td>
<td>-0.0145</td>
<td>-0.250**</td>
</tr>
<tr>
<td></td>
<td>(0.00689)</td>
<td>(0.00666)</td>
<td>(0.00524)</td>
<td>(0.00765)</td>
<td>(0.0946)</td>
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<tr>
<td>F-stat</td>
<td>4.241</td>
<td>0.120</td>
<td>20.28</td>
<td>3.582</td>
<td>6.960</td>
</tr>
<tr>
<td>R-squared</td>
<td>0.219</td>
<td>0.329</td>
<td>0.329</td>
<td>0.377</td>
<td>0.410</td>
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<tr>
<td>N</td>
<td>1,162,506</td>
<td>1,162,506</td>
<td>1,162,506</td>
<td>1,162,506</td>
<td>1,162,506</td>
</tr>
</tbody>
</table>

Notes: Standard errors in parentheses. All regressions include time, hospital, and procedure fixed effects and are clustered at the hospital level. The column headings are the outcome variables. 75 plus is an indicator variable taking the value of one if the patient’s age is 75 or older and zero otherwise. Male is an indicator variable taking the value of one if the patient is male and zero otherwise. LOS over 3 is an indicator variable taking the value of one if the patient’s length of stay over three midnights. ICU is an indicator variable taking the value of one if the patient incurred any ICU charges and zero otherwise. Total diagnoses is the number of diagnoses a patient has listed per procedure. * p < 0.05, ** p < 0.01, *** p < 0.001
<table>
<thead>
<tr>
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<th>Avg. Charges 2017</th>
<th>Avg. Charges 2018</th>
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</thead>
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<td>Inpatient</td>
<td>$85,896</td>
<td>$88,915</td>
</tr>
<tr>
<td>Cases</td>
<td>11,766</td>
<td>10,306</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$66,050</td>
<td>$71,706</td>
</tr>
<tr>
<td>Cases</td>
<td>1,632</td>
<td>3,231</td>
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</table>
Figure A1: Quarterly Growth in Inpatient TKA Surgeries Compared to Total TKA Trends by Payer, 2012-2018

Notes: Analytic data are from the universe of Florida AHCA discharge records. "FFS" represents fee-for-service (traditional) Medicare. Private is all commercially insured, non-Medicare patients.
Figure A2: Aggregate Privately Insured Hospital Outpatient Delivered TKAs Overall and by Physician Organizational Type, 2012-2018

Notes: Physician vertical integration status with a hospital or health system is from the SK&A physician office survey database. “Unclassified” Florida physicians are those that could not be matched to a SK&A record.
Figure A3: Quarterly Growth in Non-TKA Procedures by Setting and Payer, 2012-2018

Notes: Physician vertical integration status with a hospital or health system is from the SK&A physician office survey database. "Unclassified" Florida physicians are those that could not be matched to a SK&A record.
Figure A4: Medicare and Privately Insured TKA Allocation by Setting
Figure A5: Effects of IPO List Change on the Probability of the Medicare Beneficiary Being Over 75 Years of Age
Figure A6: Effects of IPO List Change on the Probability the Medicare Beneficiary is Male
Figure A7: Effects of IPO List Change on Medicare Beneficiaries’ Probability of Length of Stay over Three Days
Figure A8: Effects of IPO List Change on Medicare Beneficiaries’ Probability of Receiving ICU services
Figure A9: Effects of IPO List Change on Medicare Beneficiaries’ Total Diagnoses
Figure A10: Effects of IPO List Change on Privately Insured’s Probability of Being over 60 Years of Age
Figure A11: Effects of IPO List Change on Privately Insured’s Probability of Being Male
Figure A12: Effects of IPO List Change on Privately Insured’s Probability of Having a Length of Stay over Three Days
Figure A13: Effects of IPO List Change on Privately Insured’s Probability of Receiving ICU Services
Figure A14: Effects of IPO List Change on Privately Insured’s Total Diagnoses