Medicare 2008 OPPS NPRM Claims Accounting

Calculating OPPS payment rates consists of calculating relative resource cost and calculating budget neutrality adjustments, which are applied to estimates of resource cost and the conversion factor to create a budget neutral prospective payment system. In response to a request from the Outpatient Medicare Technical Advisory Group (MTAG), we have added a detailed description of the claims manipulation and accounting for budget neutrality, outlier, and impact calculations. The purpose of the following discussion is to provide a detailed discussion of CMS manipulation of the 2006 claims data to produce the proposed 2008 payment rates. This discussion is divided into two parts, the traditional accounting of claims behind median cost calculations and an accounting of claims behind the budget neutrality, outlier, and impact calculations.

Unlike prior years, new material is not in bold.

PART 1 - MEDIAN COST CALCULATIONS

CMS used information from 87.9 million single and generated single procedure claim records to set the APC rates to be paid under Medicare OPPS for CY 2008.[1] This is fewer single bills than were used for the 2007 proposed rule due to proposed changes to packaging under OPPS for CY 2008. The proposal to expand packaging under OPPS for CY 2008 removed from the single bills used for median setting all of the volume of single bills for the 307 codes that we propose to package, either unconditionally or under specified criteria for CY 2008. Greater packaging increased the number of "natural" single bills, but also reduced the number of codes on the bypass list.

The proposal reduced the number of codes on the bypass list in two ways: First, we removed codes that are proposed to be packaged from the bypass list to enable their costs to be packaged. Second, we removed codes from the bypass list that were previously on the bypass list because, as a result of the proposed packaging, they no longer met the bypass list empirical criteria (e.g. the packaging on the claim now exceeded $50 or occurred more on more than 5% of the natural singles). We ultimately gained more natural single claims as a result of increased packaging, and the proportion of single bills that are pseudo singles dropped from 68 percent in the CY 2007 OPPS final rule data to 66 percent in this proposed rule data. We believe that using a greater proportion of natural single bills is a positive change.

Attached is a narrative description of the accounting of claims used in the setting of proposed payment rates for Medicare's 2008 Outpatient Prospective Payment System (OPPS). Payment rates under OPPS are based on the median cost of all services (i.e. HCPCS codes) in an APC. As described in detail in the material that follows, median costs were calculated from claims for services paid under the Medicare OPPS and cost

[1] Proposed CY 2008 rates are based on 2006 calendar year outpatient claims data, specifically final action claims processed through the common working file as of December 31, 2006. Final CY 2007 rates were based on one year (January 1- December 31) of 2005 outpatient claims data.

report data for the hospitals whose claims were used. The medians were converted to payment weights by dividing the median for each APC (a group of HCPCS codes) by the median cost for APC 606, the mid level outpatient visit APC in CY 2008. As discussed in Part 2 below, the resulting unscaled weights were scaled for budget neutrality to ensure that the effect of recalibration of APC weights for CY 2008 was removed. The scaled weights were multiplied by the proposed CY 2008 conversion factor to determine the proposed national unadjusted payment rate for the APCs for CY 2008.

The purpose of this claims accounting is to help the public understand the order in which CMS processed claims to produce the proposed CY 2008 OPPS APC median costs, the proportion of claims that CMS used to set the proposed CY 2008 OPPS payment rates and the reason that not all claims could be used.

General Information:

In order to calculate the median APC costs that form the basis of OPPS payment rates, CMS must isolate the specific resources associated with a single unique payable procedure (which has a HCPCS code) in each APC. Much of the following description, Pre-stage 1 through Stage 3, covers the activity by which CMS 1) extracts the direct charge (i.e. a charge on a line with a separately paid HCPCS code) and the supporting charge(s) (i.e. a charge on a line with a packaged HCPCS or packaged revenue code) for a single, major payable procedure for one unit of the procedure and 2) packages the supporting charges with the charges for the single unit of the major procedure to acquire a full charge for the single unit of the major procedure. CMS estimates resource costs from the billed charges by applying a cost-to-charge ratio (CCR) to adjust the charges to cost. CMS uses the most recent CCRs in the CMS Hospital Healthcare Cost Report Information System (HCRIS) file in the calculation of the proposed weights. Wherever possible, departmental CCRs rather than each hospital's overall CCR are applied to charges with related revenue codes (e.g. pharmacy CCR applied to charges with a pharmacy revenue code). In general, CMS carries the following data elements from the claim through the weight setting process: revenue code, date of service, HCPCS code, charges (for all lines with a HCPCS code or if there is no HCPCS code, with an allowed revenue code), and units. Some specific median calculations may require more data elements.

Definitions of terms used:

"Excluded" means the claims were eliminated from further use.

"Removed to another file" means that we removed them from the general process but put them on another file to be used in a different process; they did not remain in the main run but were not eliminated because the claims were used to set specific medians.

"Copy to another file" means that we copied information off the claims but did not eliminate any of the copied information.

"STAGE" means a set of activities that are done in the same run or a series of related runs; the STAGE numbers follow the stages identified in a spreadsheet that accounts for the claims.

"*" Indicates a component of the limited data set (LDS) and identifiable data set (IDS) (the public use files available for purchase from CMS).

Pre-STAGE 1: Identified gross outpatient claim population used for OPPS payment and applied the hospital cost-to-charge ratios.

Pulled claims for calendar year 2006 from the national claims history, n= 131,683,468 records with a total claim count of 130,986,360. This is not the population of claims paid under OPPS, but all outpatient claims processed by fiscal intermediaries.

Excluded claims with condition code 04, 20, 21, 77 (n=371,787). These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered.

Excluded claims with more than 300 lines (n=1,210)

Excluded claims for services furnished in Maryland, Guam, US Virgin Islands, American Samoa and the Northern Marianas. (n= 1,692,616).

Balance = 128,920,747

Divided claims into three groups:

1) Claims that were not bill type 12X, 13X, 14X (hospital bill types) or 76X (CMHC bill types). Other outpatient bill types, such as ASCs, are not paid under OPPS and, therefore, these claims were not used to set OPPS payment. The 14X bill type is no longer a valid bill type for OPPS after April 2006. (n=27,980,232)

2) Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims. (n=100,738,761)

3) Bill type 76X (CMHC) (These claims are later combined with any claims in 2 above with a condition code 41 to set the per diem partial hospitalization rate through a separate process.) (n=201,754)

Balance for Bill Types 12X, 13X, and 14X = 100,738,761

Applied hospital CCRs to claims and flagged hospitals with CCRs that will be excluded in Stage 1 below. We used the most recent CCRs that were available in the CMS HCRIS system.

STAGE 1: Further refined the population of claims to those with a valid cost-to-charge ratio and removed claims for those procedures with unique packaging and median calculation processes to separate files.

Began with the set of claims with bill types 12X, 13X, or 14X, without Maryland, Guam or USVI, and with flags for invalid CCRs set (n=100,738,761).

Excluded claims with CCRs that were flagged as invalid in Pre -Stage 1. These included claims for hospitals without a CCR, for hospitals paid an all inclusive rate, for critical access hospitals, for hospitals with obviously erroneous CCRs (greater than 90 or less than .0001), and for hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs) (n=3,751,200).

*Identified claims with condition code 41 and removed to another file, (n= 34,958). These claims were combined with the 201,754 bill type 76X claims identified in Pre-Stage 1 to calculate the partial hospitalization per diem rate.

Excluded claims without a HCPCS code (n=23,216).

Removed to another file claims that contain nothing but flu and PPV vaccine (n=383,563).

Balance = 96,545,824

Copied line items for drugs, blood, and devices (the lines stay on the claim but are copied off onto another file) to a separate file. No claims were deleted. Lines copied, (n=239,775,468). We use these line-items to calculate a per unit median and a per unit mean and a per day median and mean for drugs (including therapeutic radiopharmaceuticals) and blood. We trimmed units at +/- 3 standard deviations from the geometric mean before calculating the median and mean costs per unit and per day. For drugs and biologicals, we used the April, 2007 ASP plus 5 percent and multiplied that amount by the average number of units per day for each drug or biological to arrive at its per day cost. For items that did not have an ASP, we used their mean unit cost derived from the CY 2006 hospital claims data to determine their per day cost.

The payment rates for blood and blood products were based on simulated median costs under a different methodology that is explained in the proposed rule.

STAGE 2: Excluded claims with codes not payable under OPPS, conducted initial split of claims into single and multiple bills, and prepared claims for generating pseudo single claims.

Divided claims into 5 groups using the indicators (major, minor or bypass) that are assigned to each HCPCS code. Major procedures are defined as procedure codes with status indicator S, T, V, or X. Minor procedures are defined as procedures that have status indicator N, F, G, H, K, or L.

1)*Single Major File: Claims with a single unit of one separately payable procedure (SI= S, T, V or X, which are called "major" procedures), all of which will be used in median setting, (n=30,225,412).

2)*Multiple Major File: Claims with more than one separately payable procedure and/or multiple units of "major" procedures, (n=23,831,824). We define conditional and independent bilateral codes to be multiple major procedures when the bilateral modifier is attached to the code. Multiple major claims are examined carefully in stage 3 for dates of service and content to see if they can be divided into simulated or "pseudo" single claims.

3)*Single Minor File: Claims with a single unit of a single HCPCS to which we assigned the status indicator of N (packaged item or service), F, G, H, K, or L (n=82,169). We retain this file as insurance against last minute changes in packaging decisions.

4)*Multiple Minor File: Claims with multiple HCPCS, multiple services on the same date of service, and/or that have multiple units of one or more procedure codes with status indicator N, (n = 222,616).

5)Non-OPPS claims: These claims have no services payable under OPPS on the claim and are excluded, (n=42,183,803). These claims have codes paid under other fee schedules such as the DMEPOS fee schedule, clinical laboratory fee schedule, physician fee schedule. These claims have no major or minor procedures on them. The only procedure codes on these claims have a status indicator other than S, T, X, V, N, F, G, H, K, or L.

To create the LDS (Limited Data Set) and IDS (Identifiable Data Set) we compiled claims in files 1, 2, 3 and 4 above into a single file.

STAGE 3: Generated additional single claims or "pseudo singles" from multiple claims files

From the 24,054,440 combined multiple major and multiple minor claims, we were able to use some portion of 19,555,996 claims to create 57,693,189 pseudo single claims. In this final rule data set pseudo single bills were created in several different ways.

We create one set of pseudo singles by breaking the claim by date of service where there is only one separately paid service on a date. We create another set of pseudo single bills by breaking all claims that contain multiple major procedures with unit=1 and no additional packaging on the claim into separate single bills. We create another set of pseudo singles by removing separately payable procedures that are thought to contain limited packaging (i.e. the bypass codes) from a claim on which there are multiple separately paid services with the same date of service. Because bypass codes are thought to have limited packaging, we also used the line-item for the bypass code as a pseudo single. We create another set of pseudo singles where a claim contains only multiple units of a bypass code or bypass codes by dividing the cost of multiple units of the bypass code by the number of units billed for that code and treating each unit as a single procedure bill for the code. Finally, we examine the multiple minors for claims that contained a minor code with a payable APC and no other separately paid HCPCS. These claims largely are single bills for drugs and some HCPCS with status indicator Q. Services with status indicator Q are packaged unless it is the only separately paid procedure on the claim and if so, separately paid..

We were not able to use 3,984,724 multiple major and multiple minor claims because these claims continued to contain multiple separately payable procedures with significant packaging and could not be split (n=3,763,098) or because the claims contained services with SI=N and no separately payable procedures on the claim (n=221,626).

We also were not able to use claims with the following characteristics: major procedure with a zero cost (n=51,242), major procedure with charges less than $1.01 (n=27,671); packaging flag of 3 (n= 434,807).

We were not able to use any of the 222,616 multiple minors or any of the 82,169 single minor claims because minor claims, by definition, contain only packaged HCPCS procedures (i.e. SI=N).

Balance = 87,918,601 (the sum of single majors =30,225,412, and pseudo singles from multiple majors = 57,693,189).

STAGE 4: Packaged costs into the payable HCPCS code

Began with, n=87,918,601 single procedure claim records that still had costs at the line-item level. We summed the costs on the claim to complete packaging and we standardized 60 percent of the total cost using each hospital's pre-reclassification wage index.

We left stage 4 with n= 87,918,601 single procedure claim records containing summarized costs for the payable HCPCS and all packaged codes and revenue centers on the claim.

Balance=87,918,601

STAGE 5: Calculated HCPCS and APC medians.

Began with n=87,918,601 single procedure claim records with summarized costs.

We excluded 1757 claim records that had zero costs after summing all costs on the claim in Stage 4.

We excluded no claim records because CMS lacked an appropriate wage index.

We excluded 822,881 claim records that were outside +/- 3 standard deviations from the geometric mean cost for each HCPCS code.

We excluded 1,086 claims records that contained more than 100 units of the code on the claim.

Balance = 87,092,877

We used the balance of 87,092,877 single procedure claims records to calculate HCPCS median costs for the "2 times" examination and APC medians. (Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the "2 times rule").

We added a median per diem cost for APC 0033, Partial Hospitalization. The per diem cost was calculated from the bill type 13Xclaims with condition code 41 written off in Stage 1 and the 201,754 bill type 76X claims written off in Pre-Stage 1.

We added blood medians that were calculated with the use of a simulated departmental CCR for blood for hospitals that do not have cost centers for blood and for blood processing. Where a hospital has cost centers for blood and blood processing, we apply the departmental CCRs from those cost centers to the charges on the claim to calculate the cost of blood and blood products (revenue code 38X) and the costs of processing blood and blood products (revenue code 39X). We calculate the ratio of the blood specific cost center to the overall CCR for these hospitals that have blood cost centers. We then calculate the geometric mean of these ratios. This yields two ratios: one for revenue code 38X (blood

and blood products) and one for revenue code 39X (blood processing) We then apply these ratios to the overall CCR for hospitals that do not have blood and blood processing cost centers to derive hospital specific simulated CCRs for blood and for blood processing. We apply these hospital-specific CCRs to the charges on claims from these hospitals that are reported under revenue codes 38X and 39X. The claims to which the simulations are applied are available in the LDS and the IDS. The hospital specific simulated CCRs, file layout and further explanation are available as supporting documentation to this final rule.

PART 2 – BUDGET NEUTRALITY, OUTLIER THRESHOLD, AND IMPACT CALCULATIONS

After converting medians into unscaled weights by dividing the median for each APC (a group of HCPCS codes) by the median cost for APC 606, the mid level outpatient visit APC in CY 2008, we begin the process of calculating budget neutrality adjustments and the outlier threshold to determine final payment. The result of all proposed payment policies are presented in the impact table in Section XXII Regulatory Impact Analysis of the proposed rule. The following discussion provides greater detail about our manipulation of the claims to calculate budget neutrality adjustments, to estimate outlier thresholds, and to create the impact table and overall beneficiary coinsurance percentage. The discussion below supplements discussion already provided in the proposed rule about calculation of the weight scaler, the conversion factor, the hospital and CMHC outlier threshold, and the impact table columns.

STAGE 6: Created Summary Service Utilization Files for Current and Proposed OPPS Year by Provider

We began the budget neutrality calculations by making the services, utilization, and APC assignment on the 2006 claims look like they would if they were paid under the current OPPS, CY 2007, and under the proposed OPPS, CY 2008. We create a summary utilization file of services for each provider in the 2006 claims database that would be paid under the proposed system and a summary utilization file of services that would be paid under the current system for the same set of providers. In essence, this step runs the claims with payable OPPS services through a mock Outpatient Code Editor for the current and proposed year and then summarizes utilization by provider, APC, HCPCS, and status indicator. Updated July 2007 OCE specifications (v8.2) are available at: http://www.cms.hhs.gov/transmittals/downloads/R1264CP.pdf. For example, the utilization file for the proposed CY 2008 OPPS collapses codes on claims to reflect the proposed composite measures and simulates revised payment criteria for G0379, direct admit for hospital observation.

We constructed a summary utilization file for the proposed CY 2008 OPPS using single and multiple bills from STAGE 2 of this document (n=54,362,021), the partial hospitalization claims (n=34,958) from STAGE 1, and those from CMHCs

(n=201,754) from Pre-STAGE 1. In this process we identified line-items that were not payable under OPPS, including units on drugs and biologicals greater than the upper trim level identified during the units trim discussed in STAGE 1, units greater than 100 for procedure codes, a status indicator that is not payable under OPPS (SI=A, B, E, C, D, F, L, M), and 0 units on a claim line without an associated charge. We removed 1,322 claims with no line-items relevant to OPPS. After changes in utilization and the addition of proposed policies, we summarized these files to a single CY 2008 summary file of 2,660,003 services by hospital and 199 CMHCs, which only provide one service, partial hospitalization.

We also constructed a baseline summary utilization file to reflect the existing CY 2007 OPPS. For the CY 2007 OPPS baseline file, we began with the single and multiple bills from STAGE 2 of the same claims processed without the packaging proposal and (n=54,084,016), added observation claims (n=277,897), and added the same partial and CMHC claims listed above. We again removed 1,322 claims with no line-items relevant to OPPS. After changes in utilization and the addition of proposed policies other than packaging, we summarized this second set of files to a single file of 2,635,191 services by hospital and 199 CMHCs, which only provide one service. We used this summary file as the basis for the modeling current year weight in the weight scaler calculation and estimated payment in CY 2008 without the packaging proposal in column 2A of the impact table. We assumed that the structure (discounting and composite measures) of CY 2007 OPPS and estimated CY 2008 OPPS without packaging are similar.

Utilization in both of these files includes changes for "discounting," which is any change in payment, applied to the line-item units for a specific service on a claim, resulting from application of the multiple procedure discounting to services with status indicator "T" or the presence of a modifier indicating that the procedure was terminated. Unscaled weights, the APC median cost divided by the median for APC 606, are used to rank order services on each claim for application of multiple procedure discounting because scaled weights are not yet available. As discussed in section II.B. of this proposed rule, we adjusted units for the presence of modifier '50' on a HCPCS specifically designated as independent or conditional bilateral in the most recent MPFS table available.

We took a few additional steps to prepare both files for budget neutrality calculations. We applied the AMA's estimates of new code utilization due to changes in CPT codes between 2006 and 2007, which are used for the MPFS proposed rule. We also adjusted units to accommodate changes in HCPCS descriptions between 2006 and 2007. The final summary utilization file for the proposed 2008 OPPS contains 2,692,354 observations for 4,172 providers, and the final summary utilization file for the current 2007 OPPS contains 2,717,166 observations for 4,172 providers.

Balance proposed CY 2008=2,692,354 HCPCS, by SI, by APC, by Provider
Balance baseline CY 2007=2,717,166 HCPCS, by SI, by APC, by Provider

STAGE 7: Calculated the Weight Scaler

The weight scaler is the budget neutrality adjustment for annual APC recalibration and its calculation is discussed in section II.B of the proposed rule. The weight scaler compares total unscaled weight under the current OPPS for 4,171 providers to total scaled weight under the proposed OPPS for the same providers, holding wage adjustment and rural adjustment constant to the current year's adjustments. One low volume provider from Stage 6 had no utilization for separately paid services for both years. We estimated wage adjusted weight for each provider using the formula provided in section II.H. of the proposed rule without multiplying by the conversion factor, which is held constant. For example, for a procedure with SI=S provided by an urban hospital, the total proposed weight for a service would be calculated:

```
(UNSCALED_2008_WEIGHT*.4+UNSCALED_2008_WEIGHT*.6
    *CY2008_WAGE_INDEX)*TOTAL_DISCOUNTED_UNITS
```

For a procedure with SI=S provided by a rural sole community hospital, the total proposed weight for a service would be calculated:

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(UNSCALED_2008_WEIGHT*.4+UNSCALED_2008_WEIGHT*.6
   *CY2008_WAGE_INDEX)*TOTAL_DISCOUNTED_UNITS *1.071
```

For a specified covered outpatient drug with SI=K provided by any hospital, the total proposed weight for a service would be calculated:

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UNSCALED_2008_WEIGHT*TOTAL_DISCOUNTED_UNITS
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Scaling does not apply to OPPS services that have a predetermined payment amount, especially separately paid specified covered outpatient drugs and new technology APCs. Items with a predetermined payment amount were included in the budget neutrality comparison of total weight across years by using a weight equal to the estimated conversion factor. However, scaling of the relative payment weights only applies to those items that have a predetermined payment amount. Specifically, we remove the total amount of weight for items with predetermined payment amount in the proposed year from both the proposed and current year and calculate the weight scaler from the difference. In doing this, those services without a predetermined payment amount would be scaled by the proportional amount not applied to the services with a predetermined payment amount. We do not make any behavioral predictions about changes in utilization, case mix, or beneficiary enrollment when calculating the weight scaler.

Balance proposed CY 2008= 4,171 providers
Balance baseline CY 2007=4,171 providers

Proposed CY 2008 weight scaler = 1.3665

STAGE 8: Calculated the Wage and Rural Adjustment

We used the same 4,171 providers to estimate the budget neutrality adjustment for adopting the IPPS FY 2008 post reclassification wage index for CY 2008 OPPS, discussed in section II.D. of the proposed rule and for extending the rural adjustment to include brachytherapy sources, discussed in II.F. of the proposed rule. Using the same wage-adjusted weight formulas presented above, the wage adjustment compares differences in total scaled, proposed CY 2008 weight for the 4,171 providers varying only the wage index, CY 2007 and CY 2008, and using the 2007 rural adjustment. This year, we used this same approach to first estimate the adoption of IPPS FY 2008 wage index without the rural floor budget neutrality adjustment, which is specific to IPPS. We then isolated the amount of the overall wage adjustment attributable to adopting the final post reclassification wage index with the rural floor budget neutrality adjustment. Similarly, the rural adjustment compares differences in total scaled proposed weight, wage adjusted with the CY 2008 wage index, for 4,171 providers varying only the rural adjustment, with and without application to brachytherapy sources. These adjustments are applied to the conversion factor, which is not calculated from claims.

Balance proposed CY 2008 providers = 4,171
Balance baseline CY 2008 providers =4,171

Total wage index and rural adjustment to the conversion factor = 1.0025

STAGE 9: Calculated Hospital Outlier Threshold

We started with the proposed CY 2008 set of aggregated claims from the single and multiple bills, and partial hospitalization to model the hospital fixed dollar hospital outlier threshold. After removing 1,322 claims with no line-items relevant to OPPS, we used 54,597,411 claims to estimate the proposed outlier threshold as well as anticipated outlier payment by provider. We created a cost-to-charge ratio for every hospital in our hospital base file of 4,023 hospitals using the April 2007 update to the Outpatient Provider Specific File, which contains the actual overall CCRs the fiscal intermediaries or MACs are using to make outlier payments in 2007. We did not estimate the CMHC threshold this year, continuing our policy of 3.4 times payment for APC 0033 Partial Hospitalization.

As discussed in section II.C. of the proposed rule, we simulated 2008 costs by applying a charge inflation factor of 1.1504 to charges on the 2006 claims and by applying the CCR adjustment of 0.9912 to the April 2007 OPSF CCRs. We compared estimated cost to wage adjusted payment for each separately paid service on each claim. Holding the multiple threshold constant at 1.75 times the APC payment amount, we iterated total outlier payment calculations, changing the size of the fixed dollar threshold each time, until total outlier payments amount matched our estimate of 1 percent of total payment on all included claims.

Using the resulting $2,000 fixed dollar threshold, we estimated outlier payments for 2,940 hospitals for column 5 of the impact table.

We repeated this exercise for the current year CY 2007 OPPS. After removing claims with no line-items relevant to OPPS, we used 54,597,303 claims to estimate the percentage of total payment attributable to outlier payments in 2007. We inflated charges on the CY 2006 claims by an inflation factor for one year, 1.076, and using the CCRs from the April 2007 update to the Outpatient Provider Specific File, we estimated CY 2007 costs and compared them to wage adjusted CY 2007 payment for each service. Ultimately, we estimated outlier payments for 2,964 hospitals for column 5 of the impact table. We also estimated total outlier payments to be 0.96% of total CY 2007 payments.

Balance proposed CY 2008= 2,940 hospitals
Balance baseline CY 2007=2,964 hospitals

STAGE 10: Created the Impact Table and Calculated the Beneficiary Impact Percentage

The impact table in section XXII Regulatory Impact Analysis compares OPPS payment for 4,171 hospitals in the baseline CY 2007 file to the proposed CY 2008 OPPS payment for the same set of hospitals, in aggregate and across classes of hospitals. We began with the summary utilization files created in Stage 1 and recreated each of the above total weight calculations (weight scaler, wage adjustment, and rural adjustment) as payments by adding in the conversion factor. In order to isolate the impact of the packaging proposal, we calculated a second weight scaler for a CY 2008 OPPS as it would exist without the packaging proposal. We then compared the payments that would result under the CY 2008 proposal if it did not include the packaging proposal to the CY 2007 baseline file and show this result in column 2A. We then compared the difference in payments between those under the CY 2008 proposal rule (including the packaging proposal) and those under the CY 2008 proposal if it did not include the packaging proposal to the baseline CY 2007 payment and we show this result in column 2B. The detailed calculations behind the table columns are discussed in section XXII of the proposed rule. Final payment presented in Column 5 of the impact table compares total estimated payment, including outlier payments, but excluding pass through payment for current and proposed year.

In order to group types of hospitals, we constructed a file of descriptive information from the cost report and IPPS provider files identifying different classes of hospitals. This file includes the variables we use to model adjustments including the wage index, geographic location, and provider type, as well as other descriptive information, such as bed size. We have complete information for the 4,023 hospitals with any claim used to model the proposed OPPS. We do not have complete descriptive information for CMHC's because their cost report is not included in HCRIS and because they are not hospitals paid under IPPS. We make

available a final impact file available that contains all descriptive information for the providers that we used in our calculations, as well as estimated proposed payments, including outlier payments, by provider for the subset of providers that we present in the impact table.

Finally, we estimated the overall beneficiary coinsurance percentage for the current and proposed OPPS years. We applied the calculated, adjusted (wage and rural) coinsurance to all separately paid HCPCS, and we capped coinsurance at the inpatient deductible for CY 2007 in both years as this number was not yet available for CY 2008. We summed total coinsurance for each year and divided by respective total payment.