Medicare 2008 OPPS FR 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 overview of CMS manipulation of the 2006 claims data to produce the prospective CY 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 97.3 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 final rule due to changes to packaging under OPPS for CY 2008. Expanded 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 proposed 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 number of codes on the bypass list were reduced in two ways: First, we removed codes that are 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 new 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). For this final rule with comment period, we added several codes to the bypass list based on the recommendations of commenters, notwithstanding that single bills for them did not meet our empirical criteria for inclusion on the bypass list; we did this because the commenters assured us and our clinicians agreed that these services, if correctly coded, should rarely have packaging. 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 67 percent in the data used for this final rule with comment period. We believe that using a greater proportion of natural single bills is a positive change.

[1] Final CY 2008 rates are based on 2006 calendar year outpatient claims data, specifically final action claims processed through the common working file as of June 30, 2007. Final CY 2007 rates were based on one year (January 1- December 31) of 2005 outpatient claims data.

Attached is a narrative description of the accounting of claims used in the setting of 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 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 CY 2008 conversion factor to determine the 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 CY 2008 OPPS APC median costs, the proportion of claims that CMS used to set the 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 payment 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 CCRs.

Pulled claims for calendar year 2006 from the national claims history, n= 141,250,543 records with a total claim count of 141,421,654. 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=419,303). 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=1,808)

Excluded claims for services furnished in Maryland, Guam, US Virgin Islands, American Samoa and the Northern Marianas. (n= 1,816,397).

Balance = 139,184,146

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=31,071,785)

2) Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims. (n=107,899,485)

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=212,876)

Balance for Bill Types 12X, 13X, and 14X = 107,899,485

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 CCR 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=107,899,485).

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=3,965,991).

*Identified claims with condition code 41 and removed to another file, (n= 39,431). These claims were combined with the 212,876W bill type 76X claims identified in Pre-Stage 1 to calculate the partial hospitalization per diem rate.

Excluded claims without a HCPCS code (n=25,311).

Removed to another file claims that contain nothing but flu and PPV vaccine (n=508,971).

Balance = 103,359,781

Copied line items for drugs, radiopharmaceuticals, blood, and brachytherapy sources (the lines stay on the claim but are copied off onto another file) to a separate file. No claims were deleted. Lines copied, (n=267,749,676). We use these line-items to calculate a per unit median and 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 unit, and then +/- 3 standard deviations from the geometric mean unit cost, before calculating the median and mean costs per unit and per day. For drugs and biologicals, we used the July, 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 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 CY 2008 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. Prior to splitting the claims, we identified which status indicator “Q” codes that are “T-packaged” would be paid when appearing with an S, V, or X service. For separately paid “T-packaged” codes we changed the major-minor designation from minor to major, and forced the units to one to be consistent with policy of paying only one unit.

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; claims with only one unit of a status indicator “Q” code that was an “STVX-packaged” code or “T-packaged” code where there was no other code on the claim with status indicator “S, “T, V”, “X,” or “Q” respectively, (n=32,267,552).

2)*Multiple Major File: Claims with more than one separately payable procedure and/or multiple units of “major” procedures; claims with status indicator “Q” that contain “T-packaged” codes and no procedure with a status indicator “T” on the same date of service but that appear on a claim with a code with status indicator “S”, “V” or “X”; claims that contain conditional and independent bilateral codes when the bilateral modifier is attached to the code, (n=25,928,672). 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=88,997). 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 of “F”, “G”, “H”, “K”, “L” or “N”; claims containing “STVX-packaged” and “T-packaged” codes with more than

one unit of the code or more than one line of these codes on the same date of service. (n = 97,156)

5) Non-OPPS claims: These claims have no services payable under OPPS on the claim and are excluded, (n=44,977,404). 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. Having inadvertently assigned J1567 a non-payable status indicator from STAGE 2 forward, we added 772 claims to the public use file, resulting in a total of 58,382,377 claims for the LDS and IDS. This oversight had no impact on relative weight estimates as successor codes for J1567 are separately paid in 2008. We included these claims from STAGE 6 forward.

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

From the 25,928,672 multiple major claims, we were able to use some portion of 21,821,049 claims to create 65,021,862 pseudo single claims. As noted above, the multiple major claims already contained the final payment disposition of T-packaged codes when they appeared with a S,T,V, or X services, making these services part of the pseudo single process. 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 each 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.

We were not able to use 3,656,496 claims because these claims continued to contain multiple separately payable procedures with significant packaging and could not be split (n=3,564,085) or because the claims contained services with SI=N and no separately payable procedures on the claim (n=92,411). We also were not able to use claims with the following characteristics: major procedure

with a zero cost (n=55,164), major procedure with charges less than $1.01 (n=30,455); packaging flag of 3 (n= 457,874).

We also created additional single bills from the multiple minor file. We broke "STVX-packaged" and "T-packaged" codes by date, packaged the costs into the code with the highest CY 2007 payment weight, forced the units to one to match our policy of paying only one unit of a code with SI="Q", and treated these claims as pseudo single claims. We created 11,956 pseudo singles from the multiple minor claims. We were not able to use 92,411 multiple minor claims because these claims contained only minor codes: largely drugs or packaged HCPCS procedures.

We were not able to use any of the 88,997 single minor claims because minor claims, by definition, contain only minor codes: drugs or packaged HCPCS procedures (i.e. SI=N).

Balance = 97,301,370 (the sum of single majors =32,267,552, and pseudo singles from multiple majors and multiple minors = 65,033,818).

STAGE 4: Packaged costs into the payable HCPCS code

Began with, n=97,301,370 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 deleted 228 claim records for bilateral services that were mistakenly treated as single procedure bills until this point.

We left stage 4 with n= 97,301,142 single procedure claim records containing summarized costs for the payable HCPCS and all packaged codes and revenue centers on the claim.

Balance=97,301,142

STAGE 5: Calculated HCPCS and APC medians

Began with n=97,301,142 single procedure claim records with summarized costs.

We excluded 1,243 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 926,089 claim records that were outside +/- 3 standard deviations from the geometric mean cost for each HCPCS code.

We excluded 1,215 claims records that contained more than 50 units of the code on the claim.

Balance = 96,372,595

We used the balance of 96,372,595 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 additional medians calculated outside this process. 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 212,876 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. We added APC medians for final composite APCs, as well as other customized or "offline" medians discussed in the final rule, such as nuclear medicine APCs and echocardiography with and without contrast.

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

After converting medians into unscaled weights by dividing the median for each APC 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 prospective payment policies are presented in the impact table in Section XXIV Regulatory Impact Analysis of the final rule with comment period. 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 copayment percentage. The discussion below supplements discussion already provided in the final 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 Prospective 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 the prospective year, CY 2008. We create a summary utilization file of services for each provider in the 2006 claims database that would be paid under the prospective payment 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 Integrated Outpatient Code Editor (IOCE) for the current and prospective year and then summarizes utilization by provider, APC, HCPCS, and status indicator. Updated October 2007 IOCE specifications (v8.3) are available at: http://www.cms.hhs.gov/transmittals/downloads/R1342CP.pdf. The January 2008 IOCE specifications will be posted on the CMS transmittal website soon. For example, the utilization file for the CY 2008 OPPS collapses codes on claims to reflect the composite APCs and simulates revised payment criteria for G0379, direct admit for hospital observation.

We constructed a summary utilization file for the final CY 2008 OPPS using single and multiple bills from STAGE 2 of this document (n=58,383,149), the partial hospitalization claims (n=39,431) from STAGE 1, and those from CMHCs (n=212,876) from Pre-STAGE 1. The increased number of claims from STAGE 2 includes 772 additional claims for code J1567, which was inadvertently assigned a non-payable status indicator after Stage I. Because successor codes for J1567 are separately paid in CY 2008, this had no impact on relative weight calculations. In this summary 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 specifically included the 11,956 pseudo singles for claims with multiple T-packaged or STVX-packaged codes as separately paid items. We removed 1,877 claims with no line-items relevant to OPPS. After changes in utilization and the addition of CY 2008 payment policies, we summarized these files to a single CY 2008 summary file of 2,759,372 services by 4,089 hospitals and 205 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 including observation claims (n=313,093), and the same partial and CMHC claims listed above. We removed 9,518 claims with no line-items relevant to 2007 OPPS. We summarized this second set of files to a single file of 2,728,544 services by hospital and 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 2007 of the impact table.

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. For 2008, we used unscaled weights, the APC median cost divided by the median for APC 606, to rank order services on each claim for application of multiple procedure discounting because scaled weights are not yet available. For 2007, we relied on final rule 2007 scaled weights.

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 2008, which are used for the MPFS final rule. We also adjusted units to accommodate changes in HCPCS descriptions between 2006 and 2008. The final summary utilization file for the prospective 2008 OPPS contains 2,875,048 observations for 4,250 providers, and the final summary utilization file for the current 2007 OPPS contains 2,788,182 observations for 4,250 providers. Of the original 4,294 (4,098 hospitals and 205 CMHCs) providers, 44 were low volume and did not have utilization for paid services in either year.

Balance prospective CY 2008=2,875,048 HCPCS, by SI, by APC, by Provider
Balance baseline CY 2007=2,788,182 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.A. of the final rule. The weight scaler compares total unscaled weight under the current OPPS for 4,250 providers to total scaled weight under the prospective OPPS for the same providers, holding wage adjustment and rural adjustment constant to the current year's adjustments. We estimated wage adjusted weight for each provider using the formula provided in section II.H. of this final rule with comment period 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 weight for a service would be calculated:

```
(UNSCALED_2008_WEIGHT*.4+UNSCALED_2008_WEIGHT*.6
    *CY2007_WAGE_INDEX)*TOTAL_DISCOUNTED_UNITS
```

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

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(UNSCALED_2008_WEIGHT*.4+UNSCALED_2008_WEIGHT*.6
   *CY2007_WAGE_INDEX)*TOTAL_DISCOUNTED_UNITS *1.071
```

For a specified covered outpatient drug with SI=K provided by any hospital, the total 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 payment rate divided by the NPRM conversion factor. However, scaling of the relative payment weights only applies to those items that do not have a predetermined payment amount. Specifically, we remove the total amount of weight for items with predetermined payment amount in the prospective year from both the prospective 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 CY 2008= 4,250 providers
Balance baseline CY 2007=4,250 providers

CY 2008 weight scaler = 1.3226

STAGE 8: Calculated the Wage and Rural Adjustment

We used the same 4,250 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 this final rule with comment period and for extending the rural adjustment to include brachytherapy sources, discussed in II.F. of this final rule with comment period. Using the same wage-adjusted weight formulas presented above, the wage adjustment compares differences in total scaled, prospective CY 2008 weight for the 4,250 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 weight, wage adjusted with the CY 2008 wage index, for 4,250 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 CY 2008 providers = 4,250
Balance baseline CY 2008 providers =4,250

Total wage index and rural adjustment to the conversion factor = 1.0019

STAGE 9: Calculated Hospital Outlier Threshold

We started with the prospective 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 1,877 claims with no line-items relevant to OPPS, we used 58,427,720 claims to estimate the outlier threshold as well as anticipated outlier payment by provider. We created a CCR for every hospital in our hospital base file of 4,089 hospitals using the July 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 used internally calculated CCRs to substitute for any missing CCRs on the July OPSF update, and we substituted the statewide CCR for providers with CCRs greater than the 1.2 upper limit. 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.G. of the final rule with comment period, we simulated 2008 costs by applying a charge inflation factor of 1.062 to charges on the 2006 claims and by applying the CCR adjustment of 1.0027 to the July 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 $1,575 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 58,422,712 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, 1.062, and using the CCRs from the July 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 0.73% of total CY 2007 payments.

Balance 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 XXIV Regulatory Impact Analysis compares OPPS payment for 4,250 providers in the baseline CY 2007 file to the 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 6 and recreated each of the above total weight calculations (weight scaler, wage adjustment, and rural adjustment) as payments by adding in the conversion factor. We compared the difference in payments between those under the CY 2008 rule with expanded packaging to the baseline CY 2007 payment and we show this result in column 2. The detailed calculations behind the table columns are discussed in section XXIV of the final rule with comment period. 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 prospective 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 contains 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 4,089 hospitals with any claim used to model the prospective OPPS. We do not have complete descriptive information for 205 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 CY 2008 payments, including outlier payments, by provider for the subset of 3,984 hospitals for which we present detailed information in the impact table.

Finally, we estimated the overall beneficiary copayment percentage for the current and prospective OPPS years. We applied the calculated, adjusted (wage and rural) copayment to all separately paid HCPCS, and we capped copayment at the inpatient deductible for each year. We summed total copayments for each year and divided by respective total payment.