Medicare Outpatient Prospective Payment System
Final Rule Impact Analysis – Calendar Year 2017

December 2016

Analysis Description

The calendar year (CY) 2017 Medicare Outpatient Prospective Payment System (OPPS) Final Rule Analysis is intended to show providers how Medicare outpatient fee-for-service (FFS) payments will change from CY 2016 to CY 2017 based on the policies set forth in the CY 2017 OPPS final rule. The analysis incorporates changes to outpatient payments mandated by Congress and implemented by the Centers for Medicare and Medicaid Services (CMS).

Final Rule Impact Analysis

The following changes are modeled in this analysis:

- Marketbasket Update: 2.7% marketbasket increase minus 0.0006% due to other budget neutrality (BN) adjustments.
- ACA-Mandated Marketbasket Reductions: Combined 0.3 percentage point productivity reduction and 0.75 percentage point pre-determined reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.
- Wage Index BN Adjustment: Reflects a budget neutrality adjustment of -0.01% to the rate in order to account for changes to the wage index.
- Pass-through Spending BN Adjustment: CMS' estimate of final pass-through spending for drugs, biologicals, and devices for CY 2017 is approximately $150.6 million, which represents 0.24% of total projected CY 2017 OPPS spending. The rate is adjusted by the difference between the 0.26% estimate of pass-through spending for CY 2016 and the 0.24% estimate of final pass-through spending for CY 2017, resulting in a negative adjustment for CY 2017 of 0.02%.
- Cancer Hospital BN Adjustment: CMS' updated CY 2017 estimate of the target payment-to-cost ratio (PCR) of 0.91 for the cancer hospital payment adjustment, compared to the CY 2016 estimate of 0.92, results in an adopted positive adjustment for CY 2017 of 0.03%.
- Outlier BN Adjustment: Estimated final payments for outliers equal 1.0% of total OPPS payments for CY 2017. CMS estimates that outlier payments will be 0.96% of total OPPS payments in CY 2016; the 1.0% for final CY 2017 outlier payments would result in a 0.04% increase in payment in CY 2017.

- BN Adjustment for Packaging of Unrelated Laboratory Tests: CMS will apply a budget neutrality increase of 0.04% to the rate to account for its decision to package unrelated laboratory tests into OPPS payment.
- Wage Index: Updated wage index values based on the Federal Fiscal Year (FFY) 2017 hospital wage index, including the impact of new wage data; reclassifications; rural and legislated floors, and other adjustments to the wage indexes.
- APC Factor/Updates: This impact represents the changes to the APC assignments and weights adopted for CY 2017. It is inclusive of CMS' policies regarding the creation of comprehensive APCs. The APC Factor is also inclusive of CMS' expansion of the categories of items/services that are packaged into APCs for payment as opposed to separately paid. The anticipated change in outlier payments is also included in this line. This impact is derived by attributing all remaining payment changes to this category (after impact for wage index, marketbasket, etc.).

The impacts provided do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress and currently in effect through FFY 2025 unless Congress intervenes. The impact of sequester applicable to OPPS-specific payment has been calculated separately and is provided at the bottom of the impact table.

Data Sources

Hospital characteristics, outpatient procedure volumes, and estimated 2016 and 2017 outpatient revenues are from the CMS CY 2017 OPPS final rule Impact File (CY 2015 outpatient claims data). OPPS conversion factors are from the CY 2016 final rule and the CY 2017 final rule, as published in the *Federal Register*. Wage indexes are based on the wage index tables from the federal fiscal year (FFY) 2016 Inpatient Prospective Payment Systems (IPPS) final rule correction notice (released December 2015) and the FFY 2017 IPPS final rule correction notice (released October 2016). This analysis was developed to measure the impact of OPPS policy changes only. Hospitals' rural status, volume, and patient mix are held constant at the value published in the CY 2017 Impact File.

Methods

The dollar impact of each component change has been calculated starting with estimated 2016 outpatient payments as provided by CMS in its CY 2017 OPPS final rule Impact File. Estimated 2016 outpatient payments include outliers and the rural Sole Community Hospital (SCH) add-on, where appropriate.

The CY 2016 to CY 2017 percent change, for each outpatient payment change component analyzed, is calculated and applied to estimated CY 2016 payments. The percentage impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the percent change due to the marketbasket update is applied to total CY 2016 payments. Then, the percent change in the ACA-mandated marketbasket reductions is applied to the dollar result of the first change. This method continues for the remaining changes, creating a compounded effect. The difference between the results after each layered component is the impact of that component.

Based on the limitations of CMS' Impact File, an "APC Factor/Updates" adjustment factor is calculated and used to estimate the value of payment changes that cannot be broken out by individual

component. This hospital-specific factor/impact is derived by dividing total payments by the wage index and SCH add-on-adjusted conversion factor. The result of the first calculation is divided by the Medicare service count provided in the OPPS final rule Impact File. This factor impact represents the impact of changes to the APC assignments and weights and the outlier threshold.

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding.

This analysis does not include payment estimates for services provided to Medicare Advantage patients or modifications in FFS payments as a result of provider participation in new payment models being tested under Medicare demonstration/pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods.