



HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information about the Hospital Outpatient Prospective Payment System (OPPS):

- ❖ Background;
- ❖ Ambulatory payment classifications (APCs);
- ❖ How payment rates are set;
- ❖ Payment rates;
- ❖ Hospital Outpatient Quality Reporting (OQR) Program; and
- ❖ Resources.

When “you” is used in this publication, we are referring to hospitals paid under the OPPS.

Background

On August 1, 2000, the Centers for Medicare & Medicaid Services (CMS) began using the OPPS, which was authorized by Section 1833(t) of the Social Security Act (the Act) as amended by Section 4533 of the Balanced Budget Act of 1997. The OPPS was implemented in calendar year 2000 and pays for:

- ❖ Designated hospital outpatient services;
- ❖ Certain Medicare Part B services furnished to hospital inpatients when Part A payment cannot be made;
- ❖ Partial hospitalization services furnished by hospitals or Community Mental Health Centers (CMHCs);
- ❖ Hepatitis B vaccines and their administration, splints, casts, and antigens furnished by a Home Health Agency (HHA) to patients who are not under a Home Health plan of care or to Hospice patients for treatment of non-terminal illness; and

- ❖ An initial preventive physical examination performed within the first 12 months of Medicare Part B coverage.

Certain types of services are excluded from payment under the OPSS (such as outpatient therapy services and screening and diagnostic mammography). For more information about services excluded from payment under the OPSS, refer to Section 1833(t) of the Act and the “Code of Federal Regulations” at [42 CFR 419.22](#) on the United States (U.S.) Government Publishing Office website.

The Balanced Budget Refinement Act of 1999 mandated the following additional OPSS provisions:

- ❖ Establish payments in a budget-neutral manner based on estimates of amounts payable in 1999 from the Medicare Part B Trust Fund and patient coinsurance under the system in effect prior to the OPSS;
- ❖ Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first date the OPSS is implemented;
- ❖ Require annual update of payment weights, relative payment rates, wage adjustments, outlier payments, other adjustments, and APC groups;
- ❖ Require annual consultation with an expert provider Advisory Panel for review and updating of APC groups;
- ❖ Establish budget-neutral outlier adjustments based on the charges, adjusted to costs, for all OPSS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;
- ❖ Provide transitional pass-through payments for the additional costs of new and current medical devices, drugs, and biologicals for at least 2 years but not more than 3 years;
- ❖ Provide payment under the OPSS for implantable devices, including durable medical equipment (DME), prosthetics, and DME used in diagnostic testing;
- ❖ Establish transitional corridor payments (also known as transitional outpatient payments [TOPs]) to limit providers’ losses under the OPSS as follows:
 - Three and one-half years for CMHCs (sunset December 31, 2003) and most hospitals; and
 - Permanently for cancer hospitals; and
- ❖ Limit patient copayment for an individual service paid under the OPSS to the inpatient deductible in a given year.

The Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement and Protection Act of 2000 included the following revisions to the OPSS:

- ❖ Accelerated reductions of patient copayments;
- ❖ Increased market basket updates for 2001;

- ❖ Transitional corridor provision for transitional outpatient payments for providers that did not file 1996 cost reports; and
- ❖ Established permanent transitional outpatient payments for children's hospitals.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included the following changes on how Medicare pays for drugs under the OPSS:

- ❖ For 2004 and 2005, enact payment rates for many separately payable drugs that were tied to the drugs' average wholesale price as of May 1, 2003 (rates apply to separately paid radiopharmaceuticals and drugs and biologicals that were pass-through items prior to January 1, 2003);
- ❖ For services furnished in 2006 and thereafter, pay separately payable drugs at the average hospital acquisition cost;
- ❖ May adjust APC weights for specified covered outpatient drugs to account for the costs hospitals incur in handling these drugs;
- ❖ Establish separate APCs for drugs and biologicals that cost at least \$50 per administration in 2005 and 2006 (drugs costing less were packaged). In 2007, when CMS began updating the packaging threshold, the threshold was set at the cost per day. Items with a per-day cost of less than or equal to \$95 are packaged under the OPSS; and
- ❖ Exclude separately paid drugs and biologicals from outlier payments.

The Affordable Care Act included the following change on certain preventive services:

- ❖ Effective January 1, 2011, waives patient cost-sharing requirements for most Medicare-covered preventive services, and Medicare pays fully for these services. No coinsurance or deductible is required for personalized prevention plan services and any covered preventive service that is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

The OPSS applies to designated hospital outpatient services furnished in all classes of hospitals, with the exception of the following:

- ❖ Effective January 1, 2002, hospitals that provide only Part B services to inpatients;
- ❖ Critical Access Hospitals (CAHs);
- ❖ Indian Health Service (IHS) and Tribal hospitals, including IHS Tribal CAHs;
- ❖ Hospitals located in American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands;
- ❖ Effective January 1, 2002, hospitals located in the Virgin Islands; and
- ❖ Hospitals in Maryland (that are paid under Maryland waiver provisions).

Ambulatory Payment Classifications (APCs)

In most cases, the unit of payment under the OPSS is the APC. CMS assigns individual services (Healthcare Common Procedure Coding System [HCPCS] codes) to APCs based on similar clinical characteristics and similar costs. The payment rate and copayment calculated for an APC apply to each service within the APC. Sometimes new services are assigned to New Technology APCs, which are based on similarity of resource use only, until cost data are available to permit assignment to a clinical APC. The payment rate for a New Technology APC is set at the midpoint of the applicable New Technology APC's cost range.

Some services are paid separately, including but not limited to:

- ❖ Many surgical, diagnostic, and nonsurgical therapeutic procedures;
- ❖ Blood and blood products;
- ❖ Most clinic and emergency department visits;
- ❖ Some drugs, biologicals, and radiopharmaceuticals;
- ❖ Brachytherapy sources;
- ❖ Corneal tissue acquisition costs; and
- ❖ Certain preventive services.

Partial hospitalization is paid on a per diem basis, with payment rates dependent on the number of individual services provided to the patient in one day. The payment represents the expected cost of a day of intensive outpatient mental health care in the hospital or in a CMHC. Beginning January 1, 2011, there are two APCs (based on intensity of day) for partial hospitalization furnished by hospitals and two APCs (based on intensity of day) for partial hospitalization furnished by CMHCs.

Packaging is a critical feature of the OPSS, which is a Prospective Payment System. Within each APC, payment for dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service. Separate payments are not made for packaged services, which are considered an integral part of another service that is paid under the OPSS. Some examples of usually packaged services are:

- ❖ All supplies;
- ❖ Ancillary services;
- ❖ Anesthesia;
- ❖ Operating and recovery room use;
- ❖ Clinical diagnostic laboratory tests;
- ❖ Procedures described by add-on codes;
- ❖ Implantable medical devices (such as pacemakers);
- ❖ Inexpensive drugs under a per-day drug threshold packaging amount;

- ❖ Drugs, biologicals, and radiopharmaceuticals that function as supplies (including diagnostic radiopharmaceuticals, contrast agents, stress agents, implantable biologicals, and skin substitutes);
- ❖ Guidance services;
- ❖ Image processing services;
- ❖ Intraoperative services;
- ❖ Imaging supervision and interpretation services; and
- ❖ Observation services.

Effective January 1, 2015, CMS established comprehensive APCs to provide all-inclusive payments for certain procedures. This policy packages payment for all items and services typically packaged under the OPSS. It also packages payment for other items and services that are not typically packaged under the OPSS. The single payment for a comprehensive APC excludes services that cannot be covered Outpatient Department (OPD) services or cannot by statute be paid under the OPSS.

How Payment Rates Are Set

The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates. National unadjusted payment rates and copayments for each HCPCS code, for which separate payment is made that applies to the date of service, are published in addendums located at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html> on the CMS website.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPSS payments:

- ❖ Pass-through payments for specific drugs, biologicals, and devices used in the delivery of services that meet the criteria for pass-through status (these items are generally too new to be well represented in data used to set payment rates);
- ❖ Outlier payments for individual services that cost you much more than the payment rates for the services' APC groups;
- ❖ Transitional outpatient payments for certain cancer hospitals and children's hospitals;
- ❖ An adjustment for certain cancer hospitals; and
- ❖ A rural adjustment (currently an increased payment of 7.1 percent) for most services furnished by Sole Community Hospitals (SCHs), which includes Essential Access Community Hospitals located in rural areas (effective January 1, 2006).

The annual review of APCs and their relative weights considers:

- ❖ Changes in hospital and medical practices;
- ❖ Changes in technology;
- ❖ Addition of new services and cessation of obsolete services;
- ❖ New cost data;
- ❖ Advice furnished by the Hospital Outpatient Payment Panel; and
- ❖ Other relevant information.

The OPSS is a budget-neutral payment system in which the CF is also updated annually by the OPD Fee Schedule (FS) increase factor unless Congress stipulates otherwise. The OPD FS increase factor is calculated using the hospital market basket update. As required by the Affordable Care Act, the OPD FS increase factor is calculated by reducing the hospital market basket update by a multifactor productivity adjustment and an additional 0.5 percentage points. The CF update is further reduced by 2.0 percentage points for hospitals that fail to meet the requirements of the Hospital OQR Program for the update year, resulting in reduced payment for most of their services. Payment rates are established through alternative methodologies for certain other categories of items and services, such as:

- ❖ Separately payable drugs and biologicals;
- ❖ Brachytherapy sources;
- ❖ Therapeutic radiopharmaceuticals; and
- ❖ Services assigned to New Technology APCs.

The OPSS payment files are updated on a quarterly basis to account for mid-year changes, such as:

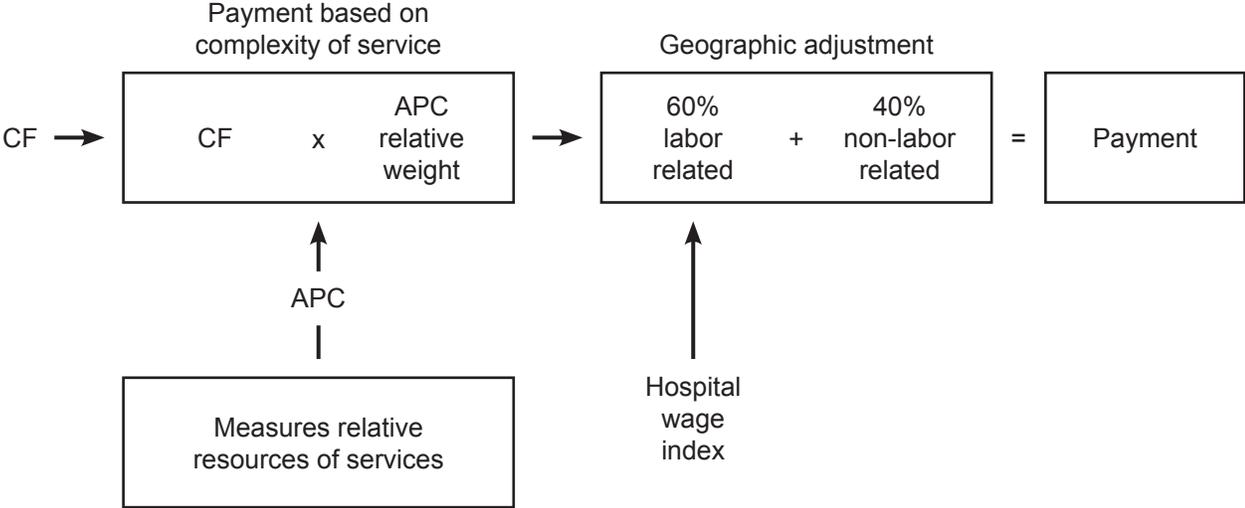
- ❖ Adding new pass-through drugs and/or devices;
- ❖ Adding new services and procedures to clinical and New Technology APCs;
- ❖ Recognizing new HCPCS codes added during the year; and
- ❖ Updating payment rates for separately payable drugs and biologicals based on the most recent available average sales price data.

However, the payments for items and services that are based on scaled relative weights are established annually and are generally not revised quarterly. Annual updates are made final through the publication of the OPSS final rules after review and response to public comments.

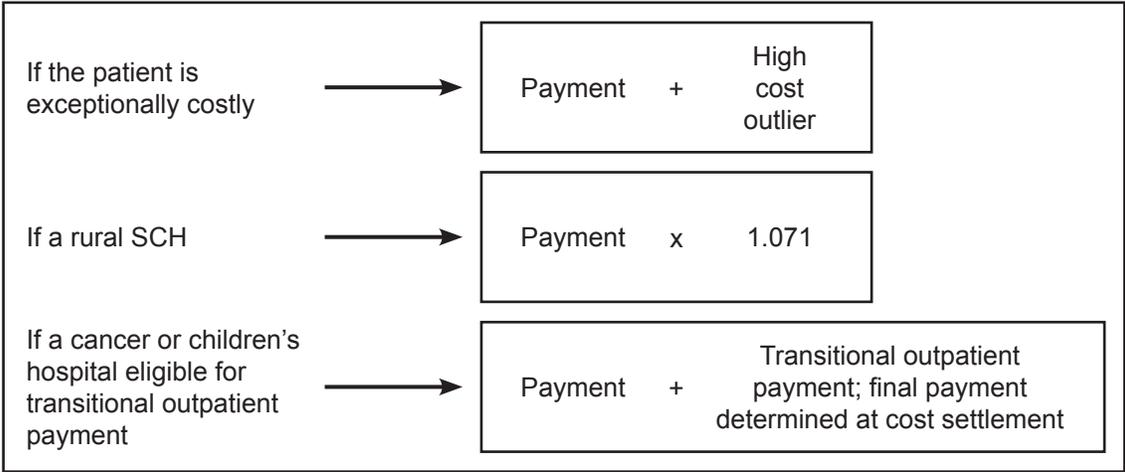
For more information about OPSS payment updates, refer to the [“CMS Finalizes Hospital Outpatient and Ambulatory Surgical Center Policy and Payment Changes, Including Changes to the Two-Midnight Rule and Quality Reporting for 2016”](#) Fact Sheet and the [“CY 2016 Hospital Outpatient Prospective Payment System \(OPSS\) Final Rule](#) with comment period on the CMS website.

Payment Rates

The chart below provides information about payment rates under the OPSS.



Special Exceptions



Hospital Outpatient Quality Reporting (OQR) Program

You must submit quality data for specific measures of quality of care to be eligible for the full OPD FS update. For more information about Hospital OQR Program requirements, visit <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1192804525137> on the QualityNet website.

Resources

The chart below provides Hospital OPPS resource information.

Hospital OPPS Resources

For More Information About...	Resource
Hospital OPPS	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS on the CMS website Chapter 4 of the “ Medicare Claims Processing Manual ” (Publication 100-04) on the CMS website
Compilation of Social Security Laws	https://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website
All Available Medicare Learning Network® (MLN) Products	“ MLN Catalog ” on the CMS website
Provider-Specific Medicare Information	MLN publication titled “ MLN Guided Pathways: Provider Specific Medicare Resources ” on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

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