



HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM



Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

TABLE OF CONTENTS

Background.....	3
Ambulatory Payment Classifications (APCs)	6
How Payment Rates Are Set.....	7
Payment Rates Under the OPPS.....	9
OQR Program.....	10
Resources	10

Learn about these Hospital Outpatient Prospective Payment System (OPPS) topics:

- Background
- Ambulatory payment classifications (APCs)
- How payment rates are set
- Payment rates under the OPPS
- Hospital Outpatient Quality Reporting (OQR) Program
- 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, a prospective payment system, as authorized by [Section 1833\(t\) of the Social Security Act \(the Act\)](#) and amended by Section 4533 of the Balanced Budget Act of 1997. It was implemented in calendar year 2000 and pays for:

- Designated hospital outpatient items and 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 not related to the terminal illness or related conditions 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 OPPS (such as outpatient therapy services and screening and diagnostic mammography). For more information about services excluded from payment under the OPPS, refer to Section 1833(t) of the Act and the Code of Federal Regulations (CFR) at [42 CFR 419.22](#).

The Balanced Budget Refinement Act of 1999 mandated these additional OPPS provisions:

- Established 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 OPPS
- Extended the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first date the OPPS is implemented

- Required annual update of payment weights, relative payment rates, wage adjustments, outlier payments, other adjustments, and APC groups
- Required annual consultation with an expert provider Advisory Panel for review and updating of APC groups
- Established 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
- Provided 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
- Provided payment under the OPSS for implantable devices, including durable medical equipment (DME), prosthetics, and DME used in diagnostic testing
- Established transitional corridor payments (also known as transitional outpatient payments [TOPs]) to limit providers' losses under the OPSS:
 - For 3 1/2 years for CMHCs (sunset December 31, 2003) and most hospitals
 - Permanently for cancer hospitals and
- Limited 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 these 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 these changes on how Medicare pays for drugs under the OPSS:

- For 2004 and 2005, enacted payment rates for many separately payable drugs tied to the drugs' average wholesale price as of May 1, 2003 (rates applied 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, paid separately payable drugs at the average hospital acquisition cost. If hospital acquisition cost data were not available, the drug would be paid based on one of several other methodologies, as calculated and adjusted by the Secretary of the Department of Health & Human Services.
- Adjusted APC weights for specified covered outpatient drugs to account for the costs hospitals incur in handling these drugs.

- Established separate APCs for drugs and biologicals costing 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 were packaged under the OPSS.
- Excluded separately paid drugs and biologicals from outlier payments.

The Affordable Care Act of 2010 included this change on certain preventive services:

- Effective January 1, 2011, waived 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 recommended with a grade of A or B by the U.S. Preventive Services Task Force.

The Bipartisan Budget Act of 2015 included this revision to the OPSS:

- Effective January 1, 2017, certain items and services furnished by off-campus provider-based departments (PBDs) are not considered covered outpatient services for purposes of OPSS payment. The items and services excepted from application of this payment change are those furnished:
 - By a dedicated emergency department (ED)
 - By an off-campus PBD billing for covered Outpatient Department (OPD) services furnished prior to November 2, 2015 (the date Section 603 of the Bipartisan Budget Act of 2015 was enacted), and has not impermissibly relocated or changed ownership or
 - In a PBD that is on the campus, or within 250 yards, of the hospital or a remote location of the hospital

Non-excepted items and services furnished in a non-excepted off-campus PBD on or after January 1, 2017, are paid under the Medicare Physician Fee Schedule.

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

- Effective January 1, 2002, hospitals providing 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 (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 (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 ED 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. The payment represents the cost of a day of intensive and structured outpatient mental health care in a partial hospitalization program provided in the hospital or in a CMHC. Beginning January 1, 2017, there is one APC (for furnishing three or more services per day) for partial hospitalization furnished by hospitals and one APC (for furnishing three or more services per day) for partial hospitalization furnished by CMHCs.

“Packaging,” or grouping payment of dependent, ancillary, supportive, and adjunctive items and services into the payment for the associated primary procedure or service, is a critical feature of the OPSS. Packaging encourages efficient use of hospital resources. Separate payments are not made for packaged services, which are considered an integral part of another service that is paid under the OPSS. These are some examples of usually packaged services:

- 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 functioning 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 not typically packaged under the OPSS. The single payment for a comprehensive APC excludes services that cannot be covered OPD services, cannot by statute be paid under the OPSS, and services separately paid as required by statute.

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. You can find national unadjusted payment rates and copayments for each HCPCS code, for which separate payment is made applying to the date of service, in the addendums CMS publishes on the [Hospital Outpatient Regulations and Notices webpage](#).

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 these payments in addition to standard OPSS payments:

- Pass-through payments for specific drugs, biologicals, and devices used in the delivery of services meeting 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 costing you much more than the payment rates for the services' APC groups. CMHCs have a separate outlier threshold from hospitals. Beginning January 1, 2017, outlier payments for each CMHC is capped at 8 percent of the CMHC's total per diem payments.
- Transitional outpatient payments for certain cancer hospitals and children's hospitals.
- An adjustment for certain cancer hospitals.
- 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 both a multifactor productivity adjustment and an additional 0.75 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
- Separately payable drugs and biologicals acquired under the 340B Program
- Brachytherapy sources
- Therapeutic radiopharmaceuticals and
- Services assigned to New Technology APCs

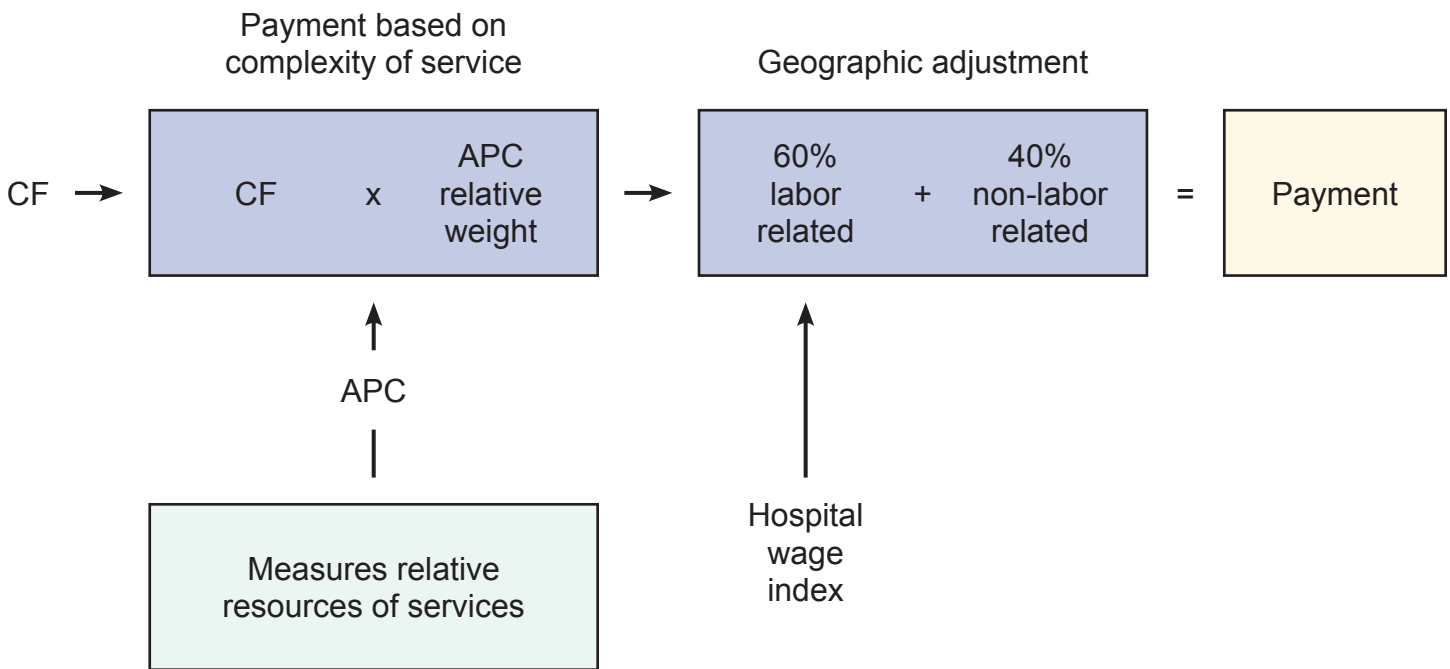
The OPSS payment files are updated on a quarterly basis to account for mid-year changes, such as:

- 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

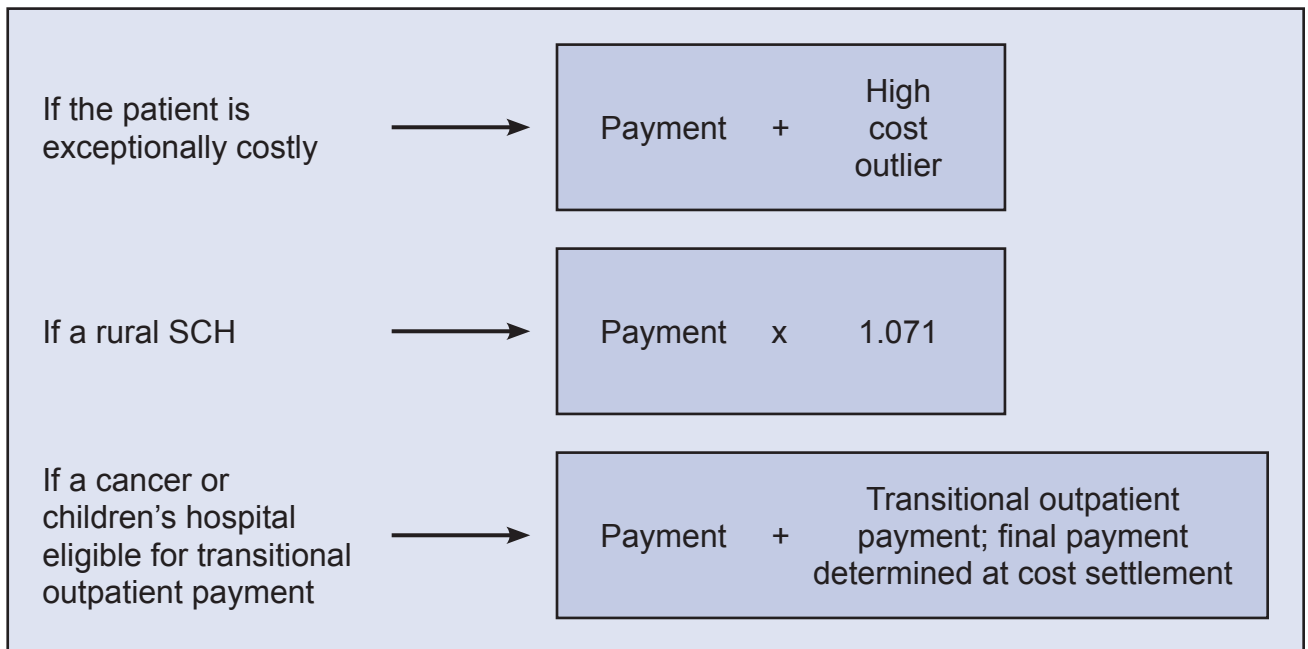
However, the payments for items and services based on scaled relative weights are established annually and are generally not revised quarterly. Annual updates are made final through the publication of the OPSS final rules after review and response to public comments.

For more information about OPSS payment updates, refer to [CMS Issues Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System and Quality Reporting Programs Changes for 2018](#) and [CY 2018 Hospital Outpatient Prospective Payment System \(OPSS\) Final Rule](#).

PAYMENT RATES UNDER THE OPPTS



Special Exceptions



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 the [CMS Hospital OQR Program webpage](#) and the [QualityNet Hospital OQR Program webpage](#).

RESOURCES

Hospital OPPS Resources

For More Information About...	Resource
Hospital OPPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS Chapter 4 of the Medicare Claims Processing Manual (Publication 100-04)
Compilation of Social Security Laws	SSA.gov/OP_Home/ssact/title18/1800.htm
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Link	Complete URL
Section 1833(t) of the Social Security Act (the Act)	https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t
42 CFR 419.22	https://www.ecfr.gov/cgi-bin/text-idx?SID=be41baebc3808313fca31adcccc2179f&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_122
Hospital Outpatient Regulations and Notices Webpage	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
CMS Issues Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System and Quality Reporting Programs Changes for 2018	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01-2.html

Hyperlink Table (cont.)

Embedded Link	Complete URL
CY 2018 Hospital Outpatient Prospective Payment System (OPPS) Final Rule	https://www.federalregister.gov/documents/2017/12/14/R1-2017-23932/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
CMS Hospital OQR Program Webpage	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html
QualityNet Hospital OQR Program Webpage	https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1192804525137
Chapter 4 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

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