DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

# Hospital Outpatient Prospective Payment System

## PAYMENT SYSTEM FACT SHEET SERIES

ICN 006820 December 2012

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

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

## 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 (CY) 2000 and pays for:

- Designated hospital outpatient services;
- Certain Medicare Part B services furnished to hospital inpatients who do not have Part A coverage;
- Partial hospitalization services furnished by hospitals or Community Mental Health Centers (CMHC);
- Hepatitis B vaccines and their administration, splints, casts, and antigens furnished by a Home Health Agency (HHA) to patients who are not under an HHA plan of treatment 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 OPPS (e.g., clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography). For more information about services that are excluded from payment under the OPPS, refer to Section 1833(t) of the Act and the "Code of Federal Regulations" at 42 CFR 419.22 located at http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR on the U.S. Government Printing Office website.

The Balanced Budget Refinement Act of 1999 mandated the following additional OPPS 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 OPPS;
- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first date the OPPS 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 OPPS 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 two years but not more than three years;
- Provide payment under the OPPS 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 [TOP]) to limit providers' losses under the OPPS 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 OPPS 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 OPPS:

- 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 regarding how Medicare pays for drugs under the OPPS:

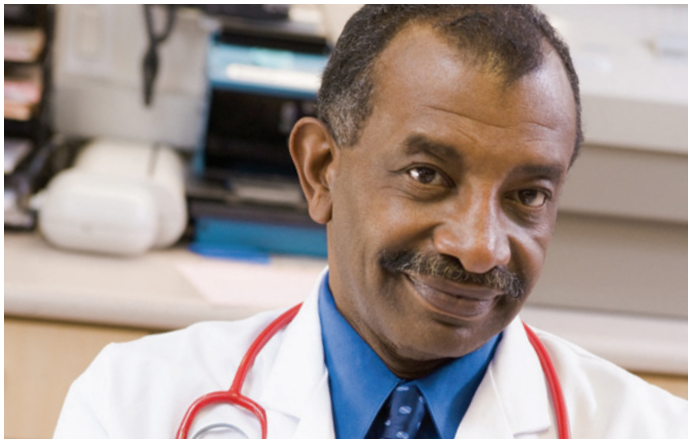
- For 2004 and 2005, enact payment rates for many separately payable drugs that were tied to the drugs' average wholesale price as of May 1, 2003 (rates apply to separately paid radiopharmaceuticals and drugs and biologicals that were pass-through items prior to January 1, 2003);
- For services furnished in 2006 and thereafter, pay separately payable drugs at the average hospital acquisition cost;
- May adjust APC weights for specified covered outpatient drugs to take into account 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; and
- Exclude separately paid drugs and biologicals from outlier payments.

The Affordable Care Act included the following changes regarding 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 OPPS applies to designated hospital outpatient services furnished in all classes of hospitals, with the exception of the following:

- Hospitals that only provide Part B services to inpatients (effective January 1, 2002);
- Critical Access Hospitals (CAH);
- 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 (APC)

In most cases, the unit of payment under the OPPS 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, the following:

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

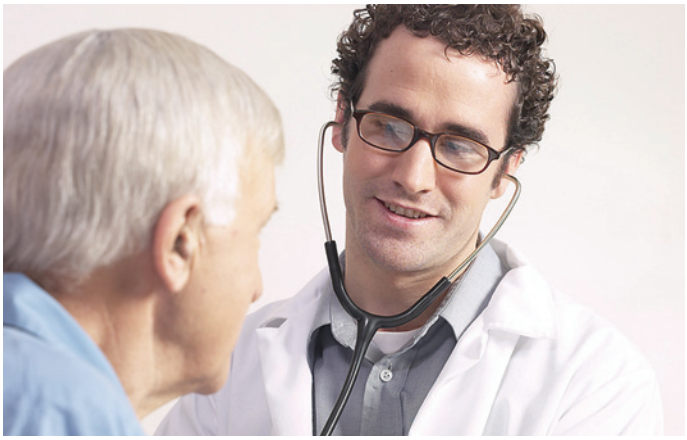
Partial hospitalization is paid on a per diem basis, with the payment rates dependent upon the number of individual services provided to the patient on one day. The payment represents the expected cost of a day of intensive outpatient mental health care in the hospital or in a CMHC. Beginning January 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 OPPS, 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 a packaged service, which is considered an integral part of another service that is paid under the OPPS. Some examples of usually packaged services are:

- Routine supplies;
- Anesthesia;
- Operating and recovery room use;
- Implantable medical devices (e.g., pacemakers);
- Inexpensive drugs under a per day drug threshold packaging amount ($80 in 2013);
- Guidance services;
- Image processing services;
- Intraoperative services;
- Imaging supervision and interpretation services;
- Diagnostic radiopharmaceuticals;
- Contrast agents; and
- Observation services.

## 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. CY 2013 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 the Addenda of the CY 2013 Hospital Outpatient Prospective Payment Final Rule with comment period (CMS-1589-FC). To access the final rule and addenda, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1589-FC.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 in which the hospital being paid is located. The remaining 40 percent is not adjusted. Hospitals may also receive the following payments in addition to standard OPPS 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 hospitals 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 (SCH), which includes Essential Access Community Hospitals that are 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 APC Advisory Panel; and
- Other relevant information.

The OPPS is a budget neutral payment system in which the CF is also updated annually by the Outpatient Department Fee Schedule (OPD 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 0.1 percentage points, resulting in an OPD FS increase factor of 1.8 percent for CY 2013. The CF update is further reduced by 2 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 the following:

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

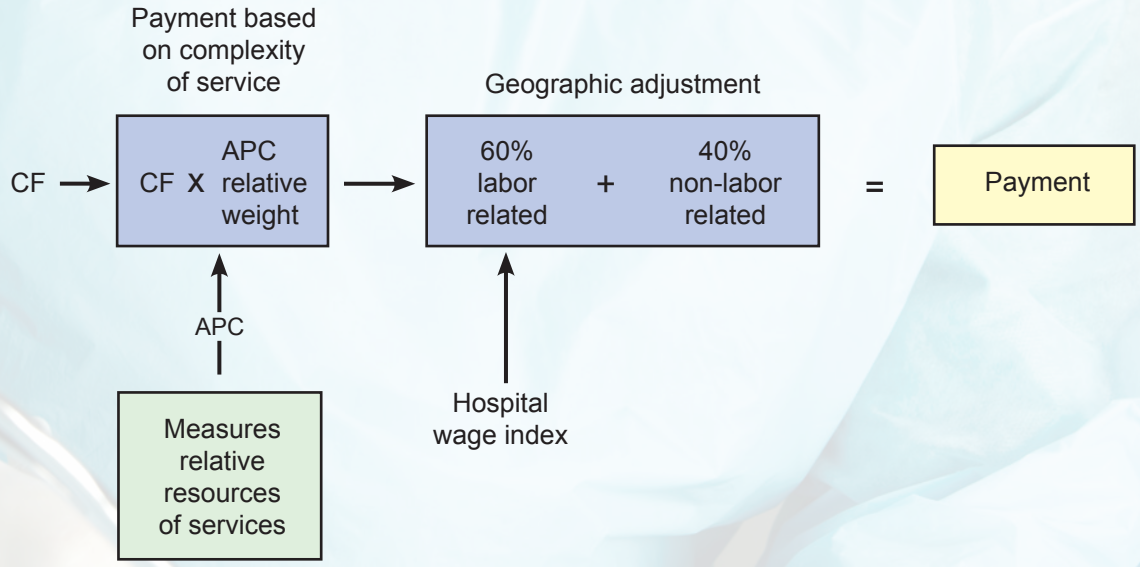
The OPPS payment files are updated on a quarterly basis to account for midyear changes such as:

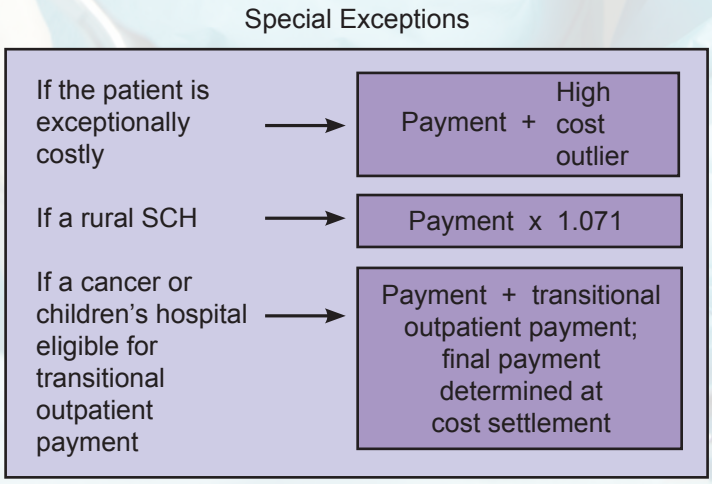
- Adding new pass-through drugs and/or devices;
- Adding new treatments and procedures to clinical and New Technology APCs;
- Recognizing new HCPCS codes that are added during the year; and
- Updating payment rates for separately payable drugs and biologicals based on the most recent available average 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 proposed and final rules in the "Federal Register" after review and response to the public comments.

## Payment Rates

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



## Hospital Outpatient Quality Reporting (OQR) Program

To be eligible for the full OPD FS update, hospitals must submit quality data for specific measures of care. For more information about Hospital OQR Program requirements, visit https://www.qualitynet.org on the QualityNet website.

## Resources

| For More Information About… | Resource |
|---|---|
| Hospital Outpatient Prospective Payment System | http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS on the CMS website<br><br>Chapter 4 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website |
| Compilation of Social Security Laws | http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website |
| The "Federal Register" | http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR on the U.S. Government Printing Office website |
| All Available Medicare Learning Network® (MLN) Products | "Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right |
| Provider-Specific Medicare Information | MLN publication titled "MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website |
| Medicare Information for Beneficiaries | http://www.medicare.gov on the CMS website |

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