



HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM



Target Audience: Medicare Fee-For-Service Providers

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

- Background
- Ambulatory payment classifications (APCs)
- Setting payment rates
- OPPS Payment rates
- Hospital Outpatient Quality Reporting (OQR) Program
- Resources

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) started the OPPS, authorized by Section 1833(t) of the Social Security Act (the Act), in 2000 to pay for:

- Designated hospital outpatient items and services
- Certain Medicare Part B services for hospital inpatients when Medicare cannot pay Part A

- Community Mental Health Centers (CMHCs) partial hospitalization services and certain inpatient hospital services paid by Medicare Part B
- Home Health Agency-furnished hepatitis B vaccines and their administration, splints, casts, and antigens for patients not under a home health plan of care or for hospice patients for treatment of non-terminal illness or related conditions
- An Initial Preventive Physical Examination (IPPE) within the first 12 months of Medicare Part B coverage

Medicare excludes payment for certain types of services from the OPSS, such as outpatient therapy services and screening and diagnostic mammography. Refer to [Section 1833\(t\)\(B\)\(iv\) of the Act](#) and the Code of Federal Regulations (CFR) at [42 CFR 419.22](#) for more information about these services.

The Balanced Budget Refinement Act of 1999 mandates these additional OPSS provisions:

- Establishes 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 prior to OPSS
- Extends the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs through the first OPSS start date
- Requires annual update of payment weights, relative payment rates, wage adjustments, outlier payments, other adjustments, and APC groups
- Requires an annual expert provider advisory panel consultation to review and update APC groups
- Establishes OPSS budget-neutral outlier adjustments based on charges adjusted to costs included on submitted outpatient bills for services before January 1, 2002, and thereafter based on individual services billed
- Provides transitional pass-through payments for additional costs of new and current medical devices, drugs, and biologicals for at least 2 years and less than 3 years
- Provides OPSS payment for implantable devices, including durable medical equipment (DME), prosthetics, and DME used in diagnostic testing
- Establishes transitional corridor payments (also known as transitional outpatient payments [TOPs]) to limit providers' OPSS losses for cancer hospitals
- Limits patient copayment for an individual OPSS service paid 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 includes the following OPSS revisions that are still in effect:

- Accelerates patient copayment reductions
- Establishes permanent transitional children's hospitals outpatient payments

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included these changes on how Medicare pays for OPPS drugs:

- Enacts 2004 and 2005 payment rates for many separately payable drugs tied to the drugs' average wholesale price (AWP) effective May 1, 2003 (applies rates to separately paid radiopharmaceuticals and drugs and biologicals formerly pass-through items prior to January 1, 2003)
- Pays drugs separately at the average hospital acquisition cost, beginning in 2006. If hospital drug acquisition cost data is unavailable, Medicare pays for them based on one of several methodologies calculated and adjusted by the Secretary of the Health & Human Services
- Adjusts APC weights for specific, covered outpatient drugs to account for handling costs hospitals incur
- Establishes separate APCs for drugs and biologicals costing at least \$50 per administration in 2005 and 2006 (drugs costing less were packaged). CMS updated the cost per day packaging threshold in 2007. OPPS packages items with a per day cost of less than or equal to \$125 for CY 2019
- Excludes outlier payments for separately paid drugs and biologicals

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

- Medicare pays for covered preventive services, starting January 1, 2011, and there is no coinsurance or deductible for any U.S. Preventive Services Task Force recommended grade A or B preventive service

The Bipartisan Budget Act of 2015 included this OPPS revision:

- Effective January 1, 2017, OPPS no longer covers certain outpatient off-campus provider-based departments' (PBDs) items and services and these items and services are instead paid under the Medicare Physician Fee Schedule (PFS). However, items and services furnished in the following outpatient settings are exempt from this provision:
 - By a dedicated emergency department (ED)
 - In a PBD on campus or within 250 yards of the hospital or a remote hospital location
 - By an off-campus PBD billing for covered Outpatient Department (OPD) services furnished before November 2, 2015 (the date Section 603 of the Bipartisan Budget Act of 2015 was enacted), and has not impermissibly relocated or changed ownership

OPPS payment applies to designated hospital outpatient services furnished in all classes of hospitals, except:

- 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, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands
- Hospitals in Maryland and those paid under Maryland All-Payer Model

AMBULATORY PAYMENT CLASSIFICATIONS (APCS)

APCs are the OPPTS unit of payment in most cases. CMS assigns individual services (HCPCS codes) to APCs based on similar clinical characteristics and similar costs. The APC payment rate and copayment calculated apply to each service within the APC.

Until cost data are available to permit assignment to a clinical APC, new services are sometimes assigned to New Technology APCs based only on similarity of resource use. A New Technology APC payment rate is set at midpoint of the applicable New Technology APC's cost range.

Medicare pays some services separately, including but not limited to:

- Many surgical, diagnostic, and non-surgical therapeutic procedures
- Blood and blood products
- Most clinic and ED visits
- Some drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Corneal tissue acquisition costs
- Certain preventive services

Medicare pays partial hospitalization on a per diem basis. The payment represents the expected daily cost of care in facilities, hospital outpatient departments, and CMHCs. Beginning in 2017, CMS replaced the formerly two-tiered APC structure for partial hospitalizations with a single APC by provider type for furnishing three or more services per day.

“Packaging,” or grouping integral, ancillary, supportive, dependent and adjunctive services into the payment for the associated primary procedure or service, is a critical OPPTS feature. Packaging encourages better use of hospital resources. Medicare makes no separate packaged service payments. Some types of packaged items and services include:

- 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
- Observation services

Starting in 2015, CMS established comprehensive APCs to provide all-inclusive payments for certain procedures. The 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 does not include services that cannot be covered OPD services, services that cannot be paid under the OPSS by statute, and services that are separately paid as required by statute.

SETTING PAYMENT RATES

CMS determines separately payable medical and surgical payment rates by multiplying the service's clinical APC, prospectively established scaled **relative weight** by a **conversion factor (CF)** to arrive at a national unadjusted APC **payment rate**. The relative weight for an APC measures the resource service needs and is based on the APC geometric mean services cost.

The CF translates the scaled relative weights into dollar payment rates. Refer to the [Hospital Outpatient Regulations and Notices](#) webpage for the national unadjusted payment rates and copayments for each HCPCS code in the addendums section of each rulemaking page.

To account for geographic differences in input prices, CMS further adjusts the labor portion of the national unadjusted payment rate (60 percent) by the hospital wage index for the area where payment is made. CMS does not adjust the remaining 40 percent.

Hospitals may receive the following payments added to standard OPSS payments:

- Pass-through payments for specific drugs, biologicals, and devices in delivering services that meet the criteria for pass-through status (these items are generally too new to have the data needed to set payment rates)
- Outlier payments for individual services that cost hospitals much more than the services' APC group payment rates
 - CMHCs receive a separate capped outlier threshold from hospitals
- 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 by Sole Community Hospitals (SCHs) including Essential Access Community Hospitals located in rural areas

The annual review of APCs and their relative weights considers:

- Changes in hospital and medical practices
- Changes in technology
- Adding new services and taking away obsolete services
- New cost data
- Hospital Outpatient Payment Panel recommendations
- Other relevant information

OPPS is a budget-neutral payment system where the CF is updated annually by the OPD Fee Schedule (FS) increase factor unless Congress stipulates otherwise. Following Affordable Care Act requirements, CMS calculates the OPD FS increase factor by reducing the hospital market basket update by a multi-factor productivity adjustment and an additional 0.75 percentage points.

CMS further updates the CF by reducing it by 2.0 percentage points for hospitals failing to meet OQR Program reporting requirements for the update year. This can result in reduced payment for most of their services. CMS creates payment rates through alternative methods for certain other items and services categories, such as:

- Separately payable drugs and biologicals
- Separately payable drugs and biologicals acquired under the 340B Program
- Brachytherapy sources
- Therapeutic radiopharmaceuticals
- Services assigned to New Technology APCs

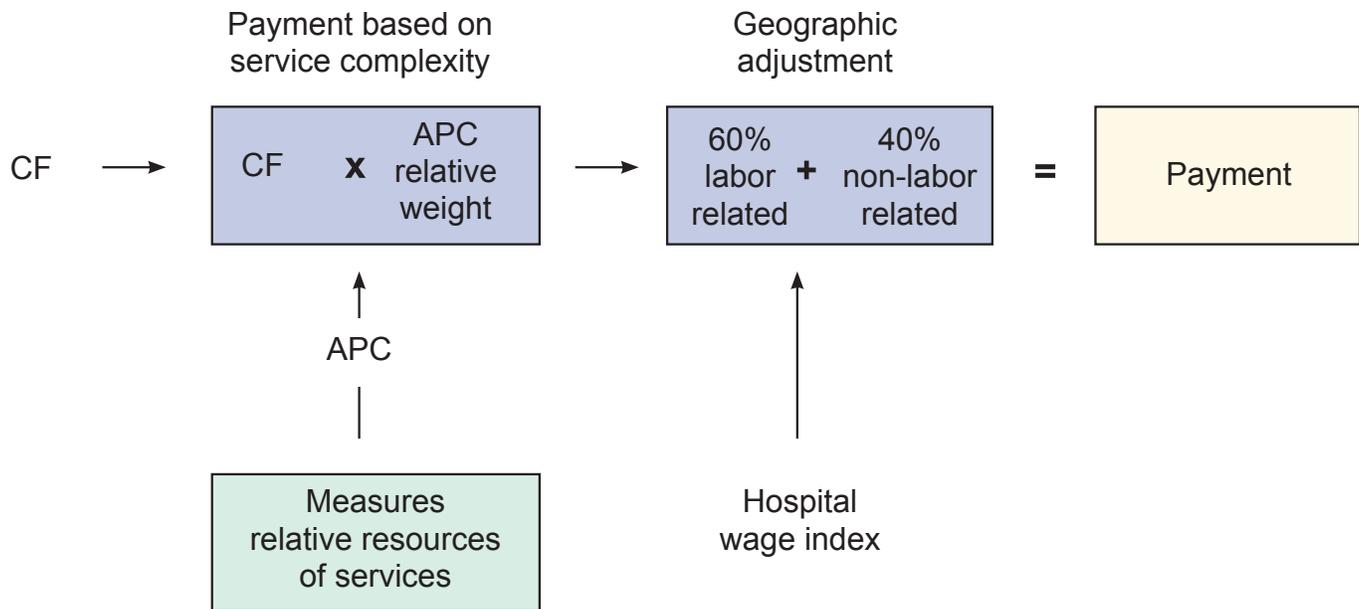
CMS updates OPPS payment files quarterly to account for mid-year changes, such as:

- 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
- Updating payment rates for separately payable drugs and biologicals based on the most recent available average sales price data

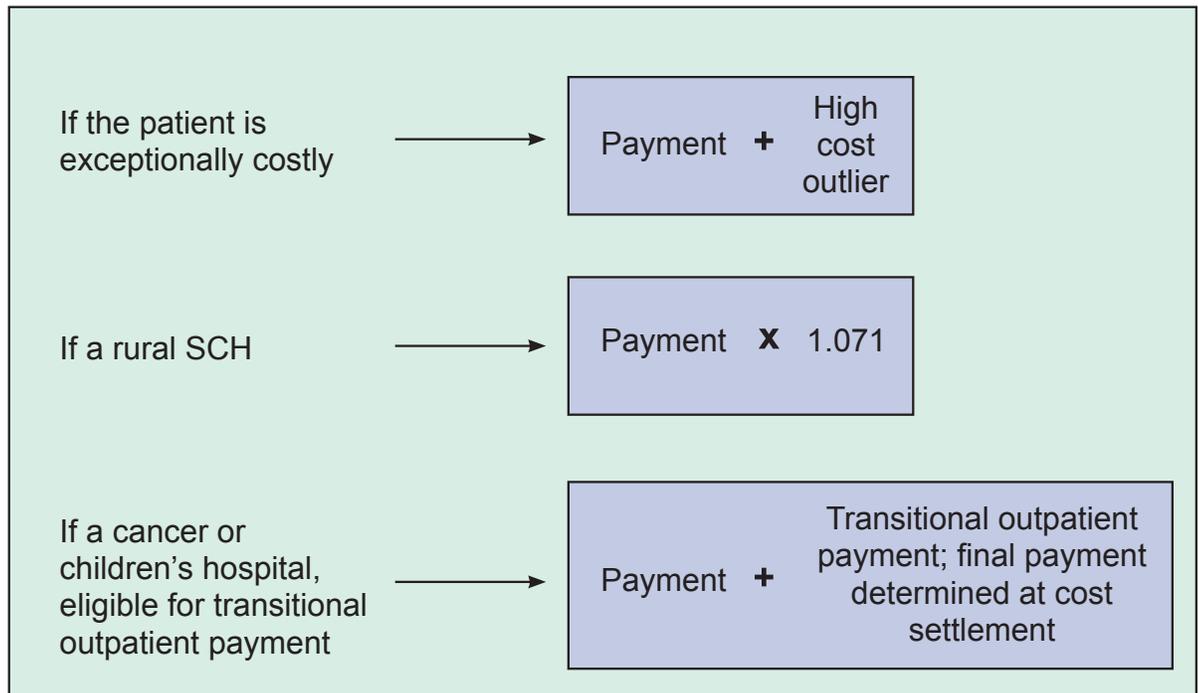
However, CMS establishes the payments for items and services based on scaled relative weights annually and generally does not update them quarterly. After review and response to public comments, CMS finalizes annual updates and publishes them in the OPPS final rules.

Effective in 2019, CMS is applying a PFS-equivalent payment rate for the clinic visit service when provided at an off-campus PBD that is paid under the OPPS. The clinic visit is the most common service billed under the OPPS. Refer to the [CY 2019 Hospital OPPS Final Rule](#) for more information about OPPS payment updates.

OPPS PAYMENT RATES



Special Exceptions



HOSPITAL OQR PROGRAM

Hospitals qualify for the full OPD FS update by submitting required quality data for specific quality of care measures. Visit the [Hospital OQR Program](#) and [QualityNet Hospital OQR Program](#) webpages for more information about Hospital OQR Program requirements.

RESOURCES

Hospital OPPS Resources

For More Information About...	Resource
Hospital OPPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
Medicare Learning Network® (MLN) Catalog	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR 419.22	https://www.ecfr.gov/cgi-bin/text-idx?SID=be41baebc3808313fca31adccc2179f&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_122
CY 2019 Hospital OPPS Final Rule	https://www.federalregister.gov/d/2018-24243
Hospital OQR Program	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html
Hospital Outpatient Regulations and Notices	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
QualityNet Hospital OQR Program	https://www.qualitynet.org/dcs/ContentServer?c=Page&pageName=QnetPublic%2FPage%2FQnetTier1&cid=1192804525137
Section 1833(t)(B)(iv) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1833.htm#act-1833-t

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