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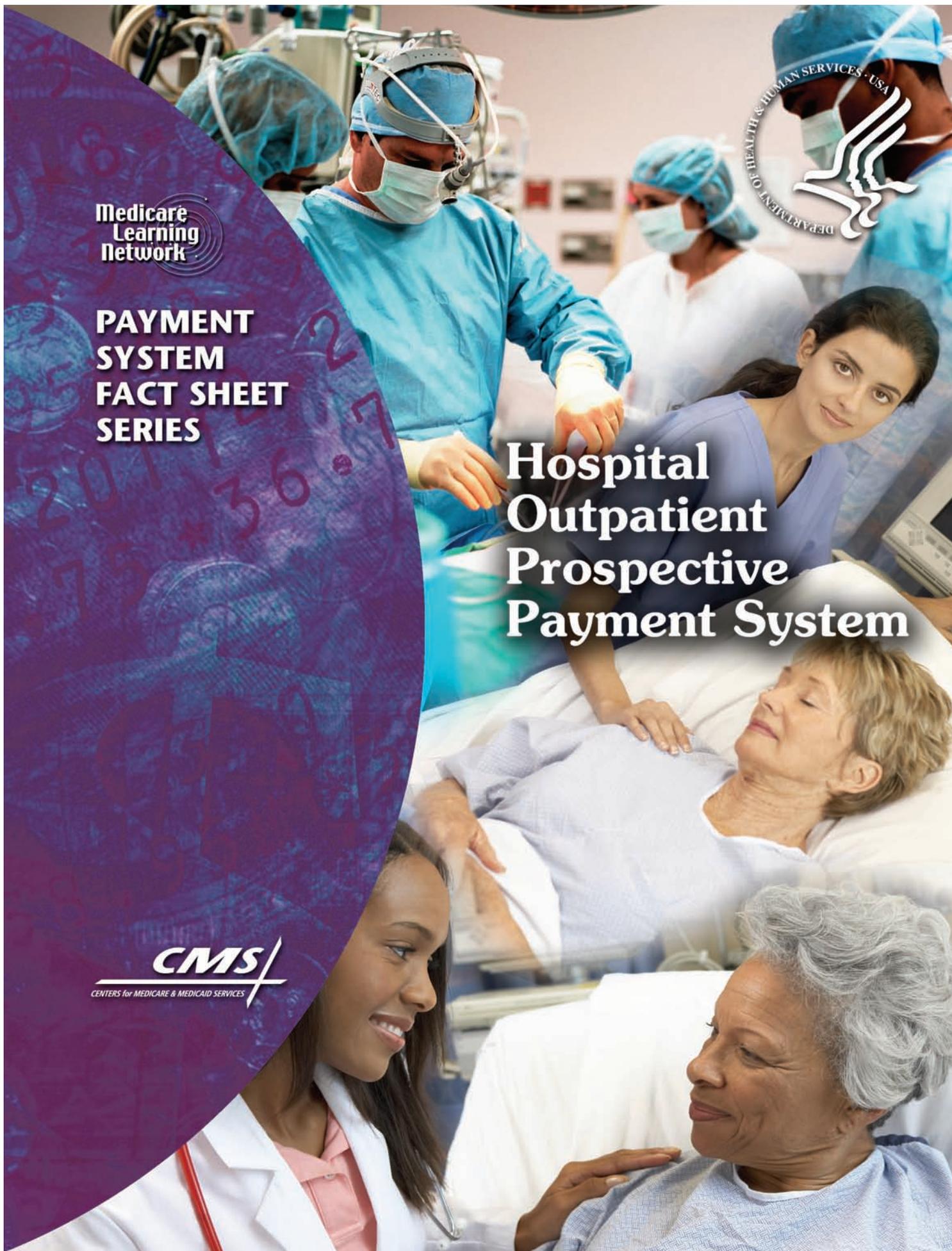
**PAYMENT
SYSTEM
FACT SHEET
SERIES**



Hospital Outpatient Prospective Payment System



CMS
CENTERS for MEDICARE & MEDICAID SERVICES



On August 1, 2000 the Centers for Medicare & Medicaid Services began using the **Outpatient Prospective Payment System (OPPS)**, which was authorized by §1833(t) of the Social Security Act as amended by §4533 of the Balanced Budget Act of 1997, for:

- Hospital outpatient services including partial hospitalization 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 Home Health Agencies that furnish medical and other health services; and
- Splints, casts, and antigens furnished to hospice patients for treatment of non-terminal illness.



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 as beneficiary 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 ambulatory payment classification (APC) groups;
- Require annual consultation with an expert provider Advisory Panel for review and update 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 payments to limit providers' losses under the OPPS as follows:
 - Three and one-half years for CMHCs and most hospitals
 - Permanently for cancer hospitals; and
- Limit beneficiary coinsurance 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 beneficiary copayments;
- Increase in market basket update for 2001;
- Transitional corridor provision for transitional outpatient payments for providers that did not file 1996 cost reports; and
- Special transitional corridor treatment 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, enacted payment rates for many separately payable drugs that are 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 2006, separately payable drugs will be paid at the average acquisition cost.

- APC weights for specified covered outpatient drugs may be adjusted to take into account the costs hospitals incur in handling these drugs;
- Separate APCs will be established for drugs and biologicals that cost at least \$50 per administration in 2005 and 2006; and
- Separately paid drugs and biologicals will be excluded from outlier payments.



The OPPS applies to all hospital outpatient departments except 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 Commonwealth of the Northern Mariana Islands;
- Effective January 1, 2002, hospitals located in the Virgin Islands; and
- Certain hospitals in Maryland that are paid under Maryland waiver provisions.

AMBULATORY PAYMENT CLASSIFICATIONS

In most cases, the unit of payment under the OPPS is the individual service or procedure as assigned to APC groups based on clinical and cost similarity. The payment rate and coinsurance calculated for an APC apply to all services within the APC. Some new services are assigned to new technology APCs, which are based on similarity of resource use only, for a period of two to three years until clinical and cost data are available to permit assignment into a clinical APC. The payment rate for a new technology APC is set at the midpoint of its cost range.

Within each APC, payment for integral items and services is packaged into payment for the primary service. Separate payments are not made for packaged services, which are considered an integral part of another service that is paid under the OPPS. Some examples of packaged services are:

- Routine supplies;
- Anesthesia;
- Operating and recovery room use;
- Implantable medical devices such as pacemakers;
- Inexpensive drugs under a per day drug threshold packaging amount (\$60 in 2008);
- Guidance services;
- Image processing services;
- Intraoperative services;
- Imaging supervision and interpretation services;
- Diagnostic radiopharmaceuticals;
- Contrast agents; and
- Observation services.

Some services are paid separately, such as:

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

Partial hospitalization is paid on a per diem basis. The payment represents the expected cost of a day of intensive mental health care in hospitals, CAHs, and CMHCs.

HOW PAYMENT RATES ARE SET

The payment rates for most separately payable medical and surgical services are determined by multiplying the relative weight for the service's clinical APC by a conversion factor (CF). The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. The CF translates the relative weights into dollar payment rates. To account for geographic differences in input prices, the labor portion of the CF (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 new technologies such as specific drugs, biologicals, and devices used in the delivery of services that are 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;
- Hold-harmless payments for cancer hospitals, children's hospitals, and from January 1, 2006 through December 31, 2009, rural hospitals with 100 or fewer beds that are not Sole Community Hospitals (SCH); and
- Increased payment of 7.1 percent for most services furnished by SCHs located in rural areas.

The annual review of APCs and their relative weights considers:

- Changes in medical practice;
- Changes in technology;
- Addition of new services;
- New cost data;
- Consultation with the APC Advisory Panel; and
- Other relevant information.

The OPSS is a budget neutral payment system in which the CF is also updated annually by the hospital

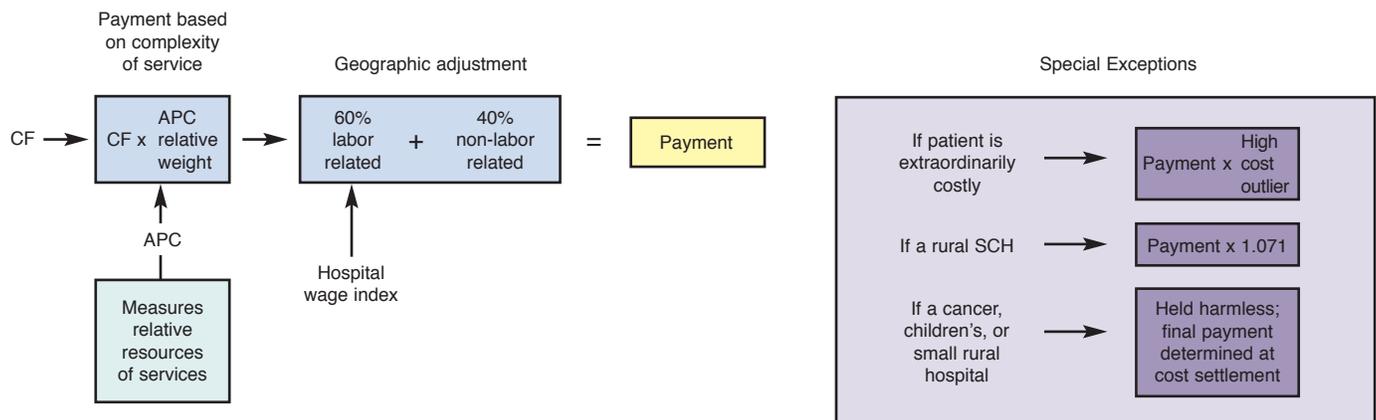
market basket index unless Congress stipulates otherwise. Payment rates for certain other categories of items and services, including separately payable drugs and biologicals, brachytherapy sources, therapeutic radiopharmaceuticals, and services assigned to new technology APCs, are established through alternative methodologies that are applicable to the payment year.

The OPSS is updated on a quarterly basis to account for mid-year changes such as:

- Adding new pass-through drugs and/or devices;
- Adding new treatments and procedures to clinical and new technology APCs;
- Recognizing new Healthcare Common Procedure Coding System codes that may be added during the year; and
- Updating payment rates for separately payable drugs and biologicals based on the most recent available average sales price data.

Annual updates are made final through the publication of proposed and final rules in the **Federal Register**, which can be accessed at <http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#> on the CMS website. To find additional information about the OPSS, visit http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp on the CMS website.

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