OUTPATIENT HOSPITAL SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2014

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to complex procedures that require anesthesia. Spending for these services has grown rapidly, largely because of changes in technology and medical practice that have led to new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for $37 billion of total Medicare program spending in 2013.

Medicare originally based payments for outpatient care on hospitals' costs, but the Centers for Medicare & Medicaid Services (CMS) began using the outpatient prospective payment system (OPPS) in August 2000. In 2013, about 3,800 hospitals provided OPPS services,[1] and about 50 percent of fee-for-service beneficiaries received at least one OPPS service.[2]

Under the cost-based system that preceded the OPPS, coinsurance had become nearly 50 percent of Medicare payments to hospitals for outpatient care. Under the OPPS, coinsurance declines each year as a share of total OPPS payments until it reaches 20 percent. In 2013, beneficiaries' copayments accounted for 21 percent of total payments under the OPPS.

The OPPS sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices. Hospitals also can receive additional payments in the form of outlier adjustments for extraordinarily high-cost services and pass-through payments for some new technologies.

When CMS began using the OPPS, the new payment system had the potential to substantially reduce hospital payments below the amounts under the cost-based system. In response, the Congress partially protected hospitals that experienced financial losses by providing "transitional corridor" and "hold harmless" provisions. The Congress has legislated permanent hold-harmless status to cancer and children's hospitals. In addition, beginning in 2006, rural sole community hospitals (SCHs) receive an additional 7.1 percent above standard payment rates on all OPPS services except drugs and biologicals. Also, beginning in 2012, cancer hospitals receive proportional adjustments to their OPPS payment rates so that the ratio of OPPS payments to OPPS costs (the payment-to-cost ratio (PCR)) for each cancer hospital is equal to the average PCR among all other hospitals providing services under the OPPS.

Defining the outpatient hospital products that Medicare buys

The unit of payment under the OPPS is the individual service as identified by Healthcare Common Procedure Coding System codes. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate. In addition, CMS assigns some new services to "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data the agency used to develop the initial payment rates for the OPPS. Services remain in these APCs for two to three years, while CMS collects the data necessary to develop payment rates for them. Each year CMS determines which new services, if any, should be placed in new technology APCs. Payments for new technology APCs are not subject to budget neutrality adjustments, so they increase total OPPS spending.

This document does not reflect proposed legislation or regulatory actions.

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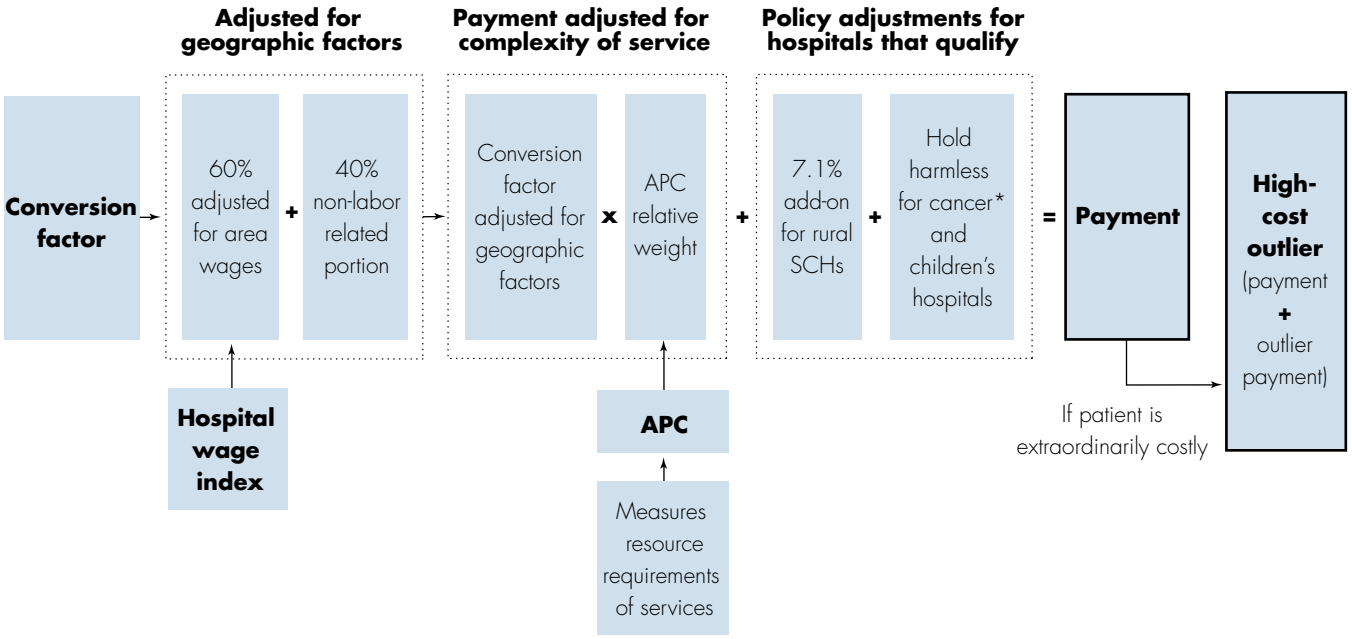
Figure 1 Hospital outpatient services prospective payment system



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system. *Medicare adjusts outpatient prospective payment system payment rates for 11 cancer hospitals so that the payment-to-cost ratio (PCR) for each cancer hospital is equal to the average PCR for all hospitals.

Within each APC, CMS packages integral services and items with the primary service. In deciding which services to package, CMS considers comments from hospitals, hospital suppliers, and others. In response to these comments, CMS pays separately for:

- corneal tissue acquisition costs,
- blood and blood products, and
- many drugs.

In 2008, CMS expanded the list of services—including observation services—that are packaged into the payment for the associated primary service. CMS further expanded the set of packaged items in 2014. The intent of this expanded packaging was to give hospitals more incentive to consider the cost of the package of services used to treat a patient during an outpatient visit. Under greater packaging, hospitals whose costs exceed the payment rate for a package of services have an incentive to evaluate their treatment methods to identify lower cost alternatives for providing care.

While CMS makes most OPPS payments on a per service basis, CMS pays for partial hospitalizations on a per diem basis. The per diem rate represents the expected costs for a day of care in the facilities that provide these services, hospital outpatient departments and community mental health centers.

Setting the payment rates

CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a conversion factor (Figure 1). The 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. CMS pays separately for professional services, such as physician services.

The conversion factor translates the relative weights into dollar payment rates.

To account for geographic differences in input prices, CMS adjusts the labor portion of the conversion factor (60 percent) by the hospital wage index. CMS does not adjust the remaining 40 percent.

CMS initially set the conversion factor so that projected total payments—including beneficiary copayments—would equal the estimated amount that would have been spent under the old payment system, after correcting for some anomalies in statutory formulas.

One exception to CMS's method for setting payment rates is the new technology APCs. Each new technology APC encompasses a cost range, the lowest being for services that cost $0 to $10, the highest for services that cost $9,500 to $10,000. CMS assigns services to new technology APCs on the basis of cost information collected from applications for new technology status. CMS sets the payment rate for a new technology APC at the midpoint of its cost range.

Hospitals can receive three payments in addition to the standard OPPS payments:

- pass-through payments for new technologies,
- outlier payments for unusually costly services, and
- hold-harmless payments for cancer hospitals and children's hospitals.

In addition to new technology APCs, pass-through payments are another way that the OPPS accounts for new technologies. In contrast to new technology APCs—which are payments for individual services—pass-through payments are for specific drugs, biologicals, and devices that providers use in the delivery of services. The purpose of pass-through payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS payment rates. For pass-through devices, CMS bases payments on each hospital's costs, determined by adjusted charges to costs using a cost-to-charge ratio.

Total pass-through payments cannot be more than 2 percent of total OPPS payments in 2004 and beyond. Before the start of each calendar year, CMS estimates total pass-through spending. If this estimate exceeds 2 percent of estimated total OPPS payments, the agency must reduce all pass-through payments in that year by a uniform percentage to meet the 2 percent threshold. Also, CMS adjusts the conversion factor to make pass-through payments budget neutral.

CMS makes outlier payments for individual services that cost hospitals much more than the payment rates for the services' APC groups. In 2014, CMS defines an outlier as a service with costs that exceed 1.75 times the APC payment rate and exceed the APC payment rate by at least $2,900. For a service meeting both thresholds, CMS will reimburse the hospital for 50 percent of the difference between the cost of furnishing the service and 1.75 times the APC rate. For 2014, CMS is limiting aggregate outlier payments to 1 percent of total OPPS payments. CMS will make the outlier payments budget neutral by reducing the conversion factor in the OPPS by 1 percent.

The OPPS has permanent hold-harmless status for cancer and children's hospitals. If PPS payments for these hospitals are lower than those they would have received under previous policies, CMS provides additional payments to make up the difference. Also, CMS makes hospital-specific proportional adjustments to the OPPS payment rates received by cancer hospitals so that the PCR of each cancer hospital equals the average PCR among all other hospitals that provide services under the OPPS. Finally, CMS adds 7.1 percent to the OPPS payments for services furnished by rural SCHs beginning in 2006, excluding drugs and biologicals. CMS makes these additional payments to cancer hospitals and rural SCHs budget neutral by applying the same proportional reduction to payments for all other hospitals.[3]

CMS reviews and revises the APCs and their relative weights annually. The review considers changes in medical practice, changes in technology, addition of new services, new cost data, and other relevant information. The Balanced Budget Refinement Act of 1999 requires CMS to consult with a panel of outside experts as part of this review. CMS also annually updates the conversion factor by the hospital market basket index minus a multi-factor productivity adjustment.[4]

Drugs and biologicals whose costs exceed a threshold ($90 per day in 2014) have separate APCs; these separately paid drugs and biologicals do not receive outlier payments. ■

1 The number of hospitals providing services under the OPPS differs between this document and Chart 7-11 of MedPAC's June 2014 Data Book because we include all hospitals in this document while our data book is limited to short-term hospitals.

2 This includes beneficiaries who received services that are covered under the OPPS but received those services in critical access hospitals.

3 For cancer hospitals, CMS first determines their OPPS payments with the additional payments then determines their hold-harmless payments based on those augmented payments.

4 For 2012 through 2019, the Patient Protection and Affordable Care Act further reduces the update. In 2014, the additional reduction is 0.3 percent.