OUTPATIENT HOSPITAL SERVICES PAYMENT SYSTEM

*payment***basics**

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The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to complex procedures that require anesthesia. Spending per Medicare Part B beneficiary for these services has grown rapidly at an annual rate of 6.9 percent from 2012 to 2022 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, acquisition of physician practices by hospitals, and the increase in physicians being employed by hospitals. Medicare spent $62 billion on outpatient care in all hospitals except for Indian Health Service in 2024.

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 2022, about 3,700 hospitals provided OPPS services,[1] and about 50 percent of fee-for-service beneficiaries received at least one OPPS service. In 2022, beneficiaries' copayments accounted for 17 percent of total payments under the OPPS.[2]

Defining the outpatient hospital care that Medicare buys

Medicare's payments under the OPPS are intended to cover the facility's portion of services provided in hospital outpatient departments (HOPDs), including nursing services, medical supplies, equipment, and rooms. CMS pays separately for professional services, such as physician services, that may be provided during an outpatient visit. Under the OPPS, hospitals bill Medicare for services defined by Healthcare Common Procedure Coding System codes. CMS classifies groups of those service codes 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 established new-technology APCs because some services are too new to be represented in the data the agency uses to set payment rates for standard APCs in the OPPS. Services remain in these APCs until CMS believes it has adequate data from hospitals to accurately represent the services' costs in standard APCs, usually two to three years. Each year, CMS determines which new services, if any, should be placed in new-technology APCs.

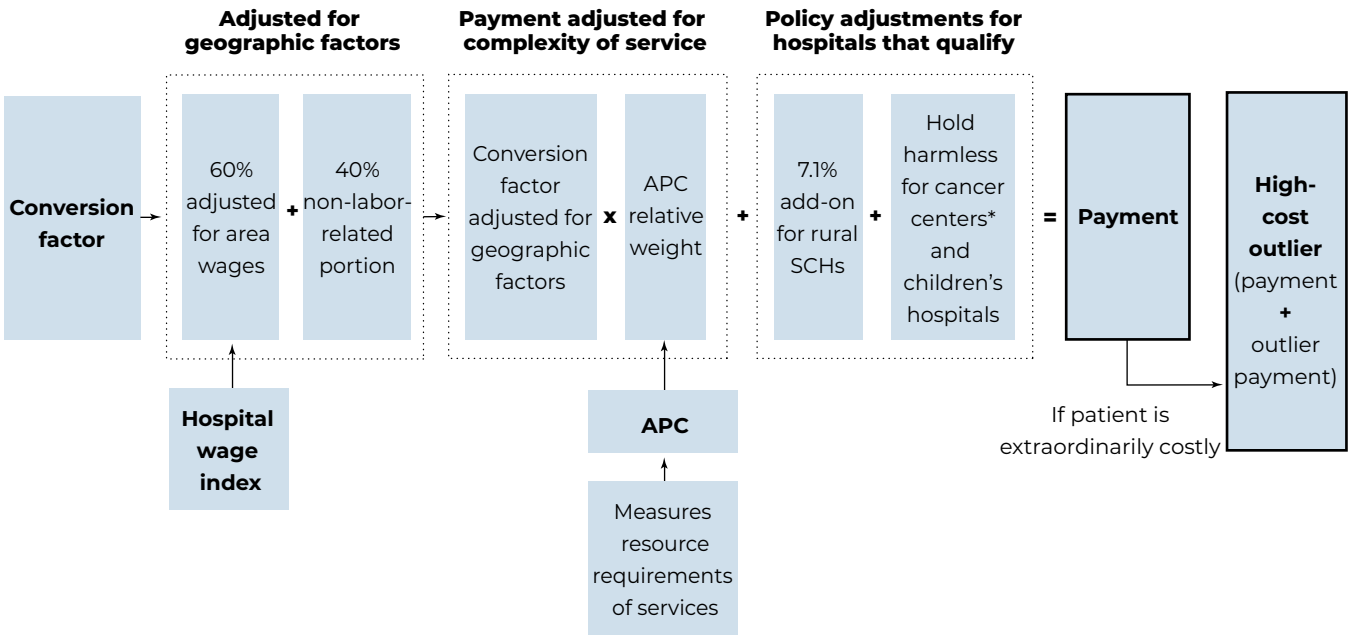
Within each APC, CMS packages integral services and items with the primary service—meaning that hospitals receive a single fixed payment for all items and services in the package. In deciding which services to package, CMS considers comments from hospitals, hospital suppliers, and others. In response to these comments, CMS pays separately for:

- corneal tissue acquisition costs,
- blood and blood products, and
- drugs and biologics whose costs exceed a threshold ($135 per day in 2024).

The intent of packaging is 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—particularly those with costs that exceed the payment rate for a package of services—have an incentive to evaluate their treatment methods to identify lower-cost alternatives to providing care.

Under the OPPS, a single payment, called a composite payment, is made for certain combinations of services that would otherwise be paid under separate APCs when they are provided on the same date of service. A single composite payment is also made when two or more related ultrasound,

Figure 1 Hospital outpatient services prospective payment system, 2024



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 rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals minus 1 percentage point.

MRI, or CT services are provided in the same outpatient visit. Comprehensive APCs (C–APCs) typically encompass larger payment bundles than do composite APCs. The idea is to provide single payments for entire outpatient encounters by combining a primary service and all other services provided during the same outpatient visit—including services that would otherwise be separately payable under the OPPS—into a single payment. However, some items and services, such as pass-through devices and drugs (see below), are required by statute to be paid separately under the OPPS. Therefore, these items and services cannot be part of a C–APC payment bundle.

While CMS makes most OPPS payments on a per service basis, CMS pays for partial hospitalizations on a per diem basis.[3] 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 wage-adjusted conversion factor (Figure 1). The relative weight for an APC measures the resource use requirements of the service relative to a clinic visit and is based on the geometric mean cost of services in that APC. (The costs associated with professional services, such as physician services, are not included.)

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. For 2024, the OPPS conversion factor is $87.38. However, hospitals must submit data on a set of standardized quality measures to receive

payments based on the full conversion factor. For hospitals that do not submit these data, the conversion factor is reduced by 2 percent to $85.69.

Payments for new technologies—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 $145,000 to $160,000. CMS assigns services to new-technology APCs on the basis of cost information collected from applications for new-technology status.[4] CMS sets the payment rate for a new-technology APC at the midpoint of its cost range. Payments for new-technology APCs are not subject to budget-neutrality adjustments, so they increase total OPPS spending.

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, biologics, 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 charges adjusted to costs using a cost-to-charge ratio. Pass-through drugs, biologics, and devices can have pass-through status for two to three years. After that period, pass-through drugs and biologics are either packaged into the payment rate of the applicable service(s) or are granted separately payable status (depending on their cost per day) while pass-through devices are packaged into the payment rate of the applicable service(s).

Total pass-through payments cannot be more than 2 percent of total OPPS payments. 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.

Site-neutral payments—Section 603 of the Bipartisan Budget Act of 2015 (BBA 15) requires CMS, beginning in 2017, to adjust the OPPS payments to certain off-campus provider-based departments (PBDs) of hospitals so that those payments equal payments that would occur under the Medicare physician fee schedule (PFS). In general, the PFS payment rates are lower than the OPPS payment rates. Off-campus PBDs that are excepted from the rules of BBA 15 (excepted PBDs) are largely those that were billing services under the OPPS before the Congress passed BBA 15 on November 2, 2015. The off-campus PBDs that must comply with BBA 15 (nonexcepted PBDs) are largely those that were not billing under the OPPS before November 2, 2015.

Most of the OPPS services provided in off-campus PBDs occur in excepted PBDs. However, CMS implemented a policy in 2019 that requires OPPS payments for clinic visits provided in all off-campus PBDs to be paid the PFS-equivalent rate, which is 40 percent of the standard OPPS rate. This change in policy is important because clinic visits are by far the most frequently billed services in off-campus PBDs.

Outlier payments—CMS makes an outlier payment when a hospital provides a service and incurs costs that are much higher than the payment rate for the service's APC. In 2024, 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 $7,750. 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. Outlier payments are financed by a prospective offsetting reduction to the conversion factor. For 2024, CMS limited aggregate outlier payments to 1 percent of total OPPS

payments, and accordingly reduced the conversion factor by 1 percent.

Hold-harmless payments—The OPPS has permanent hold-harmless status for 11 cancer centers and for children's hospitals. If OPPS 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 the 11 cancer centers so that the ratio of OPPS payments to OPPS costs (the payment-to-cost ratio (PCR)) of each cancer center equals the average PCR among all other hospitals that provide services under the OPPS minus 1 percentage point.[5] Finally, CMS adds 7.1 percent to the OPPS payments for services furnished by rural sole-community hospitals (SCHs) beginning in 2006, excluding drugs and biologics. CMS makes these additional payments to cancer centers and rural SCHs budget neutral by applying the same proportional reduction to payments for all other hospitals.

Payment updates—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 multifactor productivity adjustment. ■

1 The number of hospitals providing services under the OPPS differs between this document and Chart 7-6 of MedPAC's June 2024 Data Book because here we include all hospitals, including both short term and long term, while our data book is limited to short-term hospitals.

2 For most services covered under the OPPS, beneficiary copayments are 20 percent of the OPPS payment rate for the service. However, some preventive services have no copayment amount. A few other services have copayments that are greater than 20 percent of the payment rates. These services had very high copayments when CMS launched the OPPS in August 2000, and CMS has in place a method that will result in the copayments for these services eventually reaching 20 percent of the payment rates. Finally, by statute, copayments for services covered under the OPPS cannot exceed the hospital inpatient deductible ($1,632 in 2024). As CMS creates larger payment bundles in the OPPS, the number of services for which the copayment exceeds this threshold has increased. Taken together, these exceptions to the 20 percent copayment rate result in an average copayment rate of less than 20 percent for services covered under the OPPS.

3 Partial hospitalization is when a patient receives at least three (but usually four) mental health services from a list specified by CMS in either an HOPD or community mental health center and returns home when the services are completed.

4 CMS states that applications for new-technology APCs may be submitted by device manufacturers, hospitals, or any interested party.

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