

## **OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) FACT SHEET**

### **Background and History**

The hospital OPSS was mandated by Congress in the Balanced Budget Act of 1997 (BBA). Prior to the advent of the prospective payment system, Medicare paid for services performed in the hospital outpatient setting based on a number of different payment methods, which were based on reasonable costs.

By contrast, under the OPSS, which first went into effect in August of 2000, outpatient services are grouped into Ambulatory Payment Classifications (APCs). Each APC encompasses services that are clinically similar and require similar resources. The APC includes any supplies, drugs, devices, etc., so long as appropriate data exist to support the inclusion.

The OPSS has been modified by legislation subsequent to the BBA. Among the modifications made in 1999 were provisions for an annual updating of the APC weights, rates, payment adjustments and groups; transitional pass-through payments for the additional costs of new and current medical devices, drugs and biologicals; and limitations on beneficiary coinsurance.

In 2000, Congress required, among other things, that the Secretary establish criteria for defining special payment categories for new medical devices qualifying for transitional pass through payments, and that the rate of reduction for the beneficiary co-payments in the outpatient setting be accelerated.

Outpatient services typically are performed at a hospital and include clinical visits, emergency room visits, x-rays, and surgical procedures not performed as part of an inpatient stay. By statute, outpatient services exclude physical and speech therapies and ambulance services. Similarly, the individual physicians are not paid under the outpatient system, but are paid under the physician fee schedule.

### **OPSS Payments**

- Overall, in 2002, total estimated OPSS expenditures were \$17.7 billion.
- Estimated OPSS expenditures in 2003 are estimated to be \$18.7 billion.
- Overall payments will increase by 3.7 percent in 2003.

Between the two years, however, the impact has varied by type of hospital.

- Rural hospitals payments will increase by 6.2 percent in 2003.
- Urban hospital payments will increase 3.1 percent in 2003.
- Payments to major teaching hospitals will increase 2.6 percent in 2003.

### **Ambulatory Payment Classification Groups**

APCs group together services, supplies, drugs, and devices that are used in particular procedures. Each APC has a separate payment rate that is meant to account for all of the items used in the procedure. Each APC is assigned a relative payment weight, based on the median costs of the services within the APC. A hospital receives multiple APC payments for a single visit if multiple services are delivered in that visit. Each year, the Secretary must review and adjust as necessary the APC groupings, relative payment weights, and adjustments to assure they are consistent with clinical practice. In 2003, there will be 569 APCs in the OPSS.

### **Pass-Through Payments**

In order to develop a correct APC weighted payment for a procedure, the Secretary must be able to calculate the costs to the hospital of performing the procedure, including the costs of all drugs, devices and biologicals that may be used in the respective procedures. In some cases, there was concern that the Secretary did not have sufficient hospital cost data to determine the appropriate cost for some of these drugs and devices. Thus, in 2000, Congress required the Secretary to provide for additional payments for certain drugs, biologicals and devices. These temporary additional payments are called transitional pass-through payments.

- Transitional pass-through payments for devices are based on categories of devices. The additional payment for devices is the difference between the amount attributed to the device in the APC payment rate for the procedure and the hospital's cost for the device (possibly reduced by the pro-rata reduction described below).
- Transitional pass through payments for drugs are paid for each qualifying drug separately. The additional payment for drugs is the difference between the estimated acquisition price for the drug and 95% of the average wholesale price (AWP) of the drug. (Again, this is possibly reduced by a pro-rata reduction.)

Drugs, biologicals and devices eligible for the pass through included:

- Current Orphan Drugs
- Current Cancer Therapy Drugs
- Current Radio pharmaceutical Drugs and Biological Products
- New Medical Devices, Drugs and Biologicals

The term "current" refers to items for which Medicare was paying in hospital outpatient departments at the time the prospective payment system was implemented. "New" items are those that are first paid for after the start of the system. CMS accepts applications for transitional pass-through status for new items on a quarterly basis. To qualify, an item must be new, make a substantial medical improvement, and have costs that are "not insignificant" compared with payments that would otherwise be made.

Specific items qualify for transitional pass through for only a limited period of time. By law, items may receive pass-through payments for between two to three years. Once an item no longer qualifies for pass-through payments, CMS incorporates the payment for that item into the APC payment for the procedure for which it is associated.

### **Pro-Rata Reduction**

Congress limited the total amount of transitional pass-through payments CMS can make in a year to a percentage of total payments under the OPPS. For 2000 through 2003, the pass-through pool is limited to 2.5 percent of total outpatient payments. In 2004 and future years, the limit is 2.0 percent of total outpatient payments. If CMS estimates that pass-through payments will exceed that limit for that year, a uniform (pro-rata) reduction in all pass through payments is required. This reduction applies only to the additional, transitional pass-through payment that hospitals receive for using these items, not to the total payment for the items.

A pro-rata reduction was implemented for 2002 that reduced transitional pass-through payments uniformly by 63.6 percent. For 2003, CMS estimated that transitional pass-through payments will fall below the 2.5 percent limit and a pro-rata reduction is not necessary.

### **Expiring Pass-Through Status for Drugs and Devices**

Drugs, biologicals, and devices, to the extent they are eligible to receive pass-through payments, must receive such payments for at least two, but no more than three years. January of 2003 will be the first time that transitional pass-through status of drugs or categories of devices are scheduled to expire. A total of 236 drugs and 95 of 97 device categories will be removed from pass-through status in 2003. These drugs and devices will now generally be packaged into the APCs for which they are used. In some cases, certain drugs and biologicals will be paid in separate APCs.

- **Devices**

Device eligibility for pass-through status is based upon the category to which the device belongs, rather than on an individual device. Once the device category's eligibility for pass-through payments expires, all devices in that category expire with it. All devices in that category will be incorporated into the payment rate for the procedures that use those devices.

- In July of 2002, CMS created three new device categories.
- Effective January of 2003, three new device categories will be created.
- In total, eight device categories will receive pass-through payments in 2003. Additional categories may be added later in the year through quarterly updates.

In the proposed OPPS rule for 2003, rates for many procedures using devices would have declined from the 2002 rates, in some cases quite significantly. This decline largely resulted from efforts CMS took in 2002 to limit the need for a pro-rata reduction in transitional pass-through payments. CMS incorporated 75 percent of the estimated cost of the transitional pass-through devices into the procedure with which those devices were used. CMS used manufacturer-provided price information to determine how much money to incorporate because OPPS claims data was not yet

available. Claims data from 2001 is now available, and it now appears that the amounts incorporated in 2002 were too high in many cases.

However, because of the decline in payment rates between 2002 and 2003, that were significant in some cases, CMS has taken measures in the final rule to mitigate the decline. One measure CMS took was to employ a “dampening” mechanism to reduce by 50 percent any reduction in median costs over 15 percent. CMS calculated the difference between 15 percent and the projected reduction and then halved it.

- **Drugs and Biologicals**

About 236 drugs and biologicals that received transitional pass-through payments based on average wholesale price (AWP) in 2001 and 2002 are losing eligibility for pass-through payments in 2003.

- About 118 of these products will be rolled into the APC payment for the procedures in which they are used.
- About 115 -- those with a cost greater than \$150 per encounter -- will be paid in separate APCs.

All expiring pass-through drugs, multi-indication orphan drugs, and single source drugs that are not “new” will be included in one of these two categories in 2003.

### **Orphan Drugs**

Orphan drugs or biologicals are those that are so designated under §526 of the Federal Food, Drug and Cosmetic Act. By granting orphan drug status, the FDA grants a manufacturer marketing protection for a particular drug for a particular indication. No other manufacturer may market a generic version of the drug for that indication. Orphan drug status under the FDA does not expire, however, and certain drugs that were originally orphan drugs are now being used for multiple indications. In the final rule, CMS identified three orphan drugs whose applications are limited to the initial orphan indication. For 2003, these drugs will no longer be paid under the OPSS and will be reimbursed on a reasonable cost basis. The orphan drugs identified by CMS are the following:

- Alglucerase injection (Ceredase), used to treat Type I Gaucher’s Disease, which affects approximately 1,400 Medicare beneficiaries
- Alpha-1 proteinase inhibitor (Prolastin) used to treat Alpha-1 Antitrypsin Deficiency which affects about 400 Medicare beneficiaries
- Gemtuzumab ozogamicin (Mylotarg) used to treat Acute Myelogenous Leukemia, which affects about 10,100 new patients each year whose median age is between 65-70

### **Blood and Blood Products/Hemophilia Clotting Factors**

From the inception of OPSS, blood and blood products have received separate payments because of the high degree of variability in blood use among patients and the potential for payment inequities if the costs were to be packaged with administration in an APC. In 2003, blood and blood products and hemophilia clotting factors will be paid under their own APCs. The APC payment rates will be based on claims data from April, 2001 to

March, 2002. Additionally, payment decreases from 2002 for these APCs are limited to no more than 15 percent in the final rule.

### **New Technology APCs**

Certain new technologies such as drugs, devices, biologicals are or were eligible to receive pass-through payments. Other new technologies such as new surgical procedures may be assigned to a new technology APC. Assignment to a new technology APC allows CMS to gather additional cost data about the procedure before it is assigned to an APC with other clinically similar services. New technology APC payments are based on the estimated cost of the procedure.

Procedures are moved from new technology APCs to clinical APCs once CMS determines that it has collected sufficient data on that technology to do so. In the 2003 OPSS rule, several technologies will move from new technology APCs to clinical APCs.

### **Beneficiary Co-payments**

For most services covered under Part B, beneficiaries pay 20 percent of the total Medicare payment for the service. Prior to the implementation of the OPSS, beneficiaries paid 20 percent of what the hospital charged for outpatient services. Hospital's charges for a service are often considerably greater than the Medicare payment for the service. Beneficiaries were paying an average of 50 percent of the total payment to the hospital for outpatient services and in some instances, even more than 50 percent.

Under the OPSS, beneficiary co-payments will eventually be 20 percent of the Medicare payment amount for all services. In the first two years of the OPSS, beneficiary cost sharing has dropped 14 percent to 43 percent of the total Medicare payment.

The beneficiary's co-payment is based 20 percent of the national median charge for a particular service. As the Medicare payment rate increases over time, this dollar amount is not changed until the co-payment reaches 20 percent of the total payment. For example, if the current co-payment for a service is \$50 and the current total payment is \$150, the beneficiary is paying 33 percent of the total payment. In the following year the payment rate would be expected to increase. If it increased to \$175, for example, the beneficiary would now be paying 29 percent of the total payment. When the payment rate reaches \$250, the beneficiary will be paying 20 percent of the total. From this point on, the co-payment amount and the payment amount will increase at the same rate.

There are also several limits on the co-payments. Regardless of the nationally determined co-payment amount, beneficiaries do not pay more than the inpatient hospital deductible for an outpatient service. Congress also set annual limits on the percentage of total payments that the beneficiary can pay. In 2002 and 2003 that limit is 55 percent. The percentage is reduced each year until 2006 when it is 40 percent.