Advisory Board

C-Suite Cheat Sheet Series

Hospital Outpatient Prospective Payment System (HOPPS) 101

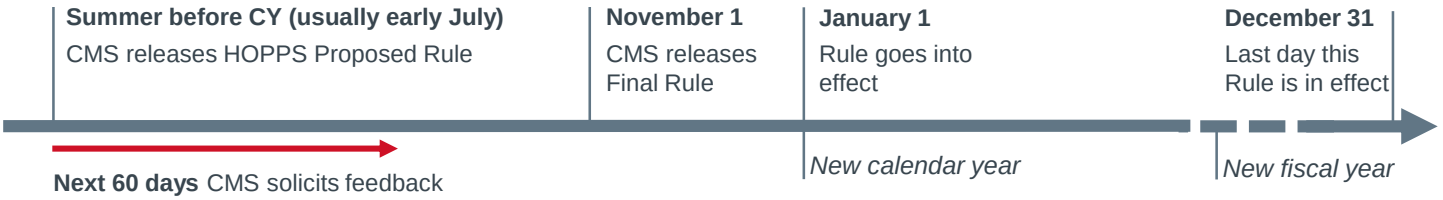
Educational Briefing for Providers and Suppliers

What is the HOPPS?

- The Outpatient Prospective Payment System (HOPPS) is the payment system through which CMS reimburses hospitals for outpatient services delivered to Medicare Fee-for-Service patients.
- HOPPS also covers certain Medicare Part B services for inpatients when Part A payments cannot be made, some partial hospitalization services, and some other varied services.

How often is the OPPS updated, and which elements are subject to change?

- CMS annually updates payments for items and services based on scaled relative weights for each calendar year. There are also quarterly HOPPS adjustments to account for mid-year changes such as new drugs or devices, new hospital codes (such as HCPCS, or Healthcare Common Procedure Coding System codes), and other price changes.
- The American Medical Association convenes a Current Procedural Terminology (CPT) editorial panel which meets three times a year to discuss CPT code revision and additions. They release new editions in October of each year.



Which hospitals are reimbursed by Medicare under the OPPS?

All Medicare-certified short-term acute care hospital outpatient departments (HOPDs), except for the following:

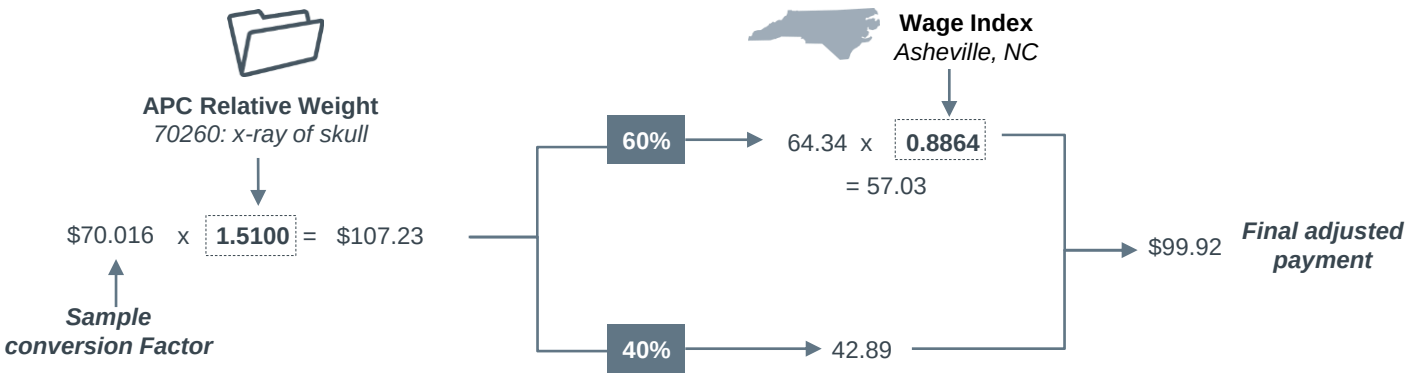
- Critical access hospitals (CAHs)
- Dedicated freestanding EDs
- Indian Health Service hospitals
- Maryland hospitals
- Ambulatory surgical centers (ASCs)
- PPS-exempt cancer hospitals
- "Non-excepted" off-campus HOPDs

How are OPPS-reimbursed hospitals paid for services they provide?

- CMS assigns individual services (classified by **CPT/HCPCS code**) to Ambulatory Payment Classifications (**APC)** code groups based on similar clinical characteristics and resource intensity.
- Most services are individually reimbursed (e.g., most surgical, diagnostic and therapeutic procedures, blood and blood products, most clinic and ED visits, and certain preventative services). However, the payment of many dependent or ancillary items (such as anesthesia or lab tests) are "packaged" into the payment for the associated primary procedure or service. Partial hospitalization is paid on a per-diem basis depending on whether it occurs in a hospital or community mental health center (CMHC).

How do APC codes translate to payments?

- Payment rates for separately payable services are determined by multiplying the relative weight for that service's APC by a conversion factor (a specific dollar amount). The national conversion factor is updated annually by a set increase factor, but a hospital's conversion factor can be decreased by 2% if the hospital fails to meet HOPD quality reporting requirements.
- Next, to account for geographic differences in input prices, 60% of the payment is adjusted by the hospital wage index. For example, payment for an X-ray at a hospital-based outpatient department in Asheville, North Carolina would be calculated as:



Source: CMS; Advisory Board interview and analysis.