

# Washington Bulletin

Health care legislative and regulatory update

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July 3, 2010

## CMS Issues CY 2010 Changes to the Hospital OPPS and ASC Payment System Rates

The Centers for Medicare and Medicare Services have issued two rules regarding the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for Calendar Year (CY) 2010 services. One rule – officially cited as a notice – addresses the final wage indices, hospital reclassifications, payment rates, and addenda for payments made under the Medicare hospital OPPS, and the payment rates and addenda for payments made under the Medicare ASC payment system. The changes contained in the notice reflect the provisions of the Affordable Care Act (ACA).

A [copy](#) of the notice is available on the *Federal Register* web site. Publication of this 816-page document is scheduled for August 3<sup>rd</sup>. The revised CY 2010 national unadjusted OPPS and ASC payment are effective for payments for services furnished on or after January 1, 2010. CMS notes that this notice makes no changes to the OPPS payment methodologies or policies.

In the other rule – cited as a correction – CMS notes that ASC payment system uses the Practice Expense RVUs and the conversion factor (CF) from the Medicare Physician Fee Schedule (MPFS) as part of the office-based and ancillary radiology payment methodology. The provisions in this correction document are also effective as if they had been included in the CY 2010 OPPS/ASC final rule appearing in the November 20, 2009 *Federal Register*. Accordingly, the corrections are effective January 1, 2010.

A [copy](#) of the correction item is also available on the *Federal Register* web site. Publication of this 140-page document is scheduled for August 3<sup>rd</sup>. *CMS is basically republishing Addenda AA and BB, pages 69505 through 69629 and 69630 through 69675 of the December 31, 2009 CY 2010 OPPS/ASC document to take into account updated CY 2010 MPFS information.* This notice incorporates a zero percent update for MPFS payment.

### Comment

CMS does not address the need to make another correction pertaining to the MPFS information in the correction rule since it does not address the June 25<sup>th</sup> Congressional action increasing the MPFS schedule amounts by 2.2 percent for services provided from June 1 through November 30, 2010. CMS does so in the notice rule.

The material that follows is from the notice:

### CY 2010 OPPS OPD Fee Schedule Increase Factor

The CY 2010 OPD fee schedule increase factor that was finalized in the CY 2010 OPPS final rule was 2.1 percent. In addition, a hospital that failed to meet quality data reporting (the Hospital Outpatient Quality Data Reporting Program (HOP QDRP)) received a 0.1 percent update (that is, the CY 2010 estimate of the OPD fee schedule increase factor of 2.1 percent minus 2.0 percentage points).

The ACA reduces such factor by an adjustment of 0.25 percentage point, effective for services furnished on or after January 1, 2010 and before January 1, 2011. Therefore, the reduction of 0.25 percentage point applied to the full market basket increase factor of 2.1 percent results in a revised market basket increase factor of 1.85 percent. A hospital that failed to meet the quality data reporting requirements receives a negative 0.15 percent market basket increase factor (that is, the revised market basket increase factor of 1.85 percent minus 2.0 percentage points.)

### **CY 2010 OPPS Conversion Factor**

CMS says that the only changes to the conversion factor, and thus to the CY 2010 OPPS payment rates, that are reflected in this notice are caused by the statutorily required reduction applied to the OPD fee schedule increase factor and the statutory changes to the wage index.

The revised full conversion factor for CY 2010 is **\$67.241** for services furnished on and after January 1, 2010 and before January 1, 2011. (The previous announced amount was \$67.406.)

The reduced conversion factor for CY 2010 of \$65.921 is for those hospitals that fail to meet the quality data reporting requirement effective for covered OPD services furnished on or after January 1, 2010 through December 31, 2010. (This previous amount was \$66.086.)

CMS notes that the recalculated CY 2010 final conversion factor of \$67.241 is reflected in the revised CY 2010 OPPS payment rates and rate dependent files that are posted on the CMS website at [www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/)

Because the conversion factor was revised, CMS says it is required to recalculate a number of aspects of the CY 2010 OPPS. *The bulk of this notice is the revised APC payment rates that are printed in Addenda A and B of this notice.*

### **Revision of Hospital Wage Index Values for CY 2010 as Required by the Affordable Care Act**

CMS has made several wage index adjustments as required by the ACA, including the extension of Section 508 hospitals. The notice does not contain these revised values. CMS notes they are available on public display on the CMS web site at: <http://www.cms.gov/AcuteInpatientPPS/WIFN/itemdetail.asp> and have also been published in the June 2, 2010, *Federal Register*.

### **Extension of Transitional Outpatient Payments (TOPs) for Small Rural Hospitals that are not Sole Community Hospitals and that have 100 or Fewer Beds and Extension of TOPs to all SCHs (including EACHs), Irrespective of the 100 Bed Limitation**

Section 3121 of the ACA extends the hold harmless provision for small rural hospitals with 100 or fewer beds and that are not sole community hospitals (as defined in section 1886(d)(5)(iii) of the Social Security Act) for an additional year – through December 31, 2010, at 85 percent of the hold harmless amount.

In addition, section 3121 of the ACA extended for an additional year the period of TOPs payments for SCHs. CMS is simply acknowledging this fact in this notice.

### **Ambulatory Surgical Center Payment System**

ASC payment rates for CY 2010 are a transitional blend of 25 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 75 percent of the payment rate for the procedure calculated under the standard rate setting methodology.

Because the standard rate setting methodology adopts the OPPS relative payment weights (not rates), reductions to OPPS payments created by the ACA do not impact payment made under the standard rate setting methodology as the ACA did not change any OPPS APC relative weights for CY 2010.

However, the ASC payment system establishes the payment rates for several services using other methodologies that are impacted by the ACA. Specifically, the calculation of device-intensive services, brachytherapy services, and bone density scans (a type of covered ancillary radiology service) under the ASC payment system rely directly on the actual payment rates under the OPPS and MPFS,

Using the revised scaled ASC payment weights and the conversion factor of \$41.873, the revised OPPS payment amounts, and the revised MPFS non-facility practice expense payment amounts, CMS recalculated the revised CY 2010 ASC payment rates for all services, including device-intensive services, brachytherapy sources, and office-based and ancillary radiology services, appearing in Addenda AA and BB of this notice. These payment rates are effective for services furnished on and after January 1, 2010 through December 31, 2010.

These files also may be viewed as supporting documentation to this notice at <http://www.cms.gov/ASCPayment>.

### **Elimination of Sunset for Reimbursement for all Medicare Part B Services in Hospitals and Clinics Operated by the Indian Health Service, Indian Tribes, or Tribal Organizations**

Section 2902 of the ACA indefinitely extends Section 630 of the *Medicare Modernization Act* (MMA), retroactive to January 1, 2010. The specific Part B services are:

- Ambulance services;
- Clinical laboratory services;
- Part B drugs processed by the J4 A/B MAC and the DME MACs;
- Influenza and pneumonia vaccinations;
- Durable medical equipment;
- Therapeutic shoes;
- Prosthetics and orthotics;
- Surgical dressings, splints, and casts; and
- Screening and preventive services not covered prior to the implementation of section 630 of the MMA.

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