§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(a) To calculate the unadjusted copayment amount for each APC group, CMS—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary copayment amount for the APC group.

(b) CMS calculates annually the program payment percentage for every APC group on the basis of each group’s unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(c) To determine payment amounts due for a service paid under the hospital outpatient prospective payment system, CMS makes the following calculations:

(1) Makes the wage index adjustment in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the preliminary Medicare program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the copayment amount.

(i) The copayment amount for an APC cannot exceed the amount of the inpatient hospital deductible established in accordance with § 409.82 of this chapter, for that year. For purposes of this paragraph (c)—

(A) Effective for drugs and biologicals furnished on or after January 1, 2001, the copayment amount for multiple APCs for a single drug or biological furnished on the same day will be aggregated and treated as the copayment amount for one APC.

(B) Effective for drugs and biologicals furnished on or after July 1, 2001, the copayment amount for the APC or APCs for a drug or biological furnished on the same day will be aggregated with the copayment amount for the APC that reflects the administration of the drug or biological furnished on that day and treated as the copayment amount for one APC.

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

(iv) The copayment amount is computed as if the adjustment under §§ 419.43(d) and (e) (and any adjustments made under § 419.43(f) in relation to these adjustments) and § 419.43(h) had not been paid.

(5) Adds the amount by which the copayment amount would have exceeded the inpatient hospital deductible for that year to the preliminary Medicare program payment amount determined in paragraph (c)(3) of this section to determine the final Medicare program payment amount.


§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than—
§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) General rule. CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) Labor-related portion of payment and copayment rates for hospital outpatient services. CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the “labor-related portion” of hospital outpatient costs) in accordance with § 419.32(c).

(c) Wage index factor. CMS uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) Outlier adjustment—(1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital’s charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under § 419.66.

(ii) At the option of CMS, a fixed dollar amount.

(2) Amount of adjustment. The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) Limit on aggregate outlier adjustments—(1) In general. The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(i)(I) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.