§ 419.31 Ambulatory payment classification (APC) system and payment weights.

(a) **APC groups.** (1) CMS classifies outpatient services and procedures that are comparable clinically and in terms of resource use into APC groups. Except as specified in paragraph (a)(2) of this section, items and services within a group are not comparable with respect to the use of resources if the highest median cost for an item or service within the group is more than 2 times greater than the lowest median cost for an item or service within the group.

(2) CMS may make exceptions to the requirements set forth in paragraph (a)(1) in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) The payment rate determined for an APC group in accordance with § 419.32, and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part, apply to every HCPCS code classified within an APC group.

(b) **APC weighting factors.** (1) Using hospital outpatient claims data from calendar year 1996 and data from the most recent available hospital cost reports, CMS determines the median costs for the services within each APC group.

(2) CMS assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) **Standardizing amounts.** (1) CMS determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the “labor-related portion” of hospital outpatient costs.

(2) CMS standardizes the median costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) **Conversion factor for 1999.** CMS calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.33(e).

(b) **Conversion factor for calendar year 2000 and subsequent years.** (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

   (i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(ii) of the Act reduced by one percentage point.

   (ii) For calendar year 2001—

   (A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(ii) of the Act reduced by one percentage point; and

   (B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(ii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

   (iii) For the portion of calendar year 2002 that is affected by these rules, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(ii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

   (iv)(A) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(ii) of the Act.

   (B) The percentage increase determined under paragraph (b)(1)(iv)(A) of
this section is reduced by the following for the specific calendar year:

(1) For calendar year 2010, 0.25 percentage point; and

(2) For calendar year 2011, 0.25 percentage point.

(2) Beginning in calendar year 2000, CMS may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) Payment rates. The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under §419.31(b).

(d) Budget neutrality. (1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under §419.50(a) are budget neutral.

(2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

§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.

[66 FR 59922, Nov. 30, 2001]