

## Centers for Medicare & Medicaid Services, HHS

## § 419.31

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

(u) Outpatient diabetes self-management training.

(v) Effective January 1, 2017, items and services that do not meet the definition of excepted items and services under § 419.48(a).

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 69 FR 65863, Nov. 15, 2004; 75 FR 72265, Nov. 24, 2010; 78 FR 50969, Aug. 19, 2013; 78 FR 75196, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 81 FR 79879, Nov. 14, 2016; 82 FR 35, Jan. 3, 2017; 85 FR 86302, Dec. 29, 2020; 86 FR 63993, Nov. 16, 2021]

### **§ 419.23 Removal of services and procedures from the Inpatient Only List.**

(a) *Inpatient Only List.* CMS maintains a list of services and procedures that the Secretary designates as requiring inpatient care under § 419.22(n) that are not paid under the hospital outpatient prospective payment system. This list is referred to as the Inpatient Only List.

(b) *Removals from the Inpatient Only List.* CMS assesses annually whether a service or procedure on the Inpatient Only List described in paragraph (a) of this section should be removed from the list by determining whether the service or procedure meets at least one of the following criteria:

(1) Most outpatient departments are equipped to provide the service or procedure to the Medicare population.

(2) The simplest service or procedure described by the code may be performed in most outpatient departments.

(3) The service or procedure is related to codes that CMS has already removed from the Inpatient Only List described in paragraph (a) of this section.

(4) CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.

(5) CMS determines that the service or procedure can be appropriately and safely performed in an ambulatory surgical center, and is specified as a cov-

ered ambulatory surgical procedure under § 416.166 of this chapter, or CMS has proposed to specify it as a covered ambulatory surgical procedure under § 416.166 of this chapter.

[86 FR 63993, Nov. 16, 2021]

### **Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services**

#### **§ 419.30 Base expenditure target for calendar year 1999.**

(a) CMS estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of coinsurance that would be payable by beneficiaries to hospitals for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part.

(b) The estimated aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

#### **§ 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 geometric mean cost for an item or service within the group is more than 2 times greater than the lowest geometric mean 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

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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

(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 geometric mean costs for the services and procedures within each APC group.

(2) CMS assigns to each APC group an appropriate weighting factor to reflect the relative geometric mean costs for the services within the APC group compared to the geometric mean 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 geometric mean costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

[65 FR 18542, Apr. 7, 2000, as amended at 77 FR 68558, Nov. 15, 2012]

### **§ 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 § 419.43(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)(iii) 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)(iii) 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)(iii) 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)(iii) 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 OPD fee schedule increase factor, which, subject to the adjustments specified in paragraph (b)(1)(iv)(B) of this section, is the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) 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;

(2) For calendar year 2011, 0.25 percentage point; and

(3) For calendar year 2012, a multi-factor productivity adjustment (as determined by CMS) and 0.1 percentage point.

(4) For calendar year 2013, a multi-factor productivity adjustment (as determined by CMS) and 0.1 percentage point.

(5) For calendar year 2014, a multi-factor productivity adjustment (as determined by CMS) and 0.3 percentage point.

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(6) For calendar year 2015, a multi-factor productivity adjustment (as determined by CMS) and 0.2 percentage point.

(7) For calendar year 2016, a multi-factor productivity adjustment (as determined by CMS), and 0.2 percentage point.

(8) For calendar year 2017, a multi-productivity adjustment (as determined by CMS) and 0.75 percentage point.

(9) For calendar year 2018, a multi-productivity adjustment (as determined by CMS) and 0.75 percentage point.

(10) For calendar year 2019, a multi-factor productivity adjustment (as determined by CMS) and 0.75 percentage point.

(11) For calendar year 2020 and subsequent years, a multifactor productivity adjustment (as determined by CMS).

(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.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 67 FR 9568, Mar. 1, 2002; 69 FR 832, Jan. 6, 2004; 75 FR 72265, Nov. 24, 2010; 76 FR 74582, Nov. 30, 2011; 77 FR 68559, Nov. 15, 2012; 78 FR 75196, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 80 FR 70606, Nov. 13, 2015; 81 FR 79879, Nov. 14, 2016; 82 FR 52637, Nov. 13, 2017; 82 FR 59497, Dec. 14, 2017; 83 FR 59179, Nov. 21, 2018; 85 FR 86302, Dec. 29, 2020]

EFFECTIVE DATE NOTE: At 66 FR 59922, Nov. 30, 2001, §419.32 was amended by revising paragraph (b)(1), effective Jan. 1, 2002. At 66 FR 67494, Dec. 31, 2001, paragraph (b)(1)(iii) was delayed indefinitely.

## Subpart D—Payments to Hospitals

### §419.40 Payment concepts.

(a) In addition to the payment rate described in §419.32, for each APC group there is a predetermined beneficiary copayment amount as described in §419.41(a). The Medicare program payment amount for each APC group is calculated by applying the program payment percentage as described in §419.41(b).

(b) For purposes of this section—

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the greater of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) Program payment percentage is calculated as the lower of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

(3) Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of copayment amount to inpatient hospital deductible amount.* The copayment amount for a procedure performed in a year cannot exceed the