

§ 419.41

42 CFR Ch. IV (10–1–24 Edition)

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 amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

[66 FR 59922, Nov. 30, 2001]

§ 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.

(d) Notwithstanding paragraphs (a) through (c) of this section, for a drug or biological for which payment is not packaged into a payment for a covered outpatient department (OPD) service (or group of services) and is not a rebatable drug (as defined in section

1847A(i)(2)(A) of the Act), to calculate the program payment and copayment amounts CMS does the following:

(1) Determines the payment rate for the drug or biological for the quarter established under the methodology described by section 1842(o), section 1847A, or section 1847B of the Act, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of paragraph (14) of section 1833(t) of the Act.

(2) Subtracts from the amount determined under paragraph (d)(1) of this section the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the amount determined under paragraph (d)(1) of this section (less any applicable deductible under paragraph (d)(2) of this section) by 20 percent. This is the beneficiary's copayment amount for the drug or biological.

(4) Subtracts the amount determined under paragraph (d)(3) of this section from the amount determined under paragraph (d)(1) of this section (less any applicable deductible determined under paragraph (d)(2) of this section). This amount is the preliminary program amount.

(5) Adds to the preliminary program amount determined under paragraph (d)(4) of this section the amount by which the copayment amount would have exceeded the inpatient hospital deductible for that year. This amount is the final Medicare program payment amount.

(e) In the case of a rebatable drug (as defined in section 1847A(i)(2)(A) of the Act), except if such drug does not have a copayment amount as a result of application of section 1833(t)(8)(E) of the Act, for which payment is not packaged into payment for a covered OPD service (or group of services) furnished on or after April 1, 2023, and the payment for such drug under the outpatient prospective payment system (OPPS) is the same as the amount for a calendar quarter under section 1847A(i)(3)(A)(ii)(I) of the Act, in lieu of the calculation of the copayment amount and the Medicare program payment amount otherwise applicable under paragraph (d) of this section (other than application of the limita-

tion described in paragraph (c)(4)(i) of this section), the copayment and Medicare program payment amounts determined under §§ 410.152(m) and 489.30(b)(6) of this chapter shall apply.

(f) In the case of a qualifying biosimilar biological product (as defined in § 414.902 of this chapter) that is furnished during the applicable five-year period (as defined in § 414.902 of this chapter) for such product, the payment amount for such product with respect to such period is the amount determined in § 414.904(j)(2) of this chapter.

(g) For dates of service on or after July 1, 2024, the payment amount for a biosimilar biological product (as defined in § 414.902 of this chapter) during the initial period is the amount determined in § 414.904(e)(4)(ii) of this chapter.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 73 FR 68814, Nov. 18, 2008; 88 FR 82180, Nov. 22, 2023]

§ 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—

(1) June 1, 2000, for coinsurance elections for the period July 1, 2000 through December 31, 2000; or

(2) December 1 preceding the beginning of each subsequent calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced coinsurance remains in effect unchanged during the year for which the election was made.

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined