

service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

(4) *Documentation.* (i) If the individual's physician initiates the request for services of the hospice medical director or physician, appropriate documentation is required.

(ii) The request or referral must be in writing, and the hospice medical director or physician employee is expected to provide a written note on the patient's medical record.

(iii) The hospice agency employing the physician providing these services is required to maintain a written record of the services furnished.

(iv) If the services are initiated by the beneficiary, the hospice agency is required to maintain a record of the services and documentation that communication between the hospice medical director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

[69 FR 66425, Nov. 15, 2004]

Subpart G—Payment for Hospice Care

§ 418.301 Basic rules.

(a) Medicare payment for covered hospice care is made in accordance with the method set forth in § 418.302.

(b) Medicare reimbursement to a hospice in a cap period is limited to a cap amount specified in § 418.309.

(c) The hospice may not charge a patient for services for which the patient is entitled to have payment made under Medicare or for services for which the patient would be entitled to payment, as described in § 489.21 of this chapter.

[48 FR 56026, Dec. 16, 1983, as amended at 56 FR 26919, June 12, 1991; 70 FR 70547, Nov. 22, 2005]

§ 418.302 Payment procedures for hospice care.

(a) CMS establishes payment amounts for specific categories of covered hospice care.

(b) Payment amounts are determined within each of the following categories:

(1) *Routine home care day.* A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care as defined in paragraph (b)(2) of this section.

(i) *Service intensity add-on.* Routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.

(ii) The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, as described in paragraph (e)(4) of this section, multiplied by the amount of direct patient care actually provided by a RN and/or social worker, up to 4 hours total per day.

(2) *Continuous home care day.* A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in § 418.204(a) and only as necessary to maintain the terminally ill patient at home.

(3) *Inpatient respite care day.* An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.

(4) *General inpatient care day.* A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

(c) The payment amounts for the categories of hospice care are fixed payment rates that are established by CMS in accordance with the procedures described in § 418.306. Payment rates are determined for the following categories:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

(d)(1) The Medicare Administrative Contractor reimburses the hospice its appropriate payment amount for each day for which an eligible Medicare beneficiary is under the hospice's care.

(2) Effective December 8, 2003, if a hospice makes arrangements with another hospice to provide services under the circumstances specified in section 1861(dd)(5)(D) of the Act, the Medicare Administrative Contractor reimburses the hospice for which the beneficiary has made an election as described in paragraph (d)(1) of this section.

(e) The Medicare Administrative Contractor makes payment according to the following procedures:

(1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day (except as set out in paragraph (b)(1)(i) of this section).

(2) Payment is made for only one of the categories of hospice care described in §418.302(b) for any particular day.

(3) On any day on which the beneficiary is not an inpatient, the hospice is paid the routine home care rate, unless the patient receives continuous care as defined in paragraph (b)(2) of this section for a period of at least 8 hours. In that case, a portion of the continuous care day rate is paid in accordance with paragraph (e)(4) of this section.

(4) The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care provided during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate.

(5) Subject to the limitations described in paragraph (f) of this section, on any day on which the beneficiary is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admis-

sion and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the beneficiary is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

(f) Payment for inpatient care is limited as follows:

(1) The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicare patients not exceed 20 percent of the total days for which these patients had elected hospice care.

(2) At the end of a cap period, the Medicare Administrative Contractor calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients. Only inpatient days that were provided and billed as general inpatient or respite days are counted as inpatient days when computing the inpatient cap.

(3) If the number of days of inpatient care furnished to Medicare patients is equal to or less than 20 percent of the total days of hospice care to Medicare patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount specified in §418.309.

(4) If the number of days of inpatient care furnished to Medicare patients exceeds 20 percent of the total days of hospice care to Medicare patients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (f)(5) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subject to the cap amount specified in §418.309.

(5) If a hospice exceeds the number of inpatient care days described in paragraph (f)(4), the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.

(ii) Multiply this ratio by the total reimbursement for inpatient care made by the Medicare Administrative Contractor.

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(iv) Add the amounts calculated in paragraphs (f)(5)(ii) and (iii) of this section.

(g) Payment for routine home care, continuous home care, general inpatient care and inpatient respite care is made on the basis of the geographic location where the services are provided.

[48 FR 56026, Dec. 16, 1983, as amended at 56 FR 26919, June 12, 1991; 70 FR 45145, Aug. 4, 2005; 70 FR 70547, Nov. 22, 2005; 72 FR 50228, Aug. 31, 2007; 74 FR 39414, Aug. 6, 2009; 80 FR 47206, Aug. 6, 2015]

§ 418.304 Payment for physician, and nurse practitioner, and physician assistant services.

(a) The following services performed by hospice physicians and nurse practitioners are included in the rates described in § 418.302:

(1) General supervisory services of the medical director.

(2) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(b) For services not described in paragraph (a) of this section, a specified Medicare contractor pays the hospice an amount equivalent to 100 percent of the physician fee schedule for those physician services furnished by hospice employees or under arrangements with the hospice. Reimbursement for these physician services is included in the amount subject to the hospice payment limit described in § 418.309. Services furnished voluntarily by physicians are not reimbursable.

(c) Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limit described in § 418.309. These services are paid by the carrier under the procedures in subpart B, part 414 of this chapter.

(d) *Payment for hospice pre-election evaluation and counseling services.* The intermediary makes payment to the hospice for the services established in § 418.205. Payment for this service is set at an amount established under the physician fee schedule, for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity other than the portion of the amount attributable to the practice expense component. Payment for this pre-election service does not count towards the hospice cap amount.

(e)(1) Effective December 8, 2003, Medicare pays for attending physician services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending physician. This applies to nurse practitioners without regard to whether they are hospice employees.

(2) Nurse practitioners may bill and receive payment for services only if the—

(i) Nurse practitioner is the beneficiary's attending physician as defined in § 418.3;

(ii) Services are medically reasonable and necessary;

(iii) Services are performed by a physician in the absence of the nurse practitioner; and

(iv) Services are not related to the certification of terminal illness specified in § 418.22.

(3) Payment for nurse practitioner services are made at 85 percent of the physician fee schedule amount.

(f)(1) Effective January 1, 2019, Medicare pays for attending physician services provided by physician assistants to

Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This applies to physician assistants without regard to whether they are hospice employees.

(2) The employer or a contractor of a physician assistant must bill and receive payment for physician assistant services only if the—

(i) Physician assistant is the beneficiary's attending physician as defined in § 418.3;

(ii) Services are medically reasonable and necessary;

(iii) Services are performed by a physician in the absence of the physician assistant and, the physician assistant services are furnished under the general supervision of a physician; and

(iv) Services are not related to the certification of terminal illness specified in § 418.22.

(3) The payment amount for physician assistant services when serving as the attending physician for hospice patients is 85 percent of what a physician is paid under the Medicare physician fee schedule.

[48 FR 56026, Dec. 16, 1983, as amended at 69 FR 66426, Nov. 15, 2004; 70 FR 45145, Aug. 4, 2005; 70 FR 70547, Nov. 22, 2005; 83 FR 38655, Aug. 6, 2018]

§ 418.306 Annual update of the payment rates and adjustment for area wage differences.

(a) *Applicability.* CMS establishes payment rates for each of the categories of hospice care described in § 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act and in accordance with section 1814(i)(6)(D) of the Act.

(b) *Annual update of the payment rates.* The payment rates for routine home care and other services included in hospice care are the payment rates in effect under this paragraph during the previous fiscal year increased by the hospice payment update percentage increase (as defined in sections 1814(i)(1)(C) of the Act), appli-

cable to discharges occurring in the fiscal year.

(1) For fiscal year 2014 and subsequent fiscal years, in accordance with section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that submits hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase.

(2) For fiscal years 2014 and through 2023, in accordance with section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that does not submit hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase, minus 2 percentage points. Beginning with fiscal year 2024 and subsequent fiscal years, the reduction increases to 4 percentage points. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the payment amounts for a subsequent fiscal year.

(c) *Adjustment for wage differences.* (1) Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the FEDERAL REGISTER, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the Medicare contractor to reflect local differences in wages according to the revised wage data.

(2) Beginning on October 1, 2022, CMS applies a cap on decreases to the hospice wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior fiscal year.

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(d) *Federal Register notices.* CMS publishes as a notice in the FEDERAL REGISTER any proposal to change the methodology for determining the payment rates.

[56 FR 26919, June 12, 1991, as amended at 59 FR 26960, May 25, 1994; 62 FR 42882, Aug. 8, 1997; 70 FR 70548, Nov. 22, 2005; 73 FR 46486, Aug. 8, 2008; 79 FR 50509, Aug. 22, 2014; 80 FR 47207, Aug. 6, 2015; 86 FR 42605, Aug. 4, 2021; 87 FR 45702, July 29, 2022]

§ 418.307 Periodic interim payments.

Subject to the provisions of § 413.64(h) of this chapter, a hospice may elect to receive periodic interim payments (PIP) effective with claims received on or after July 1, 1987. Payment is made biweekly under the PIP method unless the hospice requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payments for the reporting period (as described in §§ 418.302–418.306). Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(5) of this chapter. Under certain circumstances that are described in § 413.64(g) of this chapter, a hospice that is not receiving PIP may request an accelerated payment.

[59 FR 36713, July 19, 1994]

§ 418.308 Limitation on the amount of hospice payments.

(a) Except as specified in paragraph (b) of this section, the total Medicare payment to a hospice for care furnished during a cap period is limited by the hospice cap amount specified in § 418.309.

(b) Until October 1, 1986, payment to a hospice that began operation before January 1, 1975 is not limited by the amount of the hospice cap specified in § 418.309.

(c) The hospice must file its aggregate cap determination notice with its Medicare contractor no later than 5 months after the end of the cap year and remit any overpayment due at that time. Hospices shall file the aggregate cap using data no earlier than 3 months after the end of the cap period. The Medicare contractor will notify the hospice of the final determination of program reimbursement in accord-

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ance with procedures similar to those described in § 405.1803 of this chapter. If a provider fails to file its self-determined cap determination with its Medicare contractor within 5 months after the cap year, payments to the hospice will be suspended in whole or in part, until a self-determined cap determination is filed with the Medicare contractor, in accordance with § 405.371(e) of this chapter.

(d) Payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded.

[48 FR 56026, Dec. 16, 1983; 48 FR 57282, Dec. 29, 1983, as amended at 79 FR 50509, Aug. 22, 2014; 80 FR 47207, Aug. 6, 2015]

§ 418.309 Hospice aggregate cap.

A hospice's aggregate cap is calculated by multiplying the adjusted cap amount (determined in paragraph (a) of this section) by the number of Medicare beneficiaries, as determined by one of two methodologies for determining the number of Medicare beneficiaries for a given cap year described in paragraphs (b) and (c) of this section.

(a) *Cap Amount.* The cap amount was set at \$6,500 in 1983 and is updated using one of two methodologies described in paragraphs (a)(1) and (a)(2) of this section.

(1) For accounting years that end on or before September 30, 2016 and end on or after October 1, 2032, the cap amount is adjusted for inflation by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year.

(2) For accounting years that end after September 30, 2016, and before October 1, 2032, the cap amount is the cap amount for the preceding accounting year updated by the percentage update to payment rates for hospice care for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year as determined pursuant to section 1814(i)(1)(C) of the Act (including the application of any productivity or

other adjustments to the hospice percentage update).

(b) *Streamlined methodology defined.* A hospice's aggregate cap is calculated by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries as determined in paragraphs (b)(1) and (2) of this section. For purposes of the streamlined methodology calculation—

(1) In the case in which a beneficiary received care from only one hospice, the hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care in accordance with §418.24 during the cap period as defined in §418.3, using the best data available at the time of the calculation.

(2) In the case in which a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.

(c) *Patient-by-patient proportional methodology defined.* A hospice's aggregate cap is calculated by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries as described in paragraphs (c)(1) and (2) of this section. For the purposes of the patient-by-patient proportional methodology—

(1) A hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The total number of Medicare beneficiaries for a given hospice's cap year is determined by summing the whole or fractional share of each Medicare beneficiary that re-

ceived hospice care during the cap year, from that hospice.

(2) The aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.

(d) *Application of methodologies.* (1) For cap years ending October 31, 2011 and for prior cap years, a hospice's aggregate cap is calculated using the streamlined methodology described in paragraph (b) of this section, subject to the following:

(i) A hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, may elect to have its final cap determination for such cap years calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section; or

(ii) A hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year, and all subsequent cap years, be calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section.

(2) For cap years ending October 31, 2012, and all subsequent cap years, a hospice's aggregate cap is calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section, subject to the following:

(i) A hospice that has had its cap calculated using the patient-by-patient proportional methodology for any cap year(s) prior to the 2012 cap year is not eligible to elect the streamlined methodology, and must continue to have the patient-by-patient proportional methodology used to determine the number of Medicare beneficiaries in a given cap year.

(ii) A hospice that is eligible to make a one-time election to have its cap calculated using the streamlined methodology must make that election no later than 60 days after receipt of its 2012 cap determination. A hospice's election to have its cap calculated using the streamlined methodology would remain in effect unless:

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(A) The hospice subsequently submits a written election to change the methodology used in its cap determination to the patient-by-patient proportional methodology; or

(B) The hospice appeals the streamlined methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation.

(3) If a hospice that elected to have its aggregate cap calculated using the streamlined methodology under paragraph (d)(2)(ii) of this section subsequently elects the patient-by-patient proportional methodology or appeals the streamlined methodology, under paragraph (d)(2)(ii)(A) or (B) of this section, the hospice's aggregate cap determination for that cap year and all subsequent cap years is to be calculated using the patient-by-patient proportional methodology. As such, past cap year determinations may be adjusted to prevent the over-counting of beneficiaries, subject to existing re-opening regulations.

[48 FR 56026, Dec. 16, 1983, as amended at 76 FR 47332, Aug. 4, 2011; 80 FR 47207, Aug. 6, 2015; 83 FR 38655, Aug. 6, 2018; 86 FR 42606, Aug. 4, 2021; 88 FR 51199, Aug. 2, 2023]

§ 418.310 Reporting and recordkeeping requirements.

Hospices must provide reports and keep records as the Secretary determines necessary to administer the program.

§ 418.311 Administrative appeals.

A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least \$1,000 or \$10,000, respectively. In such a case, the procedure in 42 CFR part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under § 405.1875 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal.

[74 FR 39414, Aug. 6, 2009, as amended at 78 FR 48281, Aug. 7, 2013]

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§ 418.312 Data submission requirements under the hospice quality reporting program.

(a) *General rule.* Except as provided in paragraph (g) of this section, Medicare-certified hospices must submit to CMS data on measures selected under section 1814(i)(5)(C) of the Act in a form and manner, and at a time, specified by the Secretary.

(b) *Submission of Hospice Quality Reporting Program data.* (1) Standardized set of admission and discharge items Hospices are required to complete and submit an admission Hospice Item Set (HIS) and a discharge HIS for each patient to capture patient-level data, regardless of payer or patient age. The HIS is a standardized set of items intended to capture patient-level data.

(2) Administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay, are required and fulfill the HQRP requirements for § 418.306(b).

(3) CMS may remove a quality measure from the Hospice QRP based on one or more of the following factors:

(i) Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) A hospice that receives notice of its CMS certification number before November 1 of the calendar year before

the fiscal year for which a payment determination will be made must submit data for the calendar year.

(d) Medicare-certified hospices must contract with CMS-approved vendors to collect the CAHPS® Hospice Survey data on their behalf and submit the data to the Hospice CAHPS® Data Center.

(e) If the hospice's total, annual, unique, survey-eligible, deceased patient count for the prior calendar year is less than 50 patients, the hospice is eligible to be exempt from the CAHPS® Hospice Survey reporting requirements in the current calendar year. In order to qualify for this exemption the hospice must submit to CMS its total, annual, unique, survey-eligible, deceased patient count for the prior calendar year.

(f) Vendors that want to become CMS-approved CAHPS® Hospice Survey vendors must meet the minimum business requirements. Survey vendors must have been in business for a minimum of 4 years, have conducted surveys in the approved survey mode for a minimum of 3 years, and have conducted surveys of individual patients for a minimum of 2 years. For Hospice CAHPS®, a "survey of individual patients" is defined as the collection of data from at least 600 individual patients selected by statistical sampling methods, and the data collected are used for statistical purposes. Vendors may not use home-based or virtual interviewers to conduct the CAHPS® Hospice Survey, nor may they conduct any survey administration processes (for example, mailings) from a residence.

(g) No organization, firm, or business that owns, operates, or provides staffing for a hospice is permitted to administer its own Hospice CAHPS® survey or administer the survey on behalf of any other hospice in the capacity as a Hospice CAHPS® survey vendor. Such organizations will not be approved by CMS as CAHPS® Hospice Survey vendors.

(h) *Reconsiderations and appeals of Hospice Quality Reporting Program decisions.* (1) A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Report-

ing Program for a particular reporting period. A hospice must submit a reconsideration request to CMS no later than 30 days from the date identified on the annual payment update notification provided to the hospice.

(2) Reconsideration request submission requirements are available on the CMS Hospice Quality Reporting Web site on CMS.gov.

(3) A hospice that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

(i) *Exemptions and extensions requirements.* (1) A hospice may request and CMS may grant exemptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the hospice.

(2) A hospice requesting an exemption or extension must do so within 90 days of the date that the extraordinary circumstances occurred by sending an email to CMS Hospice QRP Reconsiderations at HospiceQRPreconsiderations@cms.hhs.gov that contains all of the following information:

(i) Hospice CMS Certification Number (CCN).

(ii) Hospice Business Name.

(iii) Hospice Business Address.

(iv) CEO or CEO-designated personnel contact information including name, title, telephone number, email address, and mailing address (the address must be a physical address, not a post office box).

(v) Hospice's reason for requesting the exemption or extension.

(vi) Evidence of the impact of extraordinary circumstances beyond the hospice's control, including, but not limited to photographs, newspaper, other media articles, or independent sources attesting to the incident that can be reasonably corroborated. Include dates of occurrence and other documentation that may support the rationale for seeking extension or exemption.

(vii) Date when the hospice believes it will be able to again submit data under paragraph (b) of this section and a justification for the proposed date.

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(3) CMS may grant exemptions or extensions to hospices without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance, such as an act of nature including a pandemic, affects an entire region or locale.

(ii) A systemic problem with one of CMS' data collection systems directly affect the ability of a hospice to submit data under paragraph (b) of this section.

(j) *Data completion thresholds.* (1) Hospices must meet or exceed data submission threshold set at 90 percent of all required HIS or successor instrument records within 30-days of the beneficiary's admission or discharge and submitted through the CMS designated data submission systems.

(2) A hospice must meet or exceed the data submission compliance threshold in paragraph (j)(1) of this section to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as described under § 412.306(b)(2) of this chapter.

[79 FR 50510, Aug. 22, 2014, as amended at 85 FR 53680, Aug. 31, 2020; 86 FR 42606, Aug. 4, 2021; 88 FR 51199, Aug. 2, 2023]

Subpart H—Coinsurance

§ 418.400 Individual liability for coinsurance for hospice care.

An individual who has filed an election for hospice care in accordance with § 418.24 is liable for the following coinsurance payments. Hospices may charge individuals the applicable coinsurance amounts.

(a) *Drugs and biologicals.* An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed \$5. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug copayment schedule must be

reviewed for reasonableness and approved by the intermediary before it is used.

(b) *Respite care.* (1) The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by CMS for a respite care day.

(2) The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

(3) The individual hospice coinsurance period—

(i) Begins on the first day an election filed in accordance with § 418.24 is in effect for the beneficiary; and

(ii) Ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

§ 418.402 Individual liability for services that are not considered hospice care.

Medicare payment to the hospice discharges an individual's liability for payment for all services, other than the hospice coinsurance amounts described in § 418.400, that are considered covered hospice care (as described in § 418.202). The individual is liable for the Medicare deductibles and coinsurance payments and for the difference between the reasonable and actual charge on unassigned claims on other covered services that are not considered hospice care. Examples of services not considered hospice care include: Services furnished before or after a hospice election period; services of the individual's attending physician, if the attending physician is not an employee of or working under an arrangement with the hospice; or Medicare services received for the treatment of an illness or injury not related to the individual's terminal condition.

§ 418.405 Effect of coinsurance liability on Medicare payment.

The Medicare payment rates established by CMS in accordance with § 418.306 are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the