

§ 418.310

(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