

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 Reporting 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](mailto: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.

(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

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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; 89 FR 64272, Aug. 6, 2024]

### 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 payment rates, CMS offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.

[56 FR 26919, June 12, 1991]