

(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), applicable 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.

(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

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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 accordance 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, 2033, 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, 2033, 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 received 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:

(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