

§ 418.400

42 CFR Ch. IV (10–1–24 Edition)

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]

PART 419—PROSPECTIVE PAYMENT SYSTEMS FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES**Subpart A—General Provisions**

Sec.

419.1 Basis and scope.

419.2 Basis of payment.

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

419.20 Hospitals subject to the hospital outpatient prospective payment system.

419.21 Hospital services subject to the outpatient prospective payment system.

419.22 Hospital services excluded from payment under the hospital outpatient prospective payment system.

419.23 Removal of services and procedures from the Inpatient Only List.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

419.30 Base expenditure target for calendar year 1999.

419.31 Ambulatory payment classification (APC) system and payment weights.

419.32 Calculation of prospective payment rates for hospital outpatient services.

Subpart D—Payments to Hospitals

419.40 Payment concepts.

419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

419.42 Hospital election to reduce copayment.

419.43 Adjustments to national program payment and beneficiary copayment amounts.

419.44 Payment reductions for procedures.

419.45 Payment and copayment reduction for devices replaced without cost or when full or partial credit is received.

419.46 Requirements under the Hospital Outpatient Quality Reporting (OQR) Program.

419.47 Coding and Payment for Category B Investigational Device Exemption (IDE) Studies.

419.48 Definition of excepted items and services.

Subpart E—Updates

419.50 Annual updates.

Subpart F—Limitations on Review

419.60 Limitations on administrative and judicial review.

Subpart G—Transitional Pass-through Payments

419.62 Transitional pass-through payments: General rules.

419.64 Transitional pass-through payments: Drugs and biologicals.

419.66 Transitional pass-through payments: Medical devices.

Subpart H—Transitional Corridors

419.70 Transitional adjustment to limit decline in payment.

419.71 Payment reduction for certain X-ray imaging services.

Subpart I—Prior Authorization for Outpatient Department Services

419.80 Basis and scope of this subpart.

419.81 Definitions.

419.82 Prior authorization for certain covered hospital outpatient department services.

419.83 List of hospital outpatient department services requiring prior authorization.

419.84–419.89 [Reserved]

Subpart J—Payments to Rural Emergency Hospitals (REHs)

419.90 Basis and scope of subpart.

419.91 Definitions.

419.92 Payment to rural emergency hospitals.

419.93 Payment for an off-campus provider-based department of a rural emergency hospital.

419.94 Preclusion of administrative and judicial review.

419.95 Requirements under the Rural Emergency Hospital Quality Reporting (REHQR) Program.

AUTHORITY: 42 U.S.C. 1302, 1395l(t), and 1395hh.

SOURCE: 65 FR 18542, Apr. 7, 2000, unless otherwise noted.

Subpart A—General Provisions**§ 419.1 Basis and scope.**

(a) *Basis.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished on or after July 1, 2000 by hospital outpatient departments to