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basket percentage increase plus 5 percentage points. However, this payment rate is effective only for the period April 1, 2001 through September 30, 2001. For the period October 1, 2000 through March 31, 2001, the payment rate is based upon the rule under paragraph (b)(3)(iv) of this section. The payment rate in effect during the period April 1, 2001 through September 30, 2001 is considered the payment rate in effect during fiscal year 2001.

(5) The payment rate for hospice services furnished during fiscal years 2001 and 2002 is increased by an additional 0.5 percent and 0.75 percent, respectively. This additional amount is not included in updating the payment rate as described in paragraph (b)(3) of this section.

(c) *Adjustment for wage differences.* 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 intermediary to reflect local differences in wages according to the revised wage data.

(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]

## § 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

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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 intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year in accordance with procedures similar to those described in § 405.1803 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]

## § 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) The cap amount is \$6,500 per year and is adjusted for inflation or deflation for cap years that end after October 1, 1984, 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. The cap year runs from November 1 of each year until October 31 of the following year.

(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 period beginning on September 28 (34 days before the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year), 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

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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 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 reopening regulations.

[48 FR 56026, Dec. 16, 1983, as amended at 76 FR 47332, Aug. 4, 2011]

### § 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 § 405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the

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statutorily defined payment rates by CMS are not subject to appeal.

[74 FR 39414, Aug. 6, 2009]

## 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.