(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 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 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.

§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 SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.

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

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

Subpart D—Payments to Hospitals

Subpart E—Updates

Subpart F—Limitations on Review

Subpart G—Transitional Pass-through Payments