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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405 and 418

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Medicare Program; Hospice Wage Index for Fiscal Year 2010

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule will set forth the hospice wage index for fiscal year 2010. The final rule adopts a MedPAC recommendation regarding a process for certification and recertification of terminal illness. In addition, this final rule will also revise the phase-out of the wage index budget neutrality adjustment factor (BNAF), with a 10 percent BNAF reduction in FY 2010. The BNAF phase-out will continue with successive 15 percent reductions from FY 2011 through FY 2016.

DATES: *Effective Date:* These regulations are effective on October 1, 2009.

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SUPPLEMENTARY INFORMATION:

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I. Background

A. General

1. Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible. Counseling services and inpatient respite services are available to the family of the hospice patient. Hospice programs consider both the patient and the family as a unit of care. Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Section 1814(i) of the Act provides payment for Medicare participating hospices.

2. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i) and 1861(dd) of the Act, and our regulations at 42 CFR part 418, establish eligibility requirements, payment standards and procedures, define covered services, and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G provides for payment in one of four prospectively-determined rate categories (routine home care, continuous home care, inpatient respite care, and general inpatient care) to hospices based on each day a qualified Medicare beneficiary is under a hospice election.

B. Hospice Wage Index

Our regulations at § 418.306(c) require that the wage index for all labor markets in which Medicare-participating hospices do business be established using the most current hospital wage data available, including any changes by Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions. OMB revised the MSA definitions beginning in 2003 with new designations called the Core Based Statistical Areas (CBSAs). For the purposes of the hospice benefit, the term ''MSA-based'' refers to wage index values and designations based on the previous MSA designations before 2003. Conversely, the term ''CBSA-based'' refers to wage index values and designations based on the OMB revised MSA designations in 2003, which now include CBSAs. In the August 11, 2004 IPPS final rule (69 FR 49026), the revised labor market area definitions were adopted at § 412.64(b), which were effective October 1, 2004 for acute care hospitals. We also revised the labor market areas for hospices using the new OMB standards that included CBSAs. In the FY 2006 hospice wage index final rule (70 FR 45130), we finalized a 1-year transition policy using a 50/50 blend of the CBSA-based wage index values and the MSA-based wage index values for FY 2006. The one-year transition policy ended on September 30, 2006. For FY 2007, FY 2008, and FY 2009, we used wage index values based on CBSA designations.

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels. The original hospice wage index was based on the 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. In 1994, because of disparity in wages from one geographical location to another, a committee was formulated to negotiate a wage index methodology that could be accepted by the industry and the government. This committee, functioning under a process established by the Negotiated Rulemaking Act of 1990, was comprised of national hospice associations; rural, urban, large and small hospices; multi-site hospices; consumer groups; and a government representative. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee signed an agreement for the methodology to be used for updating the hospice wage index.

In the August 8, 1997 **Federal Register** (62 FR 42860), we published a final rule promulgating a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking Committee, using a hospital wage index rather than continuing to use the Bureau of Labor Statistics (BLS) data. The committee statement was

included in the appendix of that final rule (62 FR 42883). The reduction in overall Medicare payments if a new wage index were adopted was noted in the November 29, 1995 notice transmitting the recommendations of the negotiated rulemaking committee (60 FR 61264). Therefore, the Committee also decided that for each year in updating the hospice wage index, aggregate Medicare payments to hospices would remain budget neutral to payments as if the 1983 wage index had been used.

As decided upon by the Committee, budget neutrality means that, in a given year, estimated aggregate payments for Medicare hospice services using the updated hospice wage index values will equal estimated payments that would have been made for these services if the 1983 hospice wage index values had remained in effect. Although payments to individual hospice programs may change each year, the total payments each year to hospices would not be affected by using the updated hospice wage index because total payments would be budget neutral as if the 1983 wage index had been used. To implement this policy, a BNAF would be computed and applied annually to the pre-floor, pre-reclassified hospital wage index, when deriving the hospice wage index.

The BNAF is calculated by computing estimated payments using the most recent completed year of hospice claims data. The units (days or hours) from those claims are multiplied by the updated hospice payment rates to calculate estimated payments. For this final rule, that means estimating payments for FY 2010 using FY 2008 hospice claims data, and applying the FY 2010 hospice payment rates (updating the FY 2009 rates by the FY 2010 hospital market basket update factor). The FY 2010 hospice wage index values are then applied to the labor portion of the payment rates only. The procedure is repeated using the same claims data and payment rates, but using the 1983 BLS-based wage index instead of the updated pre-floor, pre-reclassified hospital wage index (note that both wage indices include their respective floor adjustments). The total payments are then compared, and the adjustment required to make total payments equal is computed; that adjustment factor is the BNAF.

The hospice wage index is updated annually. Our most recent update, published in the **Federal Register** (73 FR 46464) on August 8, 2008, set forth updates to the hospice wage index for FY 2009. That update also finalized a provision for a 3-year phase-out of the BNAF, which was applied to the wage index values. As discussed in detail in section I.B.1 below, the update was later revised with the February 17, 2009 passage of the American Recovery and Reinvestment Act (ARRA), which eliminated the BNAF phase-out for FY 2009.

1. Raw Wage Index Values (Pre-floor, Pre-reclassified Hospital Wage Index)

As described in the August 8, 1997 hospice wage index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are then subject to either a BNAF or application of the hospice floor calculation to compute the hospice wage index used to determine payments to hospices.

Pre-floor, pre-reclassified hospital wage index values of 0.8 or greater are adjusted by the BNAF. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by the greater of: (1) The hospice BNAF; or (2) the hospice 15 percent floor adjustment, which is a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index (raw wage index) value of 0.4000, we would perform the following calculations using the BNAF (which for this example is 0.060988; we added 1 to simplify the calculation) and the hospice floor to determine County A's hospice wage index:

Pre-floor, pre-reclassified hospital wage index value below 0.8 multiplied by the BNAF: ($0.4000 \times 1.060988 = 0.4244$).

Pre-floor, pre-reclassified hospital wage index value below 0.8 multiplied by the hospice 15 percent floor adjustment: ($0.4000 \times 1.15 = 0.4600$).

Based on these calculations, County A's hospice wage index would be 0.4600.

The BNAF has been computed and applied annually to the labor portion of the hospice payment. Currently, the labor portion of the payment rates is as follows: for Routine Home Care, 68.71 percent; for Continuous Home Care, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore the non-labor portion of the payment rates is as follows: for Routine Home Care, 31.29 percent; for Continuous Home Care, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent.

The August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464) promulgated a phase-out of the hospice BNAF over 3 years, beginning with a 25 percent reduction in the BNAF in FY 2009, an additional 50 percent reduction for a total of 75 percent in FY 2010, and complete phase-out of the BNAF in FY 2011. However, subsequent to the publication of the FY 2009 rule, the American Recovery and Reinvestment Act of 2009 (P.L. 111–5) (ARRA) eliminated the BNAF reduction for FY 2009. Specifically, division B, section 4301(a) of ARRA prohibited the Secretary from beginning the phasing-out or eliminating of the BNAF in the Medicare hospice wage index before October 1, 2009, and instructed the Secretary to recompute and apply the final Medicare hospice wage index for FY 2009 as if there had been no reduction in the BNAF. We did so in an administrative instruction to our intermediaries, which was issued as Change Request (CR) #6418 (Transmittal #1701, dated 3/13/2009). CR 6418 is available on the Web at *http://www.cms.hhs.gov/Hospice/Transmittals/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1222448&intNumPerPage=10.*

While ARRA eliminated the BNAF phase-out for FY 2009, it neither changed the 75 percent reduction in the BNAF for FY 2010, nor prohibited the elimination of the BNAF in FY 2011, as set out in the August 8, 2008 Hospice Wage Index final rule. The provision in the ARRA that eliminated the FY 2009 BNAF reduction provided the hospice industry additional time to prepare for the FY 2010 75 percent BNAF reduction and the FY 2011 BNAF elimination. Therefore, in accordance with the August 8, 2008 FY 2009 Hospice Wage Index final rule, the rationale presented in that final rule, and consistent with section 4301(a) of ARRA, in our proposed rule we said we planned to reduce the BNAF by 75 percent in FY 2010 and ultimately eliminate the BNAF in 2011. We accepted comments on the BNAF reductions.

2. Changes to Core Based Statistical Area (CBSA) Designations

The annual update to the hospice wage index is published in the **Federal Register** and is based on the most current available hospital wage data, as well as any changes by OMB to the definitions of MSAs, which now include CBSA designations. The August 4, 2005 hospice wage index final rule (70 FR 45130) set forth the adoption of the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003),

which announced revised definitions for Micropolitan Statistical Areas and the creation of MSAs and Combined Statistical Areas. In adopting the OMB CBSA geographic designations, we provided for a 1-year transition with a blended hospice wage index for all hospices for FY 2006. Subsequent fiscal years have used the full CBSA-based hospice wage index.

3. Definition of Rural and Urban Areas

Each hospice's labor market is determined based on definitions of MSAs issued by OMB. In general, an urban area is defined as an MSA or New England County Metropolitan Area (NECMA) as defined by OMB. Under § 412.64(b)(1)(ii)(C), a rural area is defined as any area outside of the urban area. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C), and have been used for the Medicare hospice benefit since implementation.

In the August 22, 2007 FY 2008 Inpatient Prospective Payment System (IPPS) final rule with comment period (72 FR 47130), § 412.64(b)(1)(ii)(B) was revised such that the two ''New England deemed Counties'' that had been considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH) but deemed urban, were no longer considered urban effective for discharges occurring on or after October 1, 2007. Therefore, these two counties are considered rural in accordance with § 412.64(b)(1)(ii)(C). The recommendations to adjust payments to reflect local differences in wages are codified in § 418.306(c) of our regulations; however there had been no explicit reference to § 412.64 in § 418.306(c) before the promulgation of the August 8, 2008 FY 2009 Hospice Wage Index final rule. Although § 412.64 had not been explicitly referred to, the hospice program has used the definition of urban in § 412.64(b)(1)(ii)(A) and (b)(1)(ii)(B), and the definition of rural as any area outside of an urban area in § 412.64(b)(1)(ii)(C). With the promulgation of the August 8, 2008 FY 2009 Wage Index final rule, we now explicitly refer to those provisions in § 412.64 to make it absolutely clear how we define urban and rural for purposes of the hospice wage index. Litchfield County, CT and Merrimack County, NH are considered rural areas for hospital IPPS purposes in accordance with § 412.64. Effective October 1, 2008, Litchfield County, CT was no longer considered part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and Merrimack County, NH was no longer considered part of urban CBSA 31700 (Manchester-Nashua, NH). Rather, these counties are now considered to be rural areas within their respective States under the hospice payment system. When the pre-floor, pre-reclassified hospital wage index was adopted for use in deriving the hospice wage index, it was decided not to take into account IPPS geographic reclassifications. This policy of following OMB designations of rural or urban, rather than considering some Counties to be ''deemed'' urban, is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the hospice wage index.

4. Areas Without Hospital Wage Data

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data on which to base the calculation of the hospice wage index. Beginning in FY 2006, we adopted a policy to use the FY 2005 pre-floor, pre-reclassified hospital wage index value for rural areas when no hospital wage data were available. We also adopted the policy that for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the State would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. Consequently, in subsequent fiscal years, we applied the average pre-floor, pre-reclassified hospital wage index data from all urban areas in that state, to urban areas without a hospital. The only affected CBSA is 25980, Hinesville-Fort Stewart, Georgia.

Under the CBSA labor market areas, there are no hospitals in rural locations in Massachusetts and Puerto Rico. Since there was no rural proxy for more recent rural data within those areas, in the FY 2006 hospice wage index proposed rule (70 FR 22394, 22398), we proposed applying the FY 2005 pre-floor, pre-reclassified hospital wage index value to rural areas where no hospital wage data were available. In the FY 2006 final rule and in the FY 2007 update notice, we applied the FY 2005 pre-floor, pre-reclassified hospital wage index data to areas lacking hospital wage data in rural Massachusetts and rural Puerto Rico.

In the FY 2008 hospice wage index final rule (72 FR 50217), we considered alternatives to our methodology to update the pre-floor, pre-reclassified hospital wage index for rural areas without hospital wage data. We indicated that we believed that the best imputed proxy for rural areas would—(1) use pre-floor, pre-reclassified hospital data; (2) use the most local data available to impute a rural pre-floor, pre-reclassified hospital wage index; (3) be easy to evaluate; and (4) be easy to update from year-to-year.

Therefore, in FY 2008, and again in FY 2009, in cases where there was a rural area without rural hospital wage data, we used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. This approach does not use rural data; however, the approach uses pre-floor, pre-reclassified hospital wage data, is easy to evaluate, is easy to update from year-to-year, and uses the most local data available. In the FY 2008 hospice wage index final rule (72 FR 50217), we noted that in determining an imputed rural pre-floor, pre-reclassified hospital wage index, we interpret the term ''contiguous'' to mean sharing a border. For example, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket Counties are contiguous with Barnstable and Bristol Counties. Under the adopted methodology, the pre-floor, pre-reclassified hospital wage index values for the Counties of Barnstable (CBSA 12700, Barnstable Town, MA) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI–MA) would be averaged resulting in an imputed pre-floor, pre-reclassified rural hospital wage index for FY 2008. We noted in the FY 2008 final hospice wage index rule that while we believe that this policy could be readily applied to other rural areas that lack hospital wage data (possibly due to hospitals converting to a different provider type, such as a Critical Access Hospital, that does not submit the appropriate wage data), if a similar situation arose in the future, we would re-examine this policy.

We also noted that we do not believe that this policy would be appropriate for Puerto Rico, as there are sufficient economic differences between hospitals in the United States and those in Puerto Rico, including the payment of hospitals in Puerto Rico using blended Federal/Commonwealth-specific rates. Therefore, we believe that a separate and distinct policy for Puerto Rico is necessary. Any alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico would need to take into account the economic differences between hospitals in the United States and those in Puerto Rico. Our policy of imputing a rural pre-floor, pre-reclassified

hospital wage index based on the pre-floor, pre-reclassified hospital wage index(es) of CBSAs contiguous to the rural area in question does not recognize the unique circumstances of Puerto Rico. While we have not yet identified an alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico, we will continue to evaluate the feasibility of using existing hospital wage data and, possibly, wage data from other sources. For FY 2008 and FY 2009, we used the most recent pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047.

5. CBSA Nomenclature Changes

The Office of Management and Budget (OMB) regularly publishes a bulletin that updates the titles of certain CBSAs. In the FY 2008 hospice wage index final rule (72 FR 50218) we noted that the FY 2008 rule and all subsequent hospice wage index rules and notices would incorporate CBSA changes from the most recent OMB bulletins. The OMB bulletins may be accessed at *http://www.whitehouse.gov/omb/bulletins/index.html.*

6. Wage Data From Multi-Campus Hospitals

Historically, under the Medicare hospice benefit, we have established hospice wage index values calculated from the pre-floor, pre-reclassified hospital wage data (also called the IPPS wage index) without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The wage adjustment established under the Medicare hospice benefit is based on the location where services are furnished without any reclassification.

For FY 2010, the data collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005 were used to compute the 2009 pre-floor, pre-reclassified hospital wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. This 2009 pre-floor, pre-reclassified hospital wage index was used to derive the applicable wage index values for the hospice wage index because these data (FY 2005) are the most recent complete cost data.

Beginning in FY 2008, the IPPS apportioned the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses are located (*see* the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). We are continuing to use the pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values for FY 2010 because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the use of pre-floor, pre-reclassified hospital (IPPS) wage data, used to derive the FY 2010 hospice wage index values, reflects the application of our policy to use that data to establish the hospice wage index. The FY 2010 hospice wage index values presented in this notice were computed consistent with our pre-floor, pre-reclassified hospital (IPPS) wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments for hospice). As finalized in the August 8, 2008 FY 2009 Hospice Wage Index final rule, for the FY 2009 Medicare hospice benefit, the hospice wage index was computed from IPPS wage data (submitted by hospitals for cost reporting periods beginning in FY 2004 (as was the FY 2008 IPPS wage index)), which allocated salaries and hours to the campuses of two multi-campus hospitals with campuses that are located in different labor areas, one in Massachusetts and another in Illinois. Thus, the FY 2009 hospice wage index values for the following CBSAs were affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI–MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974), and Lake County-Kenosha County, IL–WI (CBSA 29404).

7. Hospice Payment Rates

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended section 1814(i)(1)(C)(ii) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the percentage increase in the hospital market basket index, minus 1 percentage point. However, neither the BBA nor subsequent legislation specified alteration to the hospital market basket adjustment to be used to compute hospice payments for fiscal years beyond 2002. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent fiscal years will be the market basket percentage for the fiscal year. It has been longstanding practice to use the inpatient hospital market basket as a proxy for a hospice market basket. In the FY 2010 Inpatient Prospective Payment System/Rate Year (RY) 2010 Long Term Care Hospital Prospective Payment System proposed rule (74 FR 24154), we proposed to rebase and revise the inpatient hospital operating market basket.

Historically, the rate update has been published through a separate administrative instruction issued annually, in the summer, to provide adequate time to implement system change requirements. Hospices determine their payments by applying the hospice wage index in this final rule to the labor portion of the published hospice rates.

II. Provisions of the Proposed Rule and Analysis of and Responses to Public Comments

On April 24, 2009 we published a proposed rule in the **Federal Register** (74 FR 18912) that set forth the proposed hospice wage index for FY 2010. We received 729 timely items of correspondence. In general, those who commented strongly opposed the policy to reduce the BNAF adjustment in hospice and were supportive of modifications to the hospice certification and recertification of the terminal illness process. An in-depth summary of the public comments and our responses to those comments are set forth under the appropriate headings.

A. FY 2010 Hospice Wage Index

1. Background

The hospice final rule published in the **Federal Register** on December 16, 1983 (48 FR 56008) provided for adjustment to hospice payment rates to reflect differences in area wage levels. We apply the appropriate hospice wage index value to the labor portion of the hospice payment rates based on the geographic area where hospice care was furnished. As noted earlier, each hospice's labor market area is based on definitions of MSAs issued by the OMB. For this final rule, we will use the pre-floor, pre-reclassified hospital wage index, based solely on the CBSA designations, as the basis for determining wage index values for the FY 2010 hospice wage index.

As noted above, our hospice payment rules utilize the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. We will again use the pre-floor and pre-reclassified hospital wage index data as the basis to determine the hospice wage index, which is then used to adjust the labor portion of the hospice payment rates based on the geographic area where the beneficiary receives hospice care. We believe the use of the pre-floor, pre-reclassified hospital wage index data, as a basis for the hospice wage index, results in the appropriate

adjustment to the labor portion of the costs. For the FY 2010 update to the hospice wage index, we will continue to use the most recent pre-floor, pre-reclassified hospital wage index available at the time of publication.

Comment: A commenter noted that the hospital-based wage index has undergone multiple changes over the past 10 years and that providers were not invited to provide comment for CMS to consider when formalizing these changes. This commenter stated that CMS previously cited the BNAF as a mitigating factor that offset some of the adverse impacts on hospice of changes in the hospital wage index. A few commenters wrote that the existence of exceptions to the hospital wage index system in the form of reclassifications demonstrates the unfairness and inadequacy of the hospital-based wage index system, and one suggested it puts hospices at a disadvantage in attracting and retaining employees. One commenter suggested that limits be established on the allowable annual changes in index values from one year to the next to achieve wage index stability. Several commenters mentioned that a 2007 MedPAC report on the hospital wage index suggested that CMS repeal the existing hospital wage index and develop a new one. The commenter stated that MedPAC recommended that CMS evaluate the use of the revised wage index in other Medicare payment systems, which includes hospice.

Response: The pre-floor, pre-reclassified hospital wage index was adopted in 1998 as the wage index from which the hospice wage index is derived. The Negotiated Rulemaking Committee considered several wage index options: (1) Continuing with Bureau of Labor Statistics data; (2) using updated hospital wage data; (3) using hospice-specific data; and (4) using data from the physician payment system. The Committee determined that the pre-floor, pre-reclassified hospital wage index was the best option for hospice. The pre-floor, pre-reclassified hospital wage index is updated annually, and reflects the wages of highly skilled hospital workers.

We agree that the hospital-based wage index has undergone some changes in the past 10 years. Those changes were implemented through rulemaking, which provided the public an opportunity to provide comments. Therefore, we disagree that hospice providers have not had an opportunity to comment on hospital wage index changes.

The reclassification provision provided at section 1886(d)(10) of the Act is specific to hospitals. We believe the use of the most recent available pre-floor and pre-reclassified hospital wage index results in the most appropriate adjustment to the labor portion of hospice costs as required in 42 CFR 418.306(c). Additionally, use of the pre-floor, pre-reclassified hospital wage data avoids further reductions in certain rural statewide wage index values that result from reclassification. We also note that the wage index adjustment is based on the geographic area where the beneficiary is located, and not where the hospice is located.

We continue to believe that the pre-floor, pre-reclassified hospital wage index, which is updated yearly and is used by many other CMS payments systems including home health, appropriately accounts for geographic variances in labor costs for hospices. Home health agencies and hospices are Medicare's only home-based benefits, and home health agencies and hospices share labor pools. Home health agencies experience the same wage index fluctuations, but do not receive an adjustment such as the BNAF. We believe that in the interest of parity, both home-based benefits should use a hospital-based wage index without a BNAF applied. In the future, when looking into reforming the hospice payment system, we will consider wage index alternatives, to include those recommended by MedPAC.

2. Areas Without Hospital Wage Data

In adopting the CBSA designations, we identified some geographic areas where there are no hospitals, and no hospital wage data on which to base the calculation of the hospice wage index. These areas are described in section I.B.4 of this final rule. Beginning in FY 2006, we adopted a policy that, for urban labor markets without an urban hospital from which a pre-floor, pre-reclassified hospital wage index can be derived, all of the urban CBSA pre-floor, pre-reclassified hospital wage index values within the State would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index to use as a reasonable proxy for these areas. Currently, the only CBSA that would be affected by this policy is CBSA 25980, Hinesville, Georgia. We will to continue this policy for FY 2010.

Currently, the only rural areas where there are no hospitals from which to calculate a pre-floor, pre-reclassified hospital wage index are Massachusetts and Puerto Rico. In August 2007 (72 FR 50217) we adopted a methodology for imputing rural pre-floor, pre-reclassified hospital wage index values for areas where no hospital wage data are available as an acceptable proxy; that methodology is also described in section I.B.4 of this final rule. In FY 2010, Dukes and Nantucket Counties are the only areas in rural Massachusetts which are affected. We are again applying this methodology for imputing a rural pre-floor, pre-reclassified hospital wage index for those rural areas without rural hospital wage data in FY 2010.

However, as noted in section I.B.4 of this final rule, we do not believe that this policy is appropriate for Puerto Rico. For FY 2010, we are continuing to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047. This pre-floor, pre-reclassified hospital wage index value will then be adjusted upward by the hospice 15 percent floor adjustment in the computing of the FY 2010 hospice wage index.

We received no comments on this section of the proposed rule.

3. FY 2010 Wage Index With a Reduced Budget Neutrality Adjustment Factor (BNAF)

The hospice wage index set forth in this final rule will be effective October 1, 2009 through September 30, 2010. We are not incorporating any modifications to the hospice wage index methodology. In accordance with our regulations at 42 CFR 418.306(c) and the agreement signed with other members of the Hospice Wage Index Negotiated Rulemaking Committee, we are using the most current hospital data available. For this final rule, the FY 2009 hospital wage index was the most current hospital wage data available for calculating the FY 2010 hospice wage index values. We used the FY 2009 pre-floor, pre-reclassified hospital wage index data for this calculation.

As noted above, for FY 2010, the hospice wage index values will be based solely on the adoption of the CBSA-based labor market definitions and the hospital wage index. We continue to use the most recent pre-floor and pre-reclassified hospital wage index data available (based on FY 2005 hospital cost report wage data). A detailed description of the methodology used to compute the hospice wage index is contained in the September 4, 1996 hospice wage index proposed rule (61 FR 46579), the August 8, 1997 hospice wage index final rule (62 FR 42860), and the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464).

The August 8, 2008 FY 2009 Hospice Wage Index final rule finalized a provision to phase out the BNAF over 3 years, starting with a 25 percent reduction in the BNAF in FY 2009, an

additional 50 percent reduction for a total of a 75 percent reduction in FY 2010, and complete phase out in FY 2011. However, on February 17, 2009, the President signed ARRA (Pub. L. 111–5); Section 4301(a) of ARRA eliminated the BNAF phase-out for FY 2009. Therefore, in an administrative instruction (Change Request 6418, Transmittal 1701, dated 3/13/2009) entitled ''Revision of the Hospice Wage Index and the Hospice Pricer for FY 2009,'' we instructed CMS contractors to use the revised FY 2009 hospice Pricer, which included a revised hospice wage index to reflect a full (unreduced) BNAF rather than the 25 percent reduced BNAF promulgated in the August 8, 2008 FY 2009 Hospice Wage Index final rule.

While ARRA eliminated the BNAF phase-out for FY 2009, it did not change the 75 percent reduction in the BNAF for FY 2010, or the complete phase-out of the BNAF in FY 2011 that was previously promulgated in the August 8, 2008 FY 2009 Hospice Wage Index final rule.

The history of the BNAF and a detailed discussion of the events which led to its application to the hospice wage index were included in the August 8, 2008 FY 2009 Hospice Wage Index final rule. We proposed and finalized the BNAF reduction in that final rule based on the following rationale.

First, the original purpose of the BNAF was to prevent reductions in payments to the majority of hospices whose wage index was based on the original hospice wage index, which was artificially high due to flaws in the 1981 BLS data. Additionally, the BNAF was adopted to ensure that aggregate payments made to the hospice industry would not be decreased or increased as a result of the wage index change. While incorporating a BNAF into hospice wage indices could be rationalized in 1997 as a way to smooth the transition from an old wage index to a new one, since hospices have had plenty of time to adjust to the then new wage index, it is difficult to justify maintaining in perpetuity a BNAF which was in part compensating for artificially high data to begin with.

Second, the new wage index adopted in 1997 resulted in increases in wage index values for hospices in certain areas. The BNAF applies to hospices in all areas. Thus, hospices in areas that would have had increases without the BNAF received an artificial boost in the wage index for the past 11 years. We believe that continuation of this excess payment can no longer be justified.

Third, an adjustment factor that is based on 24-year-old wage index values is not in keeping with our goal of using a hospice wage index that is as accurate, reliable, and equitable as possible in accounting for geographic variation in wages. We believe that those goals can be better achieved by using the pre-floor, pre-reclassified hospital wage index, without the outdated BNAF, which would be consistent with other providers. For instance, Medicare payments to home health agencies, that utilize a similar labor mix, are adjusted by the pre-floor, pre-reclassified hospital wage index without any budget neutrality adjustment. We believe that using the pre-floor, pre-reclassified hospital wage index provides a good measure of area wage differences for both these home-based reimbursement systems.

Fourth, in the 13 years since concerns about the impact of switching from an old to a new wage index were voiced, the hospice industry and hospice payments have grown substantially. Hospice expenditures in 2006 were $9.2 billion, compared to about $2.2 billion in 1998. Aggregate hospice expenditures are increasing at a rate of about $1 billion per year. MedPAC reports that expenditures are expected to grow at a rate of 9 percent per year through 2015, outpacing the growth rate of projected expenditures for hospitals, skilled nursing facilities, and physician and home health services. We believe that this growth in Medicare spending for hospice indicates that the original rationale of the BNAF, to cushion the impact of using the new wage index, is no longer justified. These spending growth figures also indicate that any negative financial impact to the hospice industry as a result of eliminating the BNAF is no longer present, and thus the need for a transitional adjustment has passed.

Fifth, 13 years ago the industry also voiced concerns about the negative financial impact on individual hospices that could occur by adopting a new wage index. In August 1994 there were 1,602 hospices; currently there are 3,328 hospices. Clearly any negative financial impact from adopting a new wage index in 1997 is no longer present, or we would not have seen this growth in the industry. The number of Medicare-certified hospices has continued to increase, with a 26 percent increase in the number of hospice providers from 2001 to 2005. This ongoing growth in the industry also suggests that phasing out the BNAF would not have a negative impact on access to care. Therefore, for these reasons, we believe that continuing to apply a BNAF for the purpose of mitigating any adverse financial impact on hospices or negative impact on access to care is no longer necessary. In the April 24, 2009 proposed rule, we stated that we intended to continue the phase-out of the BNAF with a 75 percent reduction in FY 2010 and complete elimination in FY 2011.

Comment: All but one of those who commented on the BNAF were opposed to the BNAF phase-out. One commenter felt that any reductions in payment, such as the BNAF, need to be in ''sync'' with overall health care reform as it relates to hospice. Others felt that any phase-out should be delayed to see if or how the BNAF fits into future hospice payment reform. Another commenter noted inconsistent levels of per-capita health care spending across states, particularly at the end of life.

One commenter believed that CMS proposed to reduce the BNAF by 75 percent in the FY 2010 hospice wage index proposed rule, and believes that this proposal is contrary to the intent of Congress. This commenter believed that the provision in ARRA which eliminated the FY 2009 25 percent BNAF reduction, showed that Congress intended CMS to delay the first year of the three-year BNAF phase-out to begin the 25 percent reduction of the BNAF in FY 2010 instead of FY 2009. While this commenter strongly recommended that CMS withdraw its proposal to phase out the BNAF, he also suggested that at a minimum we should spread the phase out over a 3-year period, starting in FY 2010 with a 25 percent reduction. A number of commenters also suggested different phase-out options from the current policy that we described in the proposed rule. One suggested a 7-year phase-out, with a 10 percent reduction in FY 2010, and an additional 15 percent reduction over each of the following 6 fiscal years. Another suggested a 4-year phase-out, at 25 percent per year, starting in FY 2010. Another suggested that we phase out the BNAF over 2 years, at 50 percent per year, starting in FY 2010. Another commenter suggested an even phase-out over 3 years starting in FY 2010. Several commenters noted that a more gradual phase-out would minimize the impact on hospices given the economic downturn, and the increased costs that hospices would incur in complying with the new CoPs, which were published on June 5, 2008 (73 FR 32088) and effective December 2, 2008; and with the new data collection requirements.

Response: The FY 2010 hospice wage index proposed rule did not re-*propose* the 75 percent BNAF reduction, though we did accept comments on the BNAF reductions. Instead, we promulgated the

BNAF reductions in the FY 2009 hospice wage index final rule. At that time, we announced a 25 percent reduction in FY 2009, an additional 50 percent reduction for a total of 75 percent in FY 2010, and complete elimination of the BNAF in FY 2011. ARRA eliminated the BNAF reduction in FY 2009, but the bill's language did not address the reduction in FY 2010 and the elimination of the BNAF in FY 2011 that were finalized in the FY 2009 hospice wage index final rule. Though the BNAF phase-out was finalized in the FY 2009 rule, we accepted comments on it in this rule. While we explained in the FY 2010 hospice wage index proposed rule that ARRA's delay allowed additional time to prepare for the BNAF reduction, ARRA's delay was not our rationale for the 75 percent reduction. Our rationale for the BNAF phase-out was presented in the FY 2009 hospice wage index proposed and final rules and was discussed above.

We appreciate the commenters' concerns about how the BNAF phase-out would fit into the larger scenario of health care reform. Health care reform is a major agenda item for the Administration, and may affect the Medicare hospice benefit. We are not clear what the commenter is referring to regarding inconsistent health care spending by state, and believe this comment is outside the scope of our rule. While we cannot speak to the various health care reform measures under discussion in Congress, we continue to believe that the BNAF is an outdated adjustment, for the reasons previously mentioned in this section. However, we concur with the commenter that we should evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into our plans for future hospice payment reform.

A more gradual phase-out provides additional opportunity to evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into hospice payment reform. As we describe in section IV of this final rule, we are moving forward with our plans to collect additional data from hospices to advance our goals for increasing the accuracy of hospice payments. This longer BNAF phase-out allows us the opportunity to more thoroughly assess the impact of iterative BNAF reductions while we are performing our hospice payment reform analyses. As such, we believe that a more gradual phase-out would be appropriate at this time. Therefore, in response to public comments recommending this course of action, we are finalizing a phase-out of the BNAF over 7 years, with a 10 percent reduction in FY 2010, and additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total 40 percent in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, an additional 15 percent reduction for a total of 70 percent in FY 2014, an additional 15 percent reduction for a total of 85 percent in FY 2015, and an additional 15 percent reduction for complete elimination in FY 2016. We will continue to evaluate the impact of the BNAF. To move reform forward, we look to the industry for their participation (for example, in providing technical assistance and/or offering to serve as pilot or demonstration sites in testing a new payment system). We reserve the right to revisit the BNAF phase-out should plans for hospice payment reform be delayed, or for other reasons the Secretary deems appropriate.

Comment: One commenter wrote in support of the BNAF reduction, citing possibly fraudulent behaviors by a specific hospice, and citing what the commenter believed to be inappropriate spending by that hospice, including trips to Las Vegas and dinners at five-star restaurants.

Response: We appreciate the support for the BNAF phase-out, but note that we proposed and finalized the phase-out based on the rationale presented earlier in this section. We cannot comment on the discretionary spending patterns of individual hospices. We have forwarded the comment to our Program Integrity group for review and possible action.

Comment: A commenter believes that the BNAF phase-out was advanced to meet short-term budget goals, without collecting and analyzing data to determine if substantive changes to the hospice payment system were needed, and how any proposed changes would affect hospice programs and beneficiaries. He added that MedPAC had made recommendations related to reform of the hospice payment system, and that MedPAC had suggested that those changes be undertaken in a budget neutral fashion, with a transition period, and that the changes would require Congressional action. The commenter wrote that MedPAC had pointed out the lack of sufficient data to accurately model payment changes, and suggested that those changes could not be implemented before 2013 at the earliest. The commenter felt that the payment reduction resulting from the BNAF reduction would disproportionately impact some segments of the hospice community more than others and that CMS did not have the data to determine whether improvements in the rate structure could be made, and what such changes should look like. The commenter felt that implementing an across-the-board cut is inappropriate and unfounded. Some asked that no reduction in the BNAF occur until a full review of the data related to the cost of providing services is completed. Finally, one commenter suggested we do a full study of the utility and efficacy of hospice.

Response: MedPAC's discussion of payment reform refers to an evaluation of and possible change to the entire hospice payment system. We agree with MedPAC's assessment that we do not have sufficient data yet to reform the entire hospice payment system, which would require legislative authority to do, and we are in the process of collecting the data that MedPAC has recommended. The BNAF phase-out was not included in MedPAC's discussion on reform of the entire hospice payment system. We proposed and finalized the policy to phase out the BNAF to remove an outdated adjustment from the wage index, to increase accuracy of payments, and to bring about parity with the home health wage index, since both home health agencies and hospices compete in the same labor market.

The rationale for the BNAF phase-out in the FY 2009 proposed and final rules is set out in section II.A.3 of this final rule. Discussion of the regulatory and economic impacts of the BNAF phase-out were set out in the FY 2009 proposed and final rules, in the FY 2010 proposed rule, and are in this final rule.

Comment: Several commenters wrote that CMS should use negotiated rulemaking to collaborate fully with hospice stakeholders before reducing or eliminating the BNAF. Some commenters noted that there is no requirement to phase out the BNAF, and that the negotiated rulemaking was not intended to be temporary or transitional. Several suggested that the BNAF should not be phased out without going through a negotiated rulemaking process. One commenter noted that CMS never suggested that the BNAF had ever been calculated inappropriately or that it was not achieving its intended goal of keeping total hospice payments under the new wage index the same as they would have been under the old BLS wage index. This commenter wrote that since the BNAF is achieving its intended purpose, CMS has no legal requirement or policy reason to eliminate it. This commenter also wrote that CMS insists on budget neutrality in all of its payment systems, and therefore

the public expected the BNAF implemented by the Committee to continue.

Other commenters stated that while CMS asserted that the purpose of the BNAF was to smooth the transition from an outdated BLS-based wage index to the hospital-based wage index in 1998, the language in several payment rules suggested that the BNAF was not a time limited adjustment and was to be applied annually, during and after the transition to the hospital-based wage index. A few commenters noted that hospices have adjusted to the BNAF as an integral part of the wage index. A commenter said CMS' rationale for phasing out the BNAF suggested that eliminating the BNAF would restore fairness to the hospice wage index, when in reality no wage index methodology is perfect.

Response: As we stated in the FY 2009 proposed and final rules, we continue to believe that the hospice wage index negotiating committee intended the BNAF to mitigate the negative financial impact of the 1998 hospice wage index change. We continue to believe that because of the growth in the industry and the amount of time that has passed since the wage index change, the rationale for maintaining the BNAF is no longer justified and it is time for a policy change. In addition, from a parity perspective, we believe that a pre-floor, pre-reclassified hospital wage index is appropriate for use in adjusting rates for geographic variances in both of our home-based benefits, hospice and home health. Nothing in our data analysis has shown us that hospice labor costs differ substantially from home health labor costs. Therefore, we believe we cannot justify the 6 percent increase in the hospice wage index and the corresponding approximate 4 percent increase in aggregate payments as a result of the BNAF. We believe that the BNAF was originally put into place protect beneficiary access to hospice care. We believe the Negotiated Rulemaking Committee was primarily concerned about those areas of the country that would see their payments dramatically reduced as a result of the wage index change. The Committee was concerned that the payment reductions might affect the viability of hospices in these areas, thus ultimately risking access to care. The Committee also intended that aggregate payments to hospices not be reduced as a result of the wage index change. While we agree with the commenter that our 1998 regulation describes that the BNAF be applied during and after the transition to the new wage index, we also note that that same regulation describes that in the event that we decide to change this methodology, we would propose to do so in rulemaking. In the beginning of this section of the FY 2010 hospice wage index final rule, we cited our rationale from the FY 2009 hospice wage index final rule as to why we believe a policy change was warranted. However, as noted previously, we are phasing out the BNAF more gradually, over a 7 year period. We are reducing the BNAF in FY 2010 by 10 percent, and then reducing it further by an additional 15 percent for each of the next 6 years, so that it is fully phased-out by FY 2016. We will evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into our plans for future hospice payment reform. As such, we believe that a more gradual phase-out is appropriate at this time.

As previously noted, the decision to transition from the BLS-based wage index to the hospital-based wage index was a long process. In the October 14, 1994 proposed rule (59 FR 52130), we noted that both CMS (formally HCFA) and industry projections indicated that most hospices would have their wage indices lowered if a new wage index were based on unadjusted hospital data. The preamble of the final rule stated that, ''During the discussions preliminary to developing a new wage index, the industry voiced concerns over the adverse financial impact of a new wage index on individual hospices and a possible reduction in overall Medicare hospice care payments'' (59 FR 52130). There were also concerns that access to hospice care could be affected. We noted that as a result of the impact of the lower payments to hospices in the aggregate, the new wage index would have to be at least budget neutral (59 FR 52131). The Committee Statement of April 13, 1995, which was published in a notice on November 29, 1995 (60 FR 61265), said that we would apply a factor to achieve budget neutrality, and noted that budget neutrality meant that aggregate Medicare hospice payments using the new hospital-based wage index would have to equal estimated payments that would have been made under the original hospice wage index.

We disagree with the commenter who wrote that Medicare insists on budget neutrality in all of its payment systems, and therefore we should keep the BNAF. The commenter is correct that in many (but not all) of our other payment systems, we apply a budget neutrality adjustment each year when a wage index change occurs to ensure that aggregate payments made using the new wage index are the same as payments made using the prior year's wage index. A wage index is essentially an index of wage weights which are relative to 1, reflecting relative geographic differences in labor costs. Because the hospital wage data are updated each year, and these are the usual data upon which our wage indices are built, the year-to-year change in total Medicare benefit payments is minor. The yearly update enables the relative weight values of the wage indices to reflect current geographic wage fluctuations. The hospice budget neutrality adjustment factor differs from these budget neutrality adjustments in a significant way. Because the original, 1981 Bureau of Labor Statistics based hospice wage index wasn't updated since it was first created, the relative weights of the wage index values became inaccurate over the years, ultimately resulting in inaccurate hospice payments in most areas of the country, and erroneously low payments in other areas of the country. By the mid-1990s the weights were so distorted and inaccurate, that we were paying hospices more in the aggregate than we would have paid had a wage index which was reflective of more current geographic wage variances in labor costs been used, such as the yearly updated hospital wage index. This inaccuracy resulted in an unintended increase in payments. By continuing to apply the BNAF in perpetuity, we are no longer simply adjusting hospice payments for differences in geographic variances in labor costs; rather we are perpetrating artificially-inflated payments associated with inaccurate wage weights.

As we described in the rationale provided at the beginning of this section, we do not believe that the Committee foresaw the tremendous growth in the hospice industry that has occurred in the past 12 years. As a result of this growth, the surge of new entrants into the industry over the past 12 years has benefited from this adjustment. We continue to believe that the Committee adopted the BNAF to help existing hospices transition to the 1998 wage index change. We note that in the late 1990's almost all hospices were not-for-profit. Impact analysis performed by participants in the negotiating process showed pockets of the country where the migration to the new hospital wage index would result in wage index values dramatically decreasing nearly 30 percent during the 3-year transition. The Committee was clearly concerned about hospice viability in those areas of the country, with a corresponding concern about access to care. We continue to believe that the unique BNAF

methodology, coupled with the 3-year transition period, served to address those concerns. It also continues to be our belief that because of the growth in the number of hospices, and the growth in the beneficiaries served that has occurred during the last decade, the Committee's goal to ensure that access to hospice care not be reduced as a result of the wage index change has been achieved. Therefore, we believe that this unique methodology for achieving budget neutrality has served its purpose and is no longer necessary, and we are phasing out this adjustment.

We agree with the commenter that the language in the August 8, 1997 final rule indicated that the BNAF would be applied during and after the transition period (62 FR 42862), which we believe we have done; however, this language did not imply that the BNAF could never be changed or eliminated. That same final rule clearly stated that if it became necessary to change the wage index methodology, we would do so through notice and comment rulemaking (62 FR 42863).

Comment: A commenter wrote that CMS tried to diminish the size of the BNAF reduction by noting that they will be ''mitigated'' by market basket updates. The commenter said that market basket updates are essentially cost of living increases intended to keep providers' payments in line with increased costs. The commenter felt that by doing away with the BNAF through a regulatory process, CMS is essentially eliminating the hospice payment update, and then making a further cut, and making an end-run around the congressionally-established payment system for hospice services. He added that CMS had implemented the BNAF phase-out without seeking input from knowledgeable stakeholders, including Congress, and without relying on a deliberative and inclusive process, over a short three-month timeframe.

Response: The commenter appears to suggest that, because Congress has determined that hospice payment *rates* are to be increased each year by the market basket update factor, it therefore follows that hospice *payments* must increase each year by the same percentage. We disagree, and believe that the commenter is looking at the market basket update alone, when instead Medicare payments to hospices are affected by other things—including the hospice wage index. Calculating the hospice payment rates for the four types of hospice services is merely the first step in determining how much hospices will be paid for services in any particular year. Once those rates are determined (by taking the prior year's rates and adjusting them by the market basket update factor), we apply the hospice wage index to the labor component of the payment rate. The values in that index change from year to year based on data CMS collects regarding hospital wages in different labor markets. Some hospices end up being paid at a rate lower than what they would have received based solely on the market basket update factor, while some end up being paid at a higher rate. These fluctuations occur every year, and they would continue to occur regardless of whether or not we phase out the BNAF. By requiring the hospice payment rates to be adjusted annually using the market basket update factor, Congress was not guaranteeing that hospices, individually or in the aggregate, would always receive an identical adjustment in payments. On the contrary, although Congress imposes a statutory cap on payments and sets the payment rates for the four categories of hospice services (based on the market basket update factor), it otherwise gives the Secretary the exceedingly broad authority to develop (and revise as necessary) the administrative tools used to calculate actual hospice payments under Medicare. *See* Section 1814(i)(1)(A) of the Act (''[T]he amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations * * *''). Following the commenter's reasoning, the Secretary would be prohibited from taking any action that would result in hospices receiving less than what they would receive if the adjusted rates (*i.e.,* with the market basket update factor applied) were applied with no further modification. Indeed, we would be prohibited from using the wage index entirely, because using that index necessarily means that some hospices will receive less in payments than they would if the market basket update-adjusted rates were applied without further alteration. While we have on occasion sought industry input before proposing changes, we are not required to seek stakeholder input beyond that of providing a comment period.

Comment: A commenter wrote that CMS justified phasing out the BNAF in part because the combination of increases in the wage index in certain areas with the BNAF led to an artificial boost in the wage index for the past 11 years, which CMS concluded was an excess payment. While this commenter disagrees that some hospices received an ''artificial boost'' in payments due to the BNAF, this commenter suggested that CMS change the methodology for the limited number of hospices that CMS believes benefited unduly from the ''artificial boost'' given by the BNAF. This commenter felt that CMS has failed to analyze the impact of the elimination of the BNAF on hospices and on Medicare beneficiaries in need of hospice services. The analysis should evaluate the current role and impacts of the BNAF phase-out in light of the other elements of the hospice wage index, and how those elements have changed over time, and the effects of those changes. As an example, this commenter noted that hospitals are allowed geographic reclassifications which hospices are not, and CMS has not shown whether and to what extent hospices are disadvantaged by this.

Response: We continue to believe that applying the BNAF to the hospital-based wage index does not accurately, account for geographic variances in hospice labor costs. When the hospice industry changed from the BLS-based wage index to the pre-floor, pre-reclassified hospital wage index, it began using more accurate, more current data which are updated annually. When that transition occurred, there were hospices whose wage index value increased, but many hospices saw their wage index value decrease. This is because the BLS-based wage index values, which were applied to hospice payments, were artificially high in some areas of the country. The Committee itself acknowledged that the BLS data were ''inaccurate and outdated'' in its Committee Statement (62 FR 42883). The hospital-based wage index was considered more accurate by the Committee, even though its wage index values were lower for many hospices. Therefore before the transition to the hospital-based wage index, many hospices were receiving payments that were inflated due to the artificially high BLS-based wage index.

In addition, the BNAF was put into place to mitigate the potential adverse financial impact to hospice providers of changing wage indices, since the change would lead to a reduction in payments, which could threaten access to care. However, as we previously described in the comment above, the BNAF has been applied not only to those hospices that were in existence at the time of the wage index change, but also to those new hospices that were established after 1998. We continue to believe that these new entrants have received an artificial boost to their payments as a result of the

BNAF, which was not the intent of the negotiating committee.

As noted above, because of the inaccurate and outdated nature of the BLS-based wage data, those payments would also be inaccurate, and CMS must do its best to ensure the accuracy of Medicare payments. Therefore we believe that it is appropriate to phase-out the BNAF for all hospices, and not just those who are new entrants, or whose wage index values did not drop with the shift to the hospital-based wage index.

The payment reduction which would occur as a result of a BNAF phase-out applies equally to all hospices except for providers eligible for the hospice floor calculation. That calculation lessens the effect on those providers eligible for the floor, which are typically in rural areas.

There are no statutory provisions that explicitly permit entities other than hospitals to reclassify. We note that sections 1886(d)(8)(B) & 1886 (d)(10) of the Social Security Act explicitly permit hospitals to seek reclassification. By contrast, no language in Section 1814(i)(1)(A) of the Act provides any indication that Congress intended hospices to reclassify. Our regulations at 42 CFR 418.306(c) state only that 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 definitions of Metropolitan Statistical Areas.

As noted previously, we are assessing the impact of the BNAF phase-out more slowly, due to the more gradual 7-year phase-out which is being finalized in this rule.

Comment: A few commenters mentioned that CMS had said in 2008 that since hospices and home health agencies use a similar labor pool, and since the home health wage index does not include the BNAF, this further supports phasing out the BNAF. The commenter wrote that there are significant differences between hospice and home health, and said that the issue is the difference in the payment systems. The commenter wrote that it is inappropriate to assume, without any analysis, that the absence of a BNAF in the home health wage index is evidence that the BNAF can and should be eliminated from the hospice wage index, and that do so would result in a more accurate and equitable payment methodology.

Response: There are differences in the home health and hospice payment systems. However, the purpose of a wage index is to account for geographic variances in labor costs, regardless of the system used to reimburse those costs, along with non-labor costs. As we described in our FY 2009 proposed and final rules, we believe that there should be a level playing field for recruiting and retaining staff for home-based benefits such as hospice and home health. Because hospices and home health agencies share labor pools, we believe that there should be consistency in the wage index used by both these home-based benefits. Nothing in our data analysis has shown us that hospice labor costs differ substantially from home health labor costs, making it difficult to justify the BNAF which provides a 6 percent increase in the hospice wage index, which equals about 4 percent more in payments over the payments otherwise applicable. We continue to believe that the pre-floor, pre-reclassified hospital wage index provides a good measure to account for geographic variances in labor costs for both these home-based benefits. Home health agencies also experience annual fluctuations in the hospital wage index values, however, they do not receive a BNAF adjustment. Phasing-out the BNAF enables us to achieve this consistency.

Comment: Several commenters stated that CMS has concluded that the growth in the hospice benefit was due to the BNAF, in order to justify its elimination. The commenters noted a number of factors that have contributed to the hospice industry's growth, including an increased number of beneficiaries using the benefit, longer lengths of stay, increased acceptance of hospices for end-of-life care by the physician and patient/family communities, changes in the mix of patients using hospice, and educational efforts by providers and by CMS to beneficiaries and health care providers. One commenter noted that the number of Medicare certified hospices had decreased from the 3,255 reported by CMS in December 2008 to the 3,206 hospices reported as of January 29, 2009. Another commenter stated that hospice is a small portion of all Medicare spending.

Response: We disagree with the comment that we concluded that the growth in the hospice industry was due to the BNAF or that the BNAF reduction is a reaction to the growth in hospice reimbursements. However, the commenters correctly noted several factors that have contributed to industry growth. In our FY 2009 proposed and final rules, we indicated that the BNAF phase-out was not a reaction to that growth—in the proposed rule, rather we stated that the BNAF was put in place to mitigate any adverse financial impact that then-existing individual hospices might have experienced as a result of transitioning to the new hospital-based wage index in 1998. We note that industries do not typically expand and grow during times of financial adversity; often there is industry contraction instead. We stated that the growth in the industry is an indication that any adverse financial effects of transitioning to a new wage index had ended.

We disagree with the commenter who believes that the numbers of Medicare-certified hospices have decreased, and can explain the differences in the figures which might lead to that conclusion. The report from Data Compendium dated December 2008 showed Medicare-certified hospices; these data are drawn from survey and certification records. The data in the impact tables in our wage index proposed and final rules are also originated from survey and certification data, but those data are limited to those Medicare-certified hospices which have filed claims. Because of the time allowed for claims to be submitted and for the claims files to be finalized, the claims files used in proposed and final rules typically lag. Therefore, the data presented in the impact tables in our proposed and final rules show the numbers of Medicare-certified hospices which have filed claims, and are typically less than the numbers which the survey and certification system reports, which simply show the number of Medicare-certified hospices. That number often increases between the proposed and final rules, since we receive updated claims information which we use for the final rule. Additionally, with respect to newly-certified Medicare hospices, there may be a lag between certification and submission of Medicare claims. Thus, the total number of Medicare-certified hospices may legitimately be greater in number than the number of Medicare-certified hospices that submit Medicare hospice claims in a given year.

To make a proper comparison, one must either compare impact table data for one year to impact table data for another year, or compare survey and certification data without ties to claims filed for one year to survey and certification data without ties to claims filed to another year. For example, the Table 1 of this FY 2010 final rule shows that there are 3,328 hospices. We used January 29, 2009 survey and certification data, but tied it to FY 2008 claims as of March 2009. In the FY 2009 final rule, there were 3,111 hospices; that rule tied February 2008 survey and certification data to FY 2007 claims as of March 2008. Based on these data, the number of hospices increased by 217,

which represents a 7 percent increase from 2008 to 2009.

We agree that hospice spending relative to all Medicare spending is a small portion that will account for an estimated 2.3 percent of Medicare spending overall in FY 2009. The growth in hospice spending has outpaced the rate of growth for other Medicare provider types, and the CMS Office of the Actuary projects that it will continue to do so over the next decade. Furthermore, CMS has a responsibility to safeguard trust fund dollars by paying accurately and appropriately for all Medicare services.

Comment: Several comments suggested other ways that CMS could save Medicare dollars without phasing out the BNAF. Many commenters said that we should encourage more patients to elect hospice care, and cited a Duke University study which found that hospice can save Medicare money at the end of life; one suggested we focus on assisting physicians and hospitals in providing more education about hospice. Several suggested we target fraud and abuse. One commenter suggested we target the for-profit hospices whose practices have inappropriately raised Medicare costs, rather than making a payment reduction which impacts non-profits and for-profits equally. A commenter also suggested we focus payment reductions on hospices with aberrant lengths of stay. Other commenters felt that phasing out the BNAF penalizes hospices that do the right thing with a substantial rate cut because large for-profit hospices have managed to ''game'' the system. Several commenters felt that rather than addressing potential abuses, CMS is choosing to implement across-the-board actions without regard to the impact on the lowest and most efficient end of the provider spectrum, or on access. A commenter wrote that instead of focusing on the root cause of increasing hospice expenditures (an aging population, quality services, increased understanding of the benefit, *etc.*), CMS is simply cutting reimbursement. One wrote that the rationale for payment reduction seems at odds with a careful and thoughtful consideration of changes in the payment approach that will best serve hospice patients, agencies, and the Federal budget.

Response: We encourage eligible Medicare beneficiaries who would like to receive hospice care to consider electing the benefit. We also support educational outreach to all provider types to increase understanding of the benefits associated with hospice care. We believe that hospice provides quality, compassionate care for those at the end of life, and often does so in a cost-effective fashion. We agree that hospice can save Medicare dollars, though it does not always do so.

The BNAF phase-out was not promulgated because of growing hospice expenditures, although those expenditures did suggest a favorable business climate for the hospice industry. We are aware that those rising expenditures also indicated increasing numbers of eligible beneficiaries and increasing understanding and use of the benefit which we have encouraged. The BNAF phase-out was also not promulgated as a means of limiting fraud or abuse or of recovering dollars due to questionable or inappropriate practices by some hospices. Rather, our rationale for promulgating the BNAF phase-out is the same as that described in the FY 2009 proposed and final rules, and is included at the beginning of this section of the FY 2010 hospice wage index final rule. The rationale was carefully considered as part of a thoughtful process. We determined that a special adjustment which was adopted to mitigate the impact of wage index change in 1998, which results in a greater than 4 percent annual aggregate increase in payments over what would have been paid otherwise, could not continue to be justified. We recognize that the BNAF reductions affect providers equally unless the providers are eligible for the hospice floor calculation, in which case the reductions may have less effect. The hospice floor calculation limits the impact that the BNAF reduction can have on some smaller, rural providers. As noted previously, we are phasing out the BNAF more gradually, reducing it in FY 2010 by 10 percent instead of by 75 percent, as promulgated in the FY 2009 final rule and as presented in the FY 2010 hospice wage index proposed rule. We will continue the phase-out over the next 6 years, at an additional 15 percent each year. We will evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into our goals for future hospice payment reform. As such, we believe that a more gradual phase-out is appropriate at this time.

The impact of the 10 percent BNAF reduction for FY 2010 is shown in section VII of this final rule.

Regarding the comment about targeting some for-profit hospices for a payment reduction, we typically do not adjust payments based on type of ownership, and do not have the statutory authority to do so, nor do we believe that such an approach is appropriate.

We believe that the vast majority of hospices provide care to their patients in a legal and ethical fashion that is not fraudulent or abusive of Medicare or its requirements. However, we realize that there is a small minority of providers who engage in fraud or abuse, and we remind commenters that they can report suspected fraud or abuse to the Office of the Inspector General at 1–800–HHS–TIPS or to the Medicare Customer Service Center at 1–800–MEDICARE.

After considering the comments received and alternate phase-out scenarios provided by commenters, we are finalizing the FY 2010 hospice wage index final rule with a BNAF which has been reduced by 10 percent, rather than continuing with the 75 percent reduction which was promulgated in the FY 2009 hospice wage index final rule, and planned for FY 2010. We are finalizing a 7-year phase-out, with a 10 percent reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total of 40 percent in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, an additional 15 percent reduction for a total of 70 percent in FY 2014, an additional 15 percent reduction for a total of 85 percent in FY 2015, and an additional 15 percent reduction for complete phase-out in FY 2016. We will continue to evaluate the impact of the BNAF reduction as we perform our hospice payment reform analyses.

We believe that a more gradual phase-out is appropriate given the hospice payment reform analyses which are underway; however, we reserve the right to change this phase-out timeframe through notice and comment rulemaking should hospice payment reform be delayed or for other reasons that the Secretary deems appropriate.

The unreduced BNAF for FY 2010 is computed to be 0.061775 (or 6.1755 percent). A 10 percent reduced BNAF, which is subsequently applied to the pre-floor, pre-reclassified hospital wage index values greater than or equal to 0.8, is computed to be 0.055598 (or 5.5598 percent). Pre-floor, pre-reclassified hospital wage index values which are less than 0.8 are subject to the hospice floor calculation; that calculation is described in section I.B.1.

The hospice wage index for FY 2010 is shown in Addenda A and B. Specifically, Addendum A reflects the FY 2010 wage index values for urban areas under the CBSA designations. Addendum B reflects the FY 2010 wage index values for rural areas under the CBSA designations.

4. Effects of Phasing Out the BNAF

The full (unreduced) BNAF calculated for FY 2010 is 6.1775 percent. As noted in the previous subsection, we are phasing out the BNAF over a total of 7 years. We are reducing the BNAF by 10 percent for FY 2010, with additional 15 percent reductions for each of the next 6 years. Therefore total phase-out will occur in FY 2016.

For FY 2010, this is mathematically equivalent to taking 90 percent of the full BNAF value, or multiplying 0.061775 by 0.90, which equals 0.055598 (5.5598 percent). The BNAF of 5.5598 percent reflects a 10 percent reduction in the BNAF. The 10 percent reduced BNAF (5.5598 percent) will be applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater in the FY 2010 hospice wage index.

The hospice floor calculation will still apply to any pre-floor, pre-reclassified hospital wage index values less than 0.8. Currently, the hospice floor calculation has 4 steps. First, pre-floor, pre-reclassified hospital wage index values that are less than 0.8 are multiplied by 1.15. Second, the minimum of 0.8 or the pre-floor, pre-reclassified hospital wage index value times 1.15 is chosen as the preliminary hospice wage index value. Steps 1 and 2 are referred to in this final rule as the hospice 15 percent floor adjustment. Third, the pre-floor, pre-reclassified hospital wage index value is multiplied by the BNAF. Finally, the greater result of either step 2 or step 3 is chosen as the final hospice wage index value. The hospice floor calculation is unchanged by the BNAF reduction. We note that steps 3 and 4 will become unnecessary once the BNAF is eliminated.

We examined the effects of a 10 percent reduction in the BNAF versus using the full BNAF of 6.1775 percent on the FY 2010 hospice wage index. The FY 2010 BNAF reduction of 10 percent resulted in approximately a 0.57 to 0.59 percent reduction in most hospice wage index values. The phase-out of the BNAF over the following 6 fiscal years at 15 percent per year will result in an additional estimated annual reduction of the hospice wage index values of approximately 0.9 percent per year.

Those CBSAs whose pre-floor, pre-reclassified hospital wage index values had the hospice 15 percent floor adjustment applied before the BNAF reduction would not be affected by this phase-out of the BNAF. These CBSAs, which typically include rural areas, are protected by the hospice 15 percent floor adjustment. We have estimated that 18 CBSAs are already protected by the hospice 15 percent floor adjustment, and are therefore completely unaffected by the BNAF reduction. There are over 120 hospices in these 18 CBSAs.

Additionally, some CBSAs with pre-floor, pre-reclassified wage index values less than 0.8 will become newly eligible for the hospice 15 percent floor adjustment as a result of the 10 percent reduced BNAF. Areas where the hospice floor calculation would have yielded a wage index value greater than 0.8 if the full BNAF were applied, but which will have a final wage index value less than 0.8 after the 10 percent reduced BNAF is applied, will now be eligible for the hospice 15 percent floor adjustment. These CBSAs will see a smaller reduction in their hospice wage index values since the hospice 15 percent floor adjustment will apply. We have estimated that 3 CBSAs will have their pre-floor, pre-reclassified hospital wage index value become newly protected by the hospice 15 percent floor adjustment due to the 10 percent reduction in the BNAF. This will affect those hospices with lower wage index values, which are typically in rural areas. There are 9 hospices located in these 3 CBSAs.

Finally, the hospice wage index values only apply to the labor portion of the payment rates; the labor portion is described in section I.B.1 of this final rule. Therefore the projected reduction in payments due to the updated wage data and the 10 percent reduction of the BNAF will be less than the projected reduction in the wage index value itself. We estimated a projected reduction in payments of −0.7 percent, as described in column 4 of Table 1 in section VII of this final rule. In addition, the estimated effects of the phase-out of the BNAF will be lessened by any hospital market basket updates to payments. The hospital market basket update for FY 2010 is 2.1 percent and will be officially communicated through an administrative instruction. The combined effects of the updated wage data, the 10 percent reduction of the BNAF and a hospital market basket update of 2.1 percent for FY 2010 is an overall estimated increase in payments to hospices in FY 2010 of 1.4 percent (column 5 of Table 1 in section VII of this final rule).

Comment: Many commenters wrote that they had already pared back expenses, and that they could not absorb any cuts, particularly with the present economic downturn; smaller providers and rural providers in particular said that they may not be able to survive the payment reduction. A number of commenters indicated that because of the economy, their hospices had already implemented a variety of spending reductions, including hiring or wage freezes, and a few said that they had already laid off some personnel. Some indicated that they would postpone hiring for vacant positions. Many also wrote that hiring and wage freezes, layoffs, and wage reductions would lead to higher caseloads, and likely lower the quality or quantity of services provided, as well as reduce morale. Some were concerned that they would lose nursing staff to hospitals if they could not pay nurses competitively. One wrote that when the upswing finally comes, it will be difficult to hire and train quality employees in a timely manner, adding to staffing costs overall.

Many commenters, particularly in rural areas, said that a payment reduction would force them to reduce their service area, leaving some rural beneficiaries without access to any hospice care. One commenter noted that smaller hospices generally provide better, more personal care, but if they cannot survive, only large hospices will remain in business; this commenter felt that patients and families will have lower quality care as a result. Others noted that they would cut back services provided, and mentioned that bereavement programs, outreach programs, proven alternative therapies, staff training, and volunteer training would be targeted. A number of commenters felt that the BNAF reduction would ultimately increase Medicare costs, as patients in a crisis would go to the hospital if hospice staffing was too low to respond quickly, or if patients lost access to care and were forced into other post-acute settings or into hospitals at the end of life.

One commenter reported that hospices had also postponed a planned expansion of services or of facilities. This commenter mentioned the closure of an inpatient unit or consolidation of offices as other cost cutting measures taken due to the economic climate. Multiple commenters wrote that a payment cut would force them to lay off workers, which is contrary to the Obama Administration's stated goal of preserving jobs and stimulating growth. A few stated that ARRA's delay of the FY 2009 BNAF reduction saved 3,000 jobs, and that these jobs will be at risk if the BNAF reduction is implemented for FY 2010.

Several commenters also indicated that donations usually help them to meet their expenses, but that with the recession and stock market decline, their donors had less to give; they wrote that donations were greatly reduced and fundraising was more difficult. As a

result, some said they were already operating with negative margins. Several commenters said that small or medium hospices would be more affected than larger hospices, and that their margins could not absorb greater expenses or a payment reduction. Some cited MedPAC's margin analysis, which showed average hospice margins at 3.4 percent, stating that they could not survive the 3.2 percent payment reduction reported in the FY 2010 proposed rule. A few noted that for some, the payment reduction is far greater than 3.2 percent, citing 5 percent or 9 percent reductions overall for their CBSA.

Additionally, several commenters said that a payment reduction would force them to reduce or eliminate care to indigent patients and to the uninsured. They noted that they had previously accepted all patients without regard to ability to pay, and that their revenues from Medicare and from donations enabled them to absorb the costs of providing care to the uninsured; one commenter wrote that her hospice is ''mandated'' to accept all eligible patients, regardless of ability to pay. Given the economic climate, particularly the current unemployment rate, many felt that this was the wrong time to be reducing payments.

Response: While we are sensitive to the issues raised by commenters, and to the possible effects of the BNAF reduction, we continue to believe that we cannot justify an adjustment factor which was adopted to mitigate the impact of a 1998 wage index change, and which results in what we believe to be an inappropriate increase in overall hospice payments of approximately 4 percent annually over what would have been paid in absence of the BNAF. Therefore, for the reasons described in this FY 2010 hospice wage index final rule and in the FY 2009 hospice wage index final rule, we will phase out the BNAF. However, as noted in the previous section, given the efforts to reform the hospice payment system, we are finalizing a more gradual phase-out of the BNAF over 7 years. We believe it would be prudent to take additional time to evaluate the BNAF phase-out in the context of these reforms, in order to allow for further consideration of any consequences that might result from the phase-out.

Regarding MedPAC's margin analysis, we refer commenters to MedPAC's 2008 report entitled ''Report to the Congress: Reforming the Payment System'' [*http://www.medpac.gov/documents/Jun08_EntireReport.pdf*], which lists limitations of the analysis which could lead to an underestimation of hospice margins. In response to the commenters who believed that the impact of the BNAF reduction is greater in some areas, we note that the reductions in payments which exceed the 3.2 percent reported in our FY 2010 proposed rule impact summary are not due to the BNAF phase-out, but are due to the normal fluctuations in the pre-floor, pre-reclassified hospital wage index. The BNAF affects all hospices equally, except for those eligible for the hospice floor calculation (*i.e.,* hospices with pre-floor, pre-reclassified hospital wage index values less than 0.8). Those hospices which are eligible for the hospice floor calculation are either completely protected from the effects of the BNAF reduction, or will experience lessened effects. Most of these hospices are in rural areas.

We applaud hospices which provide care to the uninsured and to indigent patients. We note that Medicare hospice patients have nearly all of their hospice care paid for by Medicare; the co-payments for prescription drugs and for respite care are very small. This benefits all hospice patients, but particularly low income patients, as the out-of-pocket costs are minimal. We also note that hospices develop their own policies about taking eligible patients without insurance or the means to pay; Medicare does not ''mandate'' that hospices take all eligible patients regardless of ability to pay or insurance status.

Finally, the costs of complying with the new CoPs and with the data collection requirements are normal costs of doing business, for which hospices have had ample time to prepare.

Comment: One commenter wrote that the Negotiated Rulemaking Committee was familiar with the serious disruptions that could occur in the delivery of healthcare services through a change in the payment distribution methodology. The commenter felt that stability in delivery of hospice care is dependent on payment stability, which is lost if CMS phases out the BNAF. A few commenters wrote that we did not have enough data or data analysis to justify the elimination of the decade old BNAF, and felt that our eliminating the BNAF was arbitrary and capricious. One said that without a careful analysis of all the effects of the phase-out, phasing out the BNAF would be arbitrary and capricious and a violation of the Administrative Procedures Act. Some wrote that we had not carefully analyzed the impact of this action. One commenter wrote that historically, Congress has rejected the Administration's requests to reduce hospice reimbursement rates, understanding that any reduction in rate must necessarily reduce quality of care or access to care. This commenter felt that the 2009 NPRM is inconsistent with the legislative intent to maintain and ensure adequate hospice funding levels.

Response: We presented our rationale for the BNAF phase-out in the FY 2009 proposed and final rules and in section II.A.3 of this final rule. Commenters have argued that we have not considered the effects of reducing the BNAF on hospices; we disagree, and refer the commenters to the impact section of our rule, which set out detailed information on the effects of reducing the BNAF.

More than adequate access to hospice care was reported by MedPAC [*see* ''Report to the Congress: Reforming the Payment System'', chapter 8, available at *http://www.medpac.gov/documents/Jun08_EntireReport.pdf*], and suggests that a BNAF phase-out will not impede access to hospice care. Given this information, we continue to believe that a BNAF phase-out will not impede access to hospice care. Congress mandated the payment rates and the market basket updates. Congress did not mandate that we apply in perpetuity a special adjustment to the hospice wage index that has the effect of raising aggregate hospice payments by about 4 percent annually over what CMS would have paid absent the BNAF.

We appreciate the commenters' concerns regarding possible effects of a payment reduction. The BNAF affects all hospices equally, except for those eligible for the hospice floor calculation (*i.e.,* hospices with a pre-floor, pre-reclassified hospital wage index values less than 0.8). Those hospices which are eligible for the hospice floor calculation are either completely protected from the effects of a BNAF reduction, or experienced lessened effects. Most of these hospices are in rural areas.

We also do not believe that our actions in phasing-out the BNAF were arbitrary or capricious. We believe that the rationale and impacts provided in the FY 2009 and FY 2010 proposed and final rules are clear, and that we met all the requirements of the Administrative Procedures Act.

Comment: Many commenters wrote that this is the wrong time for a payment reduction due to rising costs, particularly gasoline. Rural providers in particular cited the rising cost of gasoline combined with service areas that cover thousands of square miles and generate significant mileage costs. Additionally, others wrote that the 1983 per diems were not designed to cover the costs of technology and of expensive palliative treatments, and said hospices couldn't afford a payment reduction on

top of that. Another wrote that hospices had had to spend more to implement the new Conditions of Participation and data collection requirements, but received no additional reimbursement to cover the cost of these changes. They felt that if the BNAF were phased out as described in the proposed rule, hospices would be subjected to multiple significant changes over a short period of time, and that too many reforms at once could have a negative impact on access to quality hospice services and relations operations. Others cited rising wages, benefit costs, and insurance costs.

Many commenters also felt that this was the wrong time to reduce reimbursement given the nation's demographics. Some expressed concern that access to hospice would be reduced if hospices could not survive the BNAF reductions or if they had to reduce their service areas, at a time when there are more baby boomers eligible for hospice. They noted that the demand for hospice would be increasing as the geriatric population increases, and one said she was disconcerted to hear of CMS' concern over the growing utilization of hospice. One wrote that demographers in his state projected more persons without caregivers in the home; less money for hospices erodes hospices' capacity to provide care, and may lead to an increase in costly nursing home stays.

A few noted that a payment reduction was inconsistent with the health care reform being discussed in Washington, as hospice saves Medicare money and should be supported and expanded. Many commenters noted that a study done at Duke University has shown that hospice is cost-effective, and saves Medicare dollars overall while providing quality end-of-life care. A commenter also referred to the Dartmouth Atlas Report (2008) which found that hospices were the only post-acute provider to significantly reduce hospitalizations. Another commenter wrote that if patients could not access hospice and end up in hospitals, it would burden an already strained hospital healthcare delivery system. Two commenters suggested we also consider the ''secondary savings'' that hospice brings by positively affecting conditions unrelated to the patient's terminal diagnosis, by benefitting the physical and emotional health of the caregivers, and of the children of hospice patients.

Response: We appreciate the commenters' concerns about rising costs and about access to hospice care. We understand that costs are rising and that it is vital to preserve access to hospice care for Medicare beneficiaries. The hospital market basket update which is used to update payment rates for all hospices includes an energy component that is sensitive to petroleum costs among other costs. It is reasonable to expect that future market basket updates will continue to account for any continuation of rising fuel costs.

In addition, we believe that the requirements associated with the CoPs and data collection are part of the cost of doing business, and that the industry has had ample time to plan and budget for these changes. We do not believe that these requirements will have adverse affects on admissions or services, but instead expect that the emphasis on quality and the increased awareness of visits provided could enhance services.

We believe that in a time of economic pressures, all businesses, including hospices, will seek to operate more efficiently. However, we plan to monitor the effect of the BNAF reduction to assess whether unanticipated effects occur.

We agree that the Medicare hospice benefit has been of tremendous benefit to those at the end of life and to their families, and applaud those who serve the dying as hospice staff and volunteers. We also agree that the hospice benefit often saves Medicare money, and appreciate the studies which have highlighted the areas where it provides costs savings to the Medicare program. However, hospice care does not save money in every instance. In their June 2008 report, MedPAC noted that ''hospice's net reduction in Medicare spending decreases the longer the patient is enrolled and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice.'' (MedPAC, Report to the Congress: Reforming the Delivery System, chapter 8, ''Evaluating Medicare's Hospice Benefit'', MedPAC: Washington, DC, p. 209).

We agree that we should evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into our goals for future hospice payment reform that could affect payment to hospices. As such, we believe that a more gradual phase-out would be appropriate at this time. For the reasons described above, we do not believe that hospice access will be impeded due to a 10 percent BNAF reduction, and therefore, do not believe that Medicare costs would be shifted from hospice to more expensive forms of care.

The hospice industry is growing and the demand for hospice services is likely to grow in the future, particularly with an aging population. CMS has encouraged hospice usage, and we expect the hospice benefit to continue to grow. We will monitor the impact of the BNAF phase-out for any unintended impact.

Comment: A few commenters wrote that any reductions in Medicare reimbursement will trickle down to the private sector and to Medicaid, affecting funding for care for all patients, not just those on Medicare. One wrote that CMS had not considered the effects of the BNAF reduction on Medicaid.

Response: Our Medicare payments are intended to be accurate and to adequately pay for resource use in providing care to Medicare patients. We do not develop Medicare payment policy to enable providers to offset the costs of non-Medicare patients. Indeed, the Act at section 1861(v)(1) prohibits providers subject to reasonable-cost payment from using Medicare funds to subsidize care for non-Medicare patients.

We received several comments which were outside the scope of this rule, and which we are set out below.

Comment: A commenter wrote that in addition to payment reductions that would result from the elimination of the BNAF, hospices may also be faced with cuts imposed through the productivity adjustment factor proposed in the draft health reform bill being circulated by the House of Representatives.

Response: Because this comment concerns potential future legislative changes, this comment is outside the scope of this rule. Therefore we are unable to respond.

We received several other comments which were outside the scope of this rule, and which are set out below. However because they are related to hospice payments, we will briefly address them.

Comment: A few commenters requested that CMS conduct a study to determine the appropriate hospice per diem for services to rural areas.

Response: This comment is outside the scope of this rule, however we will address it briefly. Medicare pays one of four daily rates to hospice providers, based on the intensity level of care the patient requires. These per diem payment rates are the same, regardless of whether the services are provided in an urban area or a rural area. The hospice wage index, which includes a floor calculation which benefits many rural providers, is the vehicle we use to adjust for geographic variances in labor costs. In a time of high gasoline costs, we are sensitive to concerns from rural hospices that the additional time and distance required to visit a rural patient

adds significantly to their costs, and their assertion that payments are not adequate. However, an additional payment for rural providers, which is sometimes called a rural add-on payment, would have to be legislated. We will consider the situation of rural providers once we begin the process of hospice payment system reform.

Comment: One person suggested we rate all end-of-life care and fund only those hospices which provide excellent services.

Response: While outside the scope of this rule, we will consider this as we move forward hospice payment reform.

Comment: As alternative cost-cutting measures, a commenter suggested we regulate the standards of care, and ensure that providers follow the Conditions of Participation; another suggested more frequent surveys. Another suggested that unnecessary medical tests and procedures performed to avoid litigation and paid for by Medicare should be the target of funding cuts. One commenter suggested we eliminate the tax credit for not-for-profit nursing homes and hospices that don't embody that not-for-profit spirit, and make them pay taxes on their income. One suggested we focus on nursing home chains that create hospice chains solely for additional billing opportunities. Another suggested we go after providers who exploit the dying with false hope that curative measures will lengthen their lives or improve their quality of life. Two commenters felt that if the BNAF phase-out occurs, politicians would have excellent health insurance and hospice care, but that the average American would have bare-bones hospice coverage. A commenter wrote that we should require all hospices to be non-profits, so that more money goes to patient care.

Response: We appreciate these comments, but they are outside the scope of this rule.

B. Change to the Physician Certification and Recertification Process, § 418.22

The Medicare Payment Advisory Commission (MedPAC) has noted an increasing proportion of hospice patients with stays exceeding 180 days, and significant variation in hospice length of stay. MedPAC has questioned whether there is sufficient accountability and enforcement related to certification and recertification of Medicare hospice patients. Currently, our policy requires the hospice medical director or physician member of the interdisciplinary group and the patient's attending physician (if any) to certify the patient as having a terminal illness for the initial 90-day period of hospice care. Subsequent benefit periods only require recertification by the hospice medical director or by the physician member of the hospice interdisciplinary group. These certifications must indicate that the patient's life expectancy is 6 months or less if the illness runs its normal course, and must be signed by the physician. The medical record must include documentation that supports the terminal prognosis.

At their November 6, 2008 public meeting, MedPAC presented the findings of an expert panel of hospice providers convened in October 2008; that panel noted that while many hospices comply with the Medicare eligibility criteria, some are enrolling and recertifying patients who are not eligible.

The expert panel noted that there were several reasons for the variation in compliance. First, they noted that in some cases there was limited medical director engagement in the certification or recertification process. Physicians had delegated this responsibility to the staff involved with patients' day-to-day care, and simply signed off on the paperwork. Second, inadequate charting of the patient's condition or a lack of staff training had led some physicians to certify patients who were not truly eligible for Medicare's hospice benefit. Finally, some panelists cited financial incentives associated with long-stay patients. The panelists mentioned anecdotal reports of hospices using questionable marketing strategies to recruit patients without mentioning the terminal illness requirement, and of hospices failing to discharge patients who had improved or enrolling patients who had already been discharged or turned away from other hospices. Consensus emerged among the panelists that more accountability and oversight of certification and recertification are needed. MedPAC used the panel's input in making recommendations related to the certification process, which can be found in chapter 6 (''Reforming Medicare's Hospice Benefit'') of MedPAC's March 2009 report entitled ''Report to the Congress: Medicare Payment Policy'' which is available at *http://www.medpac.gov/chapters/Mar09_Ch06.pdf*.

We believe that those physicians that are certifying a hospice patient's eligibility can reasonably be expected to synthesize in a few sentences the clinical aspects of the patient's condition that support the prognosis. We believe that such a requirement, as suggested by the expert panel and by MedPAC, would encourage greater physician engagement in the certification and recertification process by focusing attention on the physician's responsibility to set out the clinical basis for the terminal prognosis indicated in the patient's medical record.

To increase accountability related to the physician certification and recertification process, we are making a change to § 418.22. Specifically, we are adding a new paragraph (b)(3) to § 418.22, to require that physicians that certify or recertify hospice patients as being terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less. We originally proposed that the narrative should be written or typed on the certification form itself.

In our proposed rule, we wrote that we do not believe that an attachment should be permissible because an attachment could easily be prepared by someone other than the physician. We solicited comments on whether this requirement would increase physician engagement in the certification and recertification process.

Comment: Many commenters stated that this requirement would be a burden to hospices. Commenters referred to our regulations at § 418.22 which require that the clinical information and other documentation supporting the terminal prognosis must be included in the medical record, stating that the narrative would duplicate information in the medical record. Several commenters further stated that many hospice doctors have no clinical contact with the hospice patients, and that doctors currently base the certification of terminal illness on the medical record information alone. Therefore, they believe that this requirement would result in physicians simply rephrasing what was already in the medical record. Several commenters suggested CMS determine whether this requirement is feasible for small hospices with only a part-time medical director. Other commenters suggested that CMS require the narrative only on recertifications, stating that MedPAC's suggestion was intended to ensure that long-stay hospice patients continue to be hospice-eligible. Additionally, they said given that two physicians determine initial eligibility, a narrative at initial certification is unnecessary and burdensome. One commenter suggested an alternative to the narrative, suggesting that an attestation statement be included on the certification and recertification form stating that the pertinent medical record information has been reviewed by the physician.

Many commenters supported this requirement as a way to ensure more

physician involvement with the patient and increase engagement in the certification of terminal illness. Some cautioned CMS to not allow a typed narrative, fearing that the hospice nurse would type it, and the physician would simply sign off without performing the sort of physician review and involvement that CMS intended.

Some commenters supported the requirement, but encouraged CMS to reconsider that the narrative must be present on the certification and recertification form, asking CMS to consider accepting an attachment. A few commenters believed that hospices which have electronic medical records may incur costly software modifications if the narrative must be included on the certification and recertification. The commenters believed that as long as the physician's written or electronic signature was included on the narrative, it would make no difference if the narrative was an addendum.

Several commenters stated that CMS should provide illustrative examples to help hospices and physicians understand the scope of acceptable responses.

Many commenters were supportive of the proposal, but cautioned CMS that not all patients show measurable indications of decline at the time of every recertification. These commenters cautioned CMS to not regulate the process such that hospices will be encouraged to discharge patients inappropriately.

Another commenter encouraged that CMS be clear that neither check boxes nor standard language should be permitted to satisfy the requirement, that we clarify that this narrative must be composed by the physician performing the certification or recertification, and that the certification and recertification forms containing the narrative should include under the physician's signature a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review.

Response: We thank the writers for their comments. We concur with the commenter who states that 42 CFR 418.22(b) requires clinical information and other documentation supporting the terminal prognosis to be included in the medical record. However, we disagree that the inclusion of the clinical narrative duplicates the medical record information, or that the narrative should be completed only at the time of recertification. Rather, as we stated in the proposed rule, we believe that the physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative, which we believe will increase physician accountability associated with the terminal prognosis. This synthesis should not be a simple restatement of the medical record facts, but instead sets out the physician's rationale as to how the facts justify the prognosis. We also disagree that a statement on the certification and recertification form that the physician attests he has reviewed the medical record accomplishes the increased physician accountability goal. Our intent is for the physician to justify his prognosis, rather than simply sign a form. While our regulations have always required the physician to perform this sort of review, we believe often the physician relies too heavily on the hospice staff for the prognosis determination in both the certification and recertification of terminal illness.

Because the physician has always been required to perform the review needed to make a terminal illness prognosis, we disagree that the corresponding short narrative which describes the physician's clinical justification associated with the prognosis is overly burdensome. However, we do understand that many physicians prefer to dictate rather than hand-write their clinical findings. And we agree with commenters who stated that some electronic health record systems may more easily produce an addendum containing the clinical justification. Therefore, we have decided that a typed addendum containing the narrative which is electronically or hand signed by the physician will be acceptable. We also agree with the commenters who suggested that the narrative include an attestation, and that we clarify some criteria associated with the narrative requirement. Therefore, we clarify that: (1) The narrative must be composed by the physician performing the certification or recertification and not by other hospice personnel; (2) the narrative should include, under the physician signature, a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, examination of the patient; (3) the narrative reflects the patient's individual clinical circumstances, and should not contain checked boxes or standard language used for all patients; and (4) in the case of the initial certification, we require either the attending physician or the hospice medical director to compose and sign the clinical narrative.

We believe that the narrative will curtail the practice described by one commenter who stated that the physician relies solely on hospice staff and hospice staff entries in the medical record for the prognosis determination, and has little interaction with the patient.

While we agree with the commenter who stated that this requirement helps address MedPAC concerns associated with long stays in hospice, we also believe that this requirement on the initial certification helps ensure that only hospice- eligible patients are admitted to hospice. We disagree with the commenter who suggested CMS include an illustrative example of narrative language, since the intent of the narrative is to capture the physician's synthesis of each patient's unique conditions.

In response to the commenter who cautioned CMS that not all patients show measurable indications of decline at the time of every recertification, we believe this commenter was concerned that CMS may regulate the process such that hospices will be encouraged to discharge patients inappropriately. This comment appears to suggest that the physician narrative may risk patients being discharged inappropriately at recertification time. We disagree that this is a risk. CMS regulations at 42 CFR 418.22, certification of terminal illness, describe in detail the requirements that are necessary to certify and recertify patients that are terminally ill. We also acknowledge that at recertification, not all patients may show measurable decline. We believe that the physician may choose to include facts such as that as part of his narrative, if he or she believes it to be pertinent in his or her justification.

We are finalizing our proposal to require that physicians who certify or recertify hospice patients as terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less. We are modifying our original proposal in that we will allow the narrative to either be part of the certification and recertification forms, or it may be on an addendum to the certification and recertification forms which is electronically or hand signed by the physician. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum. The narrative must reflect

the patient's individual clinical circumstances. The narrative must not contain check boxes or standard language used for all patients. In the case of the initial certification, we require either the attending physician or the hospice medical director to compose and sign the narrative. We also require that the narrative include under the physician signature, a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, examination of the patient.

C. Update of Covered Services, § 418.202

In Part 418, subpart F, we describe covered hospice services. In § 418.200, Requirements for Coverage, we note that covered services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. We also note that services provided must be consistent with the plan of care. The language at § 418.202, ''Covered services'', describes specific types of hospices services that are covered. Section 418.202(f) describes the coverage of medical appliances and supplies, including drugs and biologicals. The last sentence of § 418.202(f) states that covered medical supplies ''include those that are part of the written plan of care.''

The updated CoPs, which were effective as of December 2008, now require that hospices include all comorbidities in the plan of care, even if those comorbidities are not related to the terminal diagnosis. In § 418.54(c)(2) we refer to assessing the patient for complications and risk factors that affect care planning. Comorbidities that are unrelated to the terminal illness need to be addressed in the comprehensive assessment and should be on the plan of care, clearly marked as comorbidities unrelated to the terminal illness. However, the hospice is not responsible for providing care for the unrelated comorbidities. Because the hospice is not responsible for providing the care for these unrelated comorbidities, we are revising § 418.202(f) to state that medical supplies covered by the Medicare hospice benefit include only those that are part of the plan of care and that are for the palliation or management of the terminal illness or related conditions.

Comment: Commenters supported the proposed clarification in § 418.202 which currently states that medical supplies covered by the hospice benefit include those that are part of the plan of care and that are related to the palliation and management of the terminal illness or related conditions. One commenter stated that because it is difficult for hospices to determine which conditions are related to the terminal illness, that CMS should also require hospices to have written policies describing their processes for determining whether care is related to the terminal illness or related conditions. One commenter wrote that in the absence of companion rules in SNFs, this rule as written has the potential to cause confusion and conflict within the facilities as the facility providers seek resolution on the integration of the care plan and the related cost and responsible party.

Response: We appreciate the support received for the clarification at 42 CFR section 418.202. The comments regarding written policies describing the processes for determining what is related to the terminal illness, and about companion rules in SNFs, are outside the scope of this payment rule, and therefore we are unable to respond. However, we have forwarded these comments to the group within CMS which handles facility Conditions of Participation, for their consideration in future rulemaking.

We are finalizing the change to § 418.202 as proposed.

D. Clarification of Payment Procedures for Hospice Care, § 418.302

Section 1861(dd) of the Act limits coverage of and payment for inpatient days for hospice patients. There are sometimes situations when a hospice patient receives inpatient care but is unable to return home, even though the medical situation no longer warrants general inpatient care (GIP), or even though 5 days of respite have ended. In computing the inpatient cap, the hospice can only count inpatient days in which GIP or respite care is provided and billed as GIP or respite days. For example, assume a patient received 5 days of respite care while a caregiver was out of town, but the caregiver's return was delayed for a day due to circumstances beyond her control. The patient had to remain as an inpatient for a 6th day, but was no longer eligible for respite care. According to § 418.302(e)(5), the hospice should switch from billing for respite care to billing for routine home care on the 6th day. The hospice should only count 5 days toward the inpatient cap, not 6 days, since only 5 inpatient days were provided and billed to Medicare as respite days.

Because we have received several inquiries about how to count inpatient days that are provided and billed as routine home care, we are revising § 418.302(f)(2) to clarify that only inpatient days in which GIP or respite care is provided and billed are counted as inpatient days when computing the inpatient cap.

Comment: Commenters supported the proposal to clarify that inpatient care provided and billed as GIP or respite should be the only inpatient care included in the inpatient cap calculation. However one commenter wrote that her hospice does not agree that inpatient respite services should be charged against the inpatient cap, given the changes in the CoP regulations with respect to 24-hour RN coverage.

Response: We appreciate commenters' support for this proposal. The Social Security Act requires the inclusion of respite services in the inpatient cap calculation (*see* section 1861(dd)(2)(A)(iii) of the Act). Therefore, we cannot make a change to this requirement. We are finalizing the change to 42 CFR § 418.302 as proposed.

E. Clarification of Intermediary Determination and Notice of Amount of Program Reimbursement, § 405.1803

Currently, hospices that exceed either the inpatient cap or the aggregate cap are sent a letter by their contractor (regional home health and hospice intermediary (RHHI) or fiscal intermediary (FI)), detailing the cap results, along with a demand for repayment. As described in an administrative instruction (CR 6400, Transmittal 1708, issued April 3, 2009) effective July 1, 2009, this letter of determination of program reimbursement will be sent to every hospice provider, regardless of whether or not the hospice has exceeded the cap. A demand for repayment will be included for those hospices which have exceeded either cap. If a hospice disagrees with the contractor's cap calculations, the hospice has appeal rights which are set out at 42 CFR § 418.311 and Part 405, subpart R. The letter of determination of program reimbursement shall include language describing the hospice's appeal rights. We proposed clarifying the language at § 405.1803 to note that for the purposes of hospice, the determination of program reimbursement letter sent by the contractors serves as the written notice reflecting the intermediary's determination of the total amount of reimbursement due the hospice, which is commonly called a Notice of Program Reimbursement or NPR. Additionally, we proposed clarifying § 405.1803(a)(1)(i) to note that in the case of hospice, the reporting period covered by the determination of

program reimbursement letter is the hospice cap year and the bases for the letter are the cap calculations rather than reasonable cost from cost report data.

Comment: Commenters supported the proposed clarification, but asked that CMS also clarify that the time period for filing cap appeals does not begin until the hospice receives the letter of determination of program reimbursement. Additionally, they asked CMS to clarify that hospices should not be required to wait until they receive these letters to appeal issues unrelated to the caps. Many commenters also were dissatisfied with the amount of time between the end of a cap year and the hospice receiving the determination letter.

Response: We thank commenters for their support of this clarification, and for their questions, which point out an addition to regulatory text which would be helpful. Several commenters had questions related to the timing of appeals because of the location of the proposed changes to the regulatory text. To avoid confusion, we have established a separate subsection at § 405.1803(a)(3) entitled ''Hospice Caps''. This section includes the language originally proposed for § 405.1803(a) and § 405.1803(a)(1)(i). Additionally, we are adding a sentence to the regulatory text at § 405.1803(a)(3) which notes that the timeframe for hospice cap appeals begins with receipt of the determination of program reimbursement letter.

Commenters also asked about the timing when appealing issues unrelated to the caps. The timing of all other claims appeals is unrelated to the determination of program reimbursement letters, and those appeals are governed under 42 CFR 418.311. When appealing claims decisions, providers should continue to follow the procedures and timeframes outlined in the CMS Claims Processing Manual (IOM 100–04), Chapter 29 (''Appeals of Claims Decisions''), which can be accessed through the CMS Hospice Center Web page at *http://www.cms.hhs.gov/center/hospice.asp.*

Finally, we have taken note of the long timeframe some commenters currently report in receiving the results of their cap calculations, and will consider this information in any changes to the cap calculation methodology that might be made in the future.

For this final rule, we are revising the proposed changes to § 405.1803. Specifically, we are creating a separate section at § 405.1803(a)(3) subtitled ''Hospice Caps'', providing the same information that we had proposed be in § 405.1803(a) and § 405.1803(a)(1)(i). The regulatory text at § 405.1803(a) and § 405.1803(a)(1)(i)is to be unchanged. Additionally, we will add a sentence to the new section at § 405.1803(a)(3) to note that the timeframe for appeals of cap calculation results begins with receipt of the determination of program reimbursement letter.

F. Technical and Clarifying Changes

We are incorporating the following technical changes to clarify existing regulations text, correct errors that we have identified in the regulations, remove obsolete cross references, or to ensure consistent use of terminology in our regulations.

1. Clarification of the Statutory Basis for Hospice Regulation, § 418.1

Currently, the statutory basis for the hospice regulations is described at § 418.1, and notes that Part 418 implements section 1861(dd) of the Act. The regulation describes section 1861(dd) of the Act as specifying covered hospice services and the conditions that a hospice program must meet to participate in the Medicare program. While that is correct, section 1861(dd) of the Act also specifies some limitations on coverage and payment for inpatient hospice care. In the proposed rule we proposed clarifying § 418.1 by adding a sentence noting that section 1861(dd) of the Act limits coverage and payment for inpatient hospice care.

We received no comments on this proposal, and are finalizing the changes as proposed.

2. Update of the Scope of Part, § 418.2

The current regulations at § 418.2 (''Scope of part.'') describe each of the subparts in Part 418. Some of these subparts have been revised or removed due to the update of the hospice conditions of participation (CoPs) in 2008 (73 FR 32088). Specifically, subpart B specifies the eligibility and election requirements, along with the duration of benefits. Subparts C and D specify the Conditions of Participation, with subpart C now entitled ''Patient Care'' rather than ''General Provisions and Administration'', and subpart D now entitled ''Organizational Environment'' rather than ''Core Services''. Subpart E, which was previously described as specifying reimbursement methods and procedures, was removed and reserved for future use with the update of the CoPs. Subparts F and G now relate to payment policy, to include covered services and hospice payment; currently subpart F is incorrectly described in § 418.2 as specifying coinsurance amounts. Finally, subpart H should be referred to as specifying coinsurance amounts applicable to hospice care, rather than subpart F as the regulation currently reads. Accordingly, we proposed to update section § 418.2 to reflect the current organization and scope of Part 418.

We received no comments on this proposal, and are finalizing the changes as proposed.

3. Revision of Hospice Aide and Homemaker Services, § 418.76

In the proposed rule, we proposed to incorporate a technical correction at § 418.76(f)(1) to clarify that home health agencies that have been found out of compliance with paragraphs (a) or (b) of § 484.36, regarding home health aide qualifications, are prohibited from providing hospice aide training. The word ''out'' was inadvertently omitted from the regulation text in the June 5, 2008 hospice final rule.

We received no comments on this proposal, and are finalizing the changes as proposed.

4. Clarification of Hospice Multiple Location, § 418.100

For the sake of clarity, in the proposed rule we proposed to delete the word ''that'' from § 418.100(f)(1)(iii), regarding multiple locations. The revised element would require that the lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location which was issued the certification number.

We received no comments on this proposal, and are finalizing the changes as proposed.

5. Revision to Short Term Inpatient Care, § 418.108

In the proposed rule, we proposed to correct in § 418.108(b)(1)(ii) an erroneous reference to § 418.110(f), ''Patient rooms''. This section, which addresses facilities that are considered acceptable for the provision of respite care to hospice patients, was intended to reference the standard at § 418.110(e), ''Patient areas''. The published reference to standard (f) was a typographic error, and we are correcting it by changing the reference to standard (e).

We received no comments on this proposal, and are finalizing the changes as proposed.

6. Clarification of the Requirements for Coverage, § 418.200

Section 418.200 describes the requirements for coverage for Medicare

hospice services, and references § 418.58 (''Conditions of Participation—Plan of care''). This cross reference is no longer accurate; section § 418.58 was updated with the publication of the new CoPs in 2008, and is now § 418.56. In the proposed rule we proposed to detail the requirements for coverage related to the plan of care rather than cross refer to the CoPs regulations. This revision would make clearer that the statute requires review of the plan of care as a condition for coverage of hospice services. However, we are continuing to include a reference to the updated CoP section (418.56) for a comprehensive description of our expectations associated with the plan of care.

The statute specifies requirements for hospice coverage in section 1814(a)(7)(A) through (C) of the Act. The Act requires that the hospice medical director and the patient's attending physician certify the terminal illness for the initial period of hospice care and that the medical director recertify the terminal illness for each subsequent benefit period. Additionally, the Act requires that a plan of care exist before care is provided; that the plan of care be reviewed periodically by the attending physician, the medical director, and the interdisciplinary group; and that care be provided in accordance with the plan of care. In the proposed rule, we proposed to clarify § 418.200 to incorporate each of these requirements for coverage, rather than cross referencing other CoPs.

We received no comments on this proposal, and are finalizing the changes as proposed, except that we are continuing to include the CoP cross-reference.

7. Incorporation of the Term ''Hospice Aide,'' § 418.202, § 418.204, and § 418.302

Over the last several years, we have worked with the industry to update the hospice CoPs. These efforts culminated in publication of a final rule in 2008, which was effective December 2, 2008. The revised CoPs redesignated the ''home health aide'' who works in hospice as a ''hospice aide''. We are revising § 418.202(g), § 418.204(a), and § 418.302 to include the new terminology.

Comment: One commenter suggested we remove the language ''home health aide'' and just use the term ''hospice aide''.

Response: We appreciate this comment. However, we are keeping the reference to a ''home health aide'' in the regulations, because that is how the Social Security Act refers to aides in hospice. Consequently, we are finalizing the change as proposed.

8. Clarification of Administrative Appeals § 418.311

A hospice that does not believe its payments have been properly determined may request a review from the intermediary or from the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Section 418.311 details the procedures for appealing a payment decision and also refers to Part 405, Subpart R.

In the proposed rule, we proposed to clarify the last sentence of this section, which currently notes that ''the methods and standards for the calculation of the payment rates by CMS are not subject to appeal.'' The payment rates referred to are the national rates which are set by statute, and updated according to the statute using the hospital market basket (unless Congress instructs us to update the rates differently). To ensure better understanding of what is not subject to appeal, we proposed to revise § 418.311 to provide that methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal.

We received no comments on this proposal, and are finalizing the changes as proposed.

III. Comments on Other Policy Issues

A. Recertification Visits, § 418.22

As noted earlier, MedPAC convened an expert panel from the hospice industry in late 2008. That panel noted that some hospices were enrolling and recertifying patients who they determined were not eligible for hospice care under the Medicare benefit, and a consensus emerged that greater accountability and oversight were needed in the certification and recertification process. To further increase accountability in the recertification process, several of the panelists suggested to MedPAC that an additional policy change be made to the recertification process. Several panelists supported a requirement that a hospice physician or advanced practice nurse visit the patient at the time of the 180-day recertification to assess continued eligibility, and at every recertification thereafter to assess the patient's continued eligibility. MedPAC recommended that the physician or advanced practice nurse be required to attest that the visit took place. MedPAC used the panel's input in making recommendations related to the certification process, which can be found in chapter 6 (''Reforming Medicare's Hospice Benefit'') of MedPAC's March 2009 report entitled ''Report to the Congress: Medicare Payment Policy'' which is available at *http://www.medpac.gov/chapters/Mar09_Ch06.pdf.*

At this time, we are not making any policy change to require visits by physicians or advanced practice nurses in order to recertify patients. We note that the statute requires a physician to certify and recertify terminal illness for hospice patients, and specifically precludes nurse practitioners from doing so at 1814(a)(7)(A) of the Act. A recertification visit to a hospice patient by a nurse practitioner would not relieve the physician of his or her legal responsibility to recertify the terminal illness of such hospice patient. The physician is ultimately responsible for the recertification determination. However, the visit, if performed by a nurse practitioner, could potentially serve as an additional, objective source of information for the physician in the recertification of terminal illness decision. We are also considering other options related to a nurse practitioner making recertification visits. For example, a nurse practitioner who is involved in a patient's day-to-day care may not be as objective in assessing eligibility for recertification as a nurse practitioner who is not caring for that patient regularly. One option to better ensure that a nurse practitioner visit results in additional, objective clinical assessment of the patient's condition might be to require that such nurse practitioner not be involved in the hospice patient's day-to-day care. Also, there are different possible approaches regarding the timeframe for making visits. Visits by a physician or nurse practitioner could be made within a timeframe close to the recertification deadline, such as the 2 week period centered around the recertification date, thereby allowing a window of time surrounding the recertification timeframe for a visit to occur.

While we are not making a policy change regarding recertification visits at this time, we did solicit comments on the suggestion to require physician or nurse practitioner visits for hospice recertifications at or around 180 days and for every benefit period thereafter. We solicited comments on all aspects of this suggestion, including practical issues of implementation. We will analyze and consider the comments received in possible future policy development.

Comment: Many commenters supported this requirement, but only if the visits were adequately reimbursed, stating that current payments are not sufficient to cover the costs of these visits, especially where patients reside in remote areas. Some commenters

urged the visits be performed by a physician experienced in end-of-life care. Others stated that the visit be thorough and comprehensive, and include patient and family counseling about alternate care arrangements if appropriate. Many commenters stated that advanced practice nurses should not perform the visits, stating that the goal of increased physician accountability would be achieved with a physician visit. Other commenters suggested that the visits occur only at the 180 day recertification. Similarly, many commenters suggested that the visits occur at 180 days and at every other recertification after that. Many commenters suggested the visit could occur within two or three week window around the recertification timeframe. One commenter suggested an alternative process to review non-cancer patients at 90 and 180 days. Commenters encouraged CMS to work with the industry to identify all issues which may be associated with such a requirement.

In the April 24, 2009 hospice wage index proposed rule, we suggested that if it were determined appropriate for a nurse practitioner to render such a visit, that an option to better ensure that an objective clinical assessment of the patient's condition occurred might be to require that the nurse practitioner not be involved in the day-to-day care for that hospice patient. One commenter suggested that, due to shortages in nurse practitioners, we consider allowing the nurse practitioner who was involved in the patient's day-to-day care to perform some but not all of the recertification visits. The commenter further suggested that the nurse practitioner who was involved in the patient's day-to-day care not be allowed to render the first recertification visit and not be allowed to render such visits for consecutive recertifications. Additionally, this same commenter stated that the recertification visits should occur over a reasonable timeframe before the recertification date. This commenter believes that if the ''visit were to occur after the recertification date, it could create a disincentive for hospices to discharge a patient since it would result in a lack of payment for days of care already provided beyond the recertification date.'' One commenter suggested that nurse training be developed to certify nurses in hospice eligibility evaluations. Another commenter stated that the visit must be performed by someone familiar with the patient so that changes in the patient's condition are identified.

Many commenters opposed this requirement. Commenters were concerned that this recertification requirement would be burdensome to providers and would result in decreased access to care. These same commenters were concerned that the lack of physician resources in small and rural hospices that only have a part-time medical director would make it impossible to perform these visits. Some commenters indicated that nurse practitioners are just as scarce in rural areas as physicians. Some commenters stated that there would be no increased quality associated with these visits, and that visits should be used to improve care, not monitor eligibility. Similarly, other commenters suggested we target for contractor review hospices with long-stay patients rather than penalize all hospices with this costly requirement. A commenter stated that these visits would upset the families, and are not an efficient use of resources. One commenter stated that it would be difficult for hospices to hire medical directors if this requirement were adopted.

Response: We appreciate the comments received from the public concerning this matter and will continue to analyze and consider those comments and suggestions in future rulemaking.

B. Hospice Aggregate Cap Calculation

As described in section 1814(i)(2)(A) through (C) of the Act, when the Medicare hospice benefit was implemented, the Congress included an aggregate cap on hospice payments. The hospice aggregate cap limits the total aggregate payment any individual hospice can receive in a year. The Congress stipulated that a ''cap amount'' be computed each year. The cap amount was set at $6,500 per beneficiary when first enacted in 1983 and is adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers from March 1984 to March of the cap year. The cap year is defined as the period from November 1st to October 31st, and was set in place in the December 16, 1983 hospice final rule (48 FR 56022). This timeframe was chosen as the cap year since the Medicare hospice program began on November 1, 1983 (48 FR 56022). For the 2008 cap year, the cap amount was $22,386.15 per beneficiary. This cap amount is multiplied by the number of Medicare beneficiaries who received hospice care in a particular hospice during the year, resulting in its hospice aggregate cap, which is the allowable amount of total Medicare payments that hospice can receive for that cap year. A hospice's total reimbursement for the cap year cannot exceed the hospice aggregate cap. If its aggregate cap is exceeded, then the hospice must repay the excess back to Medicare.

Using the most recent (2008) payment rates before wage adjustment, the 2008 cap amount ($22,386.15) is roughly equal to the cost of providing routine home care for 166 days. Because the hospice aggregate cap is computed in the aggregate for the entire hospice, rather than on a per beneficiary basis, hospices that admit a mix of short-stay and long stay Medicare beneficiaries will rarely exceed the cap. On average, lower expenditures made on behalf of Medicare beneficiaries with shorter hospice stays offset the expenditures made on behalf of Medicare beneficiaries with longer stays such that in the aggregate, the majority of hospices do not exceed the calculated aggregate cap.

Until recently, very few hospices ever exceeded the aggregate cap. The Government Accountability Office (GAO) found that between 1999 and 2002, less than 2 percent of hospices exceeded the aggregate cap (United States Government Accountability Office, ''Medicare Hospice Care. Modifications to Payment Methodology May Be Warranted''. October 2004, Washington, DC. p. 18). MedPAC reported that the number of hospices that exceeded the aggregate cap has grown steadily between 2002 and 2005, but remains just under 8 percent as of 2005 (Medicare Payment Advisory Commission, ''Report to the Congress: Reforming the Delivery System''. June 2008. Washington, DC. p. 212). We do not believe that hospices are exceeding the aggregate cap due to our intermediaries' method of calculating the aggregate cap. Rather, MedPAC's analyses suggest that certain hospices exceed the aggregate cap due to ''significantly longer lengths of stay'' than hospices that do not exceed the cap [MedPAC, p. 214–15]. MedPAC suggests that longer average lengths of stay at certain hospices could be due, in part, to a change in their patient case-mix that has brought in more patients with less predictable disease trajectories [MedPAC, p. 213–14]. However, patient case-mix was not found to account for all of the discrepancy in length of stay [MedPAC, p. 214–15]. MedPAC also found that for-profit ownership, smaller patient loads, and being a freestanding facility were correlated with longer lengths of stay and the consequent likelihood of exceeding the aggregate cap [MedPAC, p. 212–215].

As stated above, in our current hospice aggregate cap calculation methodology, the intermediary calculates each hospice's aggregate cap

amount by multiplying the per-beneficiary cap amount by the number of Medicare beneficiaries counted in each cap year. Patients who receive hospice care in more than one cap year are counted so that, in the aggregate, the ''number of Medicare beneficiaries'' for each year is reduced to reflect the proportion of time patients receive in other years. Hospices are currently required to submit a report of their Medicare beneficiary unduplicated census to their intermediary within 30 days of the end of the cap year. Our current methodology also apportions the beneficiary across multiple hospices if the beneficiary receives care from more than one hospice during the cap year, with the proportional shares summing to 1. The intermediary reduces each hospice's Medicare beneficiary count by that fraction which represents proportional days of care the beneficiary received in another hospice during the year, with all the proportional shares summing to 1.

In counting the Medicare beneficiaries for the unduplicated census report, we instruct hospices to use a slightly different timeframe from the cap year used to count payments. When determining a hospice's expenditures during a cap year, the intermediary sums all claims submitted by the hospice for services performed during the cap year, which begins on November 1st of each year and ends on the October 31st of the following year. However, we instruct hospices to include those beneficiaries who elect the benefit between September 28th of each year and September 27th of the following year, rather than following the November 1st to October 31st cap year. CMS (then HCFA) used mean length of stay from demonstration project data to determine the point at which to include a beneficiary in calculating the hospice cap. Using half of the mean length of stay, or 70 days/2 = 35 days, CMS implemented a timeframe for counting beneficiaries that began less than 35 days from the end of the cap year. Therefore, the timeframe for counting beneficiaries was set as September 28th through September 27th (48 FR 56022). This method of reducing the number of Medicare beneficiaries counted in a cap year to reflect time spent in other years was implemented because it allows for counting the beneficiary in the reporting period where he or she used most of the days of covered hospice care (48 FR 38158). We believe that the regulation complies with the statutory requirements without being unduly burdensome. This approach has the major advantage of allowing each hospice to estimate its aggregate cap calculation within a short period of time after the close of a cap year. While we believe that the current hospice aggregate cap methodology equitably meets the statutory requirements for calculating the hospice aggregate cap set out at section 1814(i)(2) of the Act, the availability of more sophisticated databases and data systems provides us with an opportunity to incorporate efficiencies in the cap calculation process. The lack of sophisticated data systems in place in the 1980's limited our options for how to efficiently compute the hospice aggregate cap. In the 1980's access to claims data was very slow, and searchable claims databases were virtually non-existent. While the current system still has limitations, the advancement of technology has brought with it provider access to benefit period information in the Common Working File (CWF), which was created in the 1990's, and faster processing speeds, which allow contractors and hospices easier access to claims information for hospice aggregate cap calculation purposes. Therefore, we are now able to consider more efficient approaches to calculating the aggregate cap.

The time required for intermediaries to compute each hospice's aggregate cap and send demand letters when overpayments exist delays our recovery of those overpayments and may also contribute to some hospices exceeding the cap in subsequent years. Hospices have described receiving demands for cap overpayments more than a year after the end of the cap year, and have expressed concern that they are not timely notified about their cap overpayments. Hospices which don't closely monitor compliance with their aggregate cap may not have anticipated an overpayment, and the lag in notification may contribute to the risk of a hospice exceeding its aggregate cap in the subsequent year. More timely notification of overpayments would enable hospices to more quickly review their admissions practices, and make necessary changes to ensure that all their patients meet the eligibility requirements for hospice care.

We are exploring a number of different hospice aggregate cap implementation methodology changes to address these issues, and to take advantage of the technological efficiencies available. Specifically, we are exploring enhancements to our current methodology which will improve the timeliness of hospices' notification of cap overpayments, will enable such overpayments to be collected more quickly, and which will encourage hospices to be more proactively involved in managing their admissions practices such that they do not exceed their hospice aggregate cap. We are considering several changes to the annual hospice aggregate cap calculation implementation methodology which could help hospices avoid exceeding the aggregate cap.

If a beneficiary receives hospice care for an extended period of time, or elects hospice toward the end of a cap year, he or she is more likely to cross into more than 1 cap year, or to receive care from more than 1 hospice. If we made a mathematically precise determination of the proportion of time each patient spent in each cap year at each hospice from which they received care, in order for a given cap year report to be final, adjustments to that cap year report would have to continue until the beneficiary actually died. Only then could a final determination of the aggregate cap be made for a given year for each hospice that had treated the beneficiary. Such an approach could be viewed as particularly burdensome to the hospice as a hospice's financial system would likely need to be able to continually react to subsequent hospice aggregate cap calculations, readjusting payments to Medicare to account for an overpayment amount that is ever-changing, that is, until the beneficiary dies.

A variation of this approach would allow apportioning of beneficiaries who receive care in more than 1 cap period over 2 consecutive years. This approach would minimize, but not completely eliminate, the adjustments required to prior year cap calculations. This method still has the effect of delaying the final cap determination. However, it raises questions about scenarios where a beneficiary received hospice care in his first and second cap year, either revoked or was discharged from the benefit, and returned to a different hospice at a much later date, such as in the third cap year. We would like public input from hospices, patient groups, other provider types, academics, and members of the general public on how to best handle this or similar scenarios.

Besides considering different approaches to counting beneficiaries, another option is to require hospices to compute their own hospice aggregate cap and submit a certified cap report to their contractors, along with any overpayment, 7 months after the end of the cap year. The information used for the hospice aggregate cap calculation originates with hospices, and is available to them through the CWF or through their own accounting records. Requiring hospices to compute and

report their own hospice aggregate cap would result in hospices being proactive in managing their cap calculations. In this approach, contractors would still verify the reported cap.

We solicited comments on these and other policy options in an effort to gather more information on this issue, and any other possible underlying issues that may exist.

Comment: Most commenters encouraged CMS to more timely notify providers of their cap overpayments, stating that the current delay in notification is burdensome, results in overpayments generated for prior years, and does not allow providers to make timely corrections. Many commenters suggested CMS apportion the cap over consecutive years if the patient received service over more than 1 year. Some hospices were agreeable to CMS' suggestion that hospices should calculate and report their own certified cap report, with the caveat that patients' full utilization history be made available to hospices in order for them to accurately compute the report. Others expressed concern that there should be penalties imposed for erroneous reporting. Other commenters opposed submission of a cap report, for burden reasons, and because patients' full utilization is not currently available to them. Several commenters suggested that cap amount be adjusted for geographic variances in costs. Commenters also requested that CMS allow a new cap amount for readmitted beneficiaries who experience a break in hospice utilization. Some commenters suggested we consider common ownership as a factor in the cap calculation. Many commenters stated that the cap needs to be modernized. Others stated that the suggestions CMS described in the solicitation for comments will only exacerbate the cap problems, suggesting CMS instead should consider methods that will ensure admissions and discharge decisions are not based on fears of financial liability associated with a cap. One commenter expressed concerns about how we would transition to a new calculation methodology. Another commenter stated that all hospices should receive cap feedback from the fiscal intermediary to enable them to monitor their cap better.

Many submitted comments that were beyond the scope of the solicitation for suggestions associated with cap calculation methodology improvements. Some stated that the cap currently encourages hospice providers to focus on their financial bottom line instead of patient needs, and incentivizes hospices to inappropriately discharge patients, and not admit patients with less predictable trajectories. Others suggested that CMS suspend the aggregate cap until hospice payment reform occurs, and suggesting CMS improve national coverage determination processes. One commenter stated that the cap doesn't account for geographic factors that may affect a hospice's patient population, which may increase their risk of exceeding the cap. Many commenters expressed support for the aggregate cap, with one stating that CMS should generate alerts to physicians and hospice medical directors with a high percentage of long-stay patients, and ultimately revoke their billing privileges.

Response: We appreciate the comments received from the public concerning this matter and will continue to analyze and consider those comments and suggestions in future rulemaking.

C. Hospice Payment Reform

Since the inception of the hospice benefit in 1983, the amount that the Medicare program has spent on this benefit has grown considerably. The number of unduplicated hospice Medicare beneficiaries has increased from 401,140 in FY 1998 to 986,435 in FY 2007, which represents a 146 percent increase. Additionally, at the inception of the benefit, most hospice patients elected hospice care due to terminal cancer. The profile of the hospice patient has changed in recent years such that hospices now provide care to beneficiaries with a wide range of terminal conditions. In calendar year (CY) 1998, 54 percent of hospice patients had terminal cancer diagnoses. In CY 2007, only 28 percent of hospice patients had terminal cancer diagnoses. With the diversity of diagnoses, hospice stays began to increase. The national average length of stay for patients in hospice has risen from 48 days per patient in CY 1998 to 73 days per patient in CY 2006. Additionally, long hospice stays have grown even longer by about 50 percent. Between 2000 and 2005, hospices in the 90th percentile for average length of stay increased their average length of stay from 144 to 212 days.

MedPAC has performed extensive analysis of the hospice benefit over the past few years, and has recommended that CMS reform the hospice payment structure to ensure greater accountability in the hospice benefit. MedPAC believes that the current hospice payment system contains incentives that make long hospice stays more profitable, which may result in misuse of the benefit.

Medicare spending for hospice is rapidly growing, more than tripling between 2000 and 2007. In fiscal year (FY) 1998, expenditures for the Medicare hospice benefit were $2.2 billion, while in FY 2007, expenditures for the Medicare hospice benefit were $10.6 billion, more than the Medicare program spends on inpatient rehabilitation hospitals, critical access hospitals, long term care hospitals, or psychiatric hospitals. Medicare hospice spending is expected to continue to grow, and will account for roughly 2.3 percent of overall Medicare spending in FY 2009.

The number of hospice agencies has also grown by over 80 percent since 1997. The growth is overwhelmingly in the for-profit category. In 1997, there were 1,834 hospices, about 20 percent of which were for-profit and 80 percent were non-profit. In 2009, there were 3,328 hospices, and 51 percent of these are for-profit entities. Since 2000, nearly all hospices newly participating in Medicare are for-profit entities. MedPAC reports that the newly participating hospices have margins five to six times higher than more established hospices. MedPAC estimates that, on average, hospice Medicare margins were approximately 3.4 percent in 2005. However, the for-profit hospices are estimated to have margins ranging from 15.9 percent in 2003 to 11.8 percent in 2005.

In their analyses of the hospice benefit in their June 2008 ''Report to the Congress,'' MedPAC found that hospice care is more costly at the beginning and end of an episode of hospice care, because of the intensity of services provided during those times. Hospices provide more visits to a patient right after a patient elects hospice and in the time shortly before death, than they provide during the middle of the episode. In its March, 2009 report entitled ''Report to the Congress: Medicare Payment Policy'', MedPAC suggested that payments to hospices should decline as the beneficiary's length of stay increases, thus better reflecting intensity and frequency of the hospice services provided over the course of treatment. MedPAC also suggested that payment to hospices should increase during the period just prior to the patient's death to reflect the higher resource usage during this time [*see,* chapter 6 (''Reforming Medicare's Hospice Benefit'') of MedPAC's March 2009 report entitled ''Report to the Congress: Medicare Payment Policy'' which is available at *http://*

www.medpac.gov/chapters/Mar09_Ch06.pdf].

MedPAC believes this payment structure would better reflect hospice patient resource usage and hospice costs, and would encourage hospices to admit patients at the time in their illness which provides the most benefit to the patient.

We solicited comments regarding MedPAC's suggestions on reforming the hospice payment system, as well as broader comments and suggestions regarding hospice payment reform. We note that MedPAC's suggested payment reforms would require Congressional action to change the statute.

Comment: Many commenters supported MedPAC's payment model. Some made specific recommendations regarding which time periods in the stay should warrant a higher payment. Some commenters suggested that a hospice payment system that is a case-mix adjusted would be appropriate. One commenter suggested a site of care adjustment, to reflect more adequate compensation for hospices in rural versus urban areas, and for care provided to patients in congregate living arrangements. The commenter suggested that CMS also require Medicaid to pay room and board charges directly to the nursing home in the case of dually eligible routine home care patients who reside in nursing homes. This commenter also suggested CMS analyze the appropriateness of payments for respite and continuous home care. Commenters feared that the MedPAC payment model would result in decreased access to hospice care, especially for patients with non-cancer diagnoses, with one commenter suggesting that CMS shouldn't change the payment structure simply because a small number of providers are abusing the system. Rather, this commenter suggested that CMS deal with inappropriate use of hospice via increased surveying.

Other commenters feared that MedPAC's suggestion would create incentives for inappropriate hospice provider behavior such as incentivizing admission late in a patient's disease trajectory. One commenter suggested instead of reforming hospice payments, CMS should consider the role of hospice and costs in the total health care picture. Other commenters encouraged CMS to consider the impact payment changes would have on quality of care. Some commenters expressed concern about the administrative burden associated with a payment system change, with one suggesting that CMS consider an approach that would blend rates. One commenter encouraged CMS to consider other possible payment models. Commenters urged CMS to carefully analyze all data including cost data before reforming the hospice payment structure, to avoid unintended consequences. A few commenters suggested that CMS consider a pilot or demonstration to test a revised payment model prior to national implementation. Commenters also suggested that CMS involve the industry by holding technical expert panel (TEP) sessions in order to more fully identify, address, and consider the issues surrounding hospice payment reform. Many commenters urged CMS to ensure that payment reform would be effectuated in a budget neutral way.

Response: We appreciate the comments received from the public concerning possible hospice payment reform. We will continue to review and consider those comments received as we analyze hospice data (to include recent expansions of the hospice data collected on the claim) in our work towards ensuring the accuracy and appropriateness of payments to hospices.

IV. Update on Additional Hospice Data Collection

Over the past several years MedPAC, the GAO, and the Office of the Inspector General have all recommended that CMS collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit. We have been phasing in this process to collect more comprehensive data on hospice claims. We also began collecting additional data on hospice claims beginning in January 2007 through an administrative instruction (CR 5245, Transmittal 1011, issued July 28, 2006), when we started required reporting of a HCPCS code on the claim to describe the location where services were provided (Phase 1). In addition, we issued an administrative instruction (CR 5567, Transmittal 1494, issued April 29, 2008) requiring Medicare hospices to provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. The start date of this mandatory CR 5567 reporting requirement was July 2008 (Phase 2). On several occasions, industry representatives have communicated to CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care. A major concern was that CMS was not requiring reporting of the visit intensity. As a result of these concerns, we committed to working with the industry to expand the data collection requirements. In October 2008, we solicited comments via a posting on CMS' hospice center Web site *(http://www.cms.hhs.gov/center/hospice.asp)* on an approach to collecting additional data about hospice resource use. We asked about data collection using hospice claims, along with data collection using hospice cost reports. This final rule provides an update on the additional data collection.

Based on the feedback received from our October 2008 Web posting, we revised our plans for Phase 3 of the claims data collection. Those plans were described in CR 6440 (Transmittal 1738), which was issued on May 15, 2009, and will have a mandatory effective date of January 1, 2010.

Phase 3 will involve collecting new data on hospice claims. In addition to the existing visit reporting requirement, we are requiring visit time reporting in 15 minute increments for nurses, social workers, and aides. We are requiring visit and visit time reporting in 15 minute increments from physical therapists, occupational therapists, and speech language therapists. We are also requiring reporting of some social worker phone calls and their associated time, within certain limits. Specifically, we are requiring the reporting of social worker calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care (for example, counseling, speaking with a patient's family, or arranging for a placement). Furthermore, only social worker phone calls related to providing and or coordinating care to the patient and family, and documented as such in the clinical records, are to be reported. Visit and time data collection for respite and general inpatient care provided by non-hospice staff in contract facilities would be exempt from the reporting requirement. Finally, travel time, documentation time, and interdisciplinary group time are not to be included in the time reporting. These changes necessitate line-item billing on hospice claims.

While other Medicare provider types (for example, home health agencies) have had to provide similar information on their claims, hospices have historically not been required to provide this information. This additional data collection will bring the requirements for hospice claims more in line with the claim requirements of other Medicare benefits, and provide valuable information about services provided to Medicare beneficiaries.

We also note that this additional data collection uses existing revenue codes and existing UB–04 and 837I claim forms. Those claims forms were

previously approved by the OMB under control number #0938–0997. As stated above, these changes were issued through an administrative instruction (CR 6440, Transmittal 1738) issued on May 15, 2009.

Additionally, we are developing plans to revise the hospice cost reports to include additional sources of revenue, and to gather more detailed data on services provided by volunteers, by chaplains, by counselors, and by pharmacists. We will continue to work with the industry to seek out the best approach to these and any other changes we may make in order to collect useful information on hospice services.

V. Provisions of the Final Regulations

This final rule incorporates many of the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

In section II.A.3, instead of reducing the BNAF by 75 percent in FY 2010 and eliminating it in FY 2011, we are finalizing the BNAF phase-out over 7 years, with a 10 percent BNAF reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total of 40 percent in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, an additional 15 percent reduction for a total of 70 percent in FY 2014, an additional 15 percent reduction for a total of 85 percent in FY 2015, and an additional 15 percent reduction for complete phase-out in FY 2016.

In section II.B, we are finalizing our proposal to require that physicians who certify or recertify hospice patients as terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less. We are revising our original proposal to allow the narrative to either be part of the certification and recertification forms, or an addendum to the certification and recertification forms which is electronically or hand signed by the physician. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum. The narrative must reflect the patient's individual clinical circumstances. The narrative must not contain checked boxes or standard language used for all patients. In the case of the initial certification, we require either the attending physician or the hospice medical director compose and sign the narrative. We also require that the narrative include under the physician signature, a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, examination of the patient.

In section II.E, we are modifying our proposal to change regulatory text in 42 CFR 405.1803. We are creating a separate section at § 405.1803(a)(3) which will be subtitled ''Hospice Caps'' and which will provide the same information that we had proposed be in § 405.1803(a) and § 405.1803(a)(1)(i). We are leaving the regulatory text at § 405.1803(a) and § 405.1803(a)(1)(i) unchanged. Additionally, we are adding a sentence to the new section at § 405.1803(a)(3) to note that the timeframe for appeals of cap calculation results begins with receipt of the determination of program reimbursement letter.

In section II.F, we are modifying our proposal to change the regulatory text in 42 CFR § 418.200. We are continuing to include a reference to the updated CoP section (418.56) for a comprehensive description of our expectations associated with the plan of care, rather than the removing the reference as proposed.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on the issue for the following section of this document that contains information collection requirements (ICRs):

Section 418.22 Certification of terminal illness.

Section 418.22 requires the physician to include on or with the certification or recertification a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

The burden associated with this requirement is the time and effort put forth by the physician to include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less. We received the following comment during the 60-day comment period for the proposed stage of this rule:

Comment: One commenter felt that the burden on hospices would be more than 5 minutes, suggesting that it would take physicians 30 minutes per certification to comply with the narrative requirements.

Response: We disagree that requiring a narrative on the certification would take 30 minutes of the physician's time. As we stated in the proposed rule, physicians are already supposed to be reviewing the patient's clinical record when certifying or recertifying a patient. If hospices are complying with the current certification requirements, then the additional time to add a narrative would only be the time to synthesize the medical information. After reviewing the data, we still believe that composing the narrative should take a physician approximately 5 minutes. However, in re-examining the data and our previous assumptions and estimates from the proposed rule, we have re-estimated our burden estimate, which is now consistent with those assumptions used in the associated PRA package.

We estimate that a narrative would be provided on 1,138,653 certifications and recertifications annually. At 5 minutes per narrative, the total annual burden associated with this requirement is 5 minutes × 1,138,653/60 minutes per hour = 94,888 hours. The current requirements for § 418.22 are approved under OMB# 0938–0302 with an expiration date of 8/31/2009. We will revise the PRA package to reflect this change in burden.

If you would like to comment on this information collection and recordkeeping requirement, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, [1420–F]

Fax: (202) 395 6974; or *E-mail: OIRA_submission@omb.eop.gov.*

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). We estimated the impact on hospices, as a result of the changes to the FY 2010 hospice wage index and of reducing the BNAF by 10 percent.

As discussed previously, the methodology for computing the hospice wage index was determined through a negotiated rulemaking committee and promulgated in the August 8, 1997 hospice wage index final rule (62 FR 42860). The BNAF, which was promulgated in the August 8, 1997 rule, is being phased out. This rule updates the hospice wage index in accordance with the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), which originally finalized a 75 percent reduced BNAF for FY 2010 as the second year of a 3-year phase-out of the BNAF. However, as noted previously, we believe that a more gradual phase-out provides additional opportunity to evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into our goals for hospice payment reform. We are finalizing a 10 percent BNAF reduction in FY 2010 as the first year of a 7-year phase-out, with an additional 15 percent BNAF reduction to occur in each of the next 6 years. Total phase-out will be complete by FY 2016.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this final rule is not an economically significant rule under this Executive Order.

Column 4 of Table 1 shows the combined effects of the updated wage data (the 2009 pre-floor, pre-reclassified hospital wage index) and of the 10 percent reduction in the BNAF, comparing estimated payments for FY 2010 to estimated payments for FY 2009. In keeping with the American Recovery and Reinvestment Act (ARRA) mentioned earlier in this final rule, the FY 2009 payments used for comparison have a full (unreduced) BNAF applied. We estimate that the total hospice payments for FY 2010 will decrease by $90 million as a result of the application of the updated wage data (−$40 million) and the 10 percent reduction in the BNAF (−$50 million). This estimate does not take into account any hospital market basket update, which is 2.1 percent for FY 2010. The final hospital market basket update and associated payment rates will be communicated through an administrative instruction. The effect of a 2.1 percent hospital market basket update on payments to hospices is approximately $260 million. Taking into account a 2.1 percent hospital market basket update (+$260 million), in addition to the updated wage data (−$40 million) and the 10 percent reduction in the BNAF (−$50 million), it is estimated that hospice payments would increase by $170 million in FY 2010 ($260 million −$90 million = $170 million). The percent change in payments to hospices due to the combined effects of the updated wage data, the 10 percent reduction in the BNAF, and the hospital market basket update of 2.1 percent is reflected in column 5 of the impact table (Table 1).

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The majority of hospices and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7 million to $34.5 million in any 1 year (for details, *see http://www.sba.gov/contractingopportunities/officials/size/index.html*). While the Small Business Administration (SBA) does not define a size threshold in terms of annual revenues for hospices, they do define one for home health agencies ($13.5 million; *see http://www.sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf*). For the purposes of this final rule, because the hospice benefit is a home-based benefit, we are applying the SBA definition of ''small'' for home health agencies to hospices; we will use this definition of ''small'' in determining if this final rule has a significant impact on a substantial number of small entities (for example, hospices). Using 2007 Medicare hospice claims data, we estimate that 96 percent of hospices have Medicare revenues below $13.5 million. Additionally, using available 2007 Medicare cost report data, we estimate that roughly 94 percent of hospices have total patient revenues below $13.5 million.

As indicated in Table 1 below, there are 3,328 hospices as of January 29, 2009. Approximately 48.5 percent of Medicare certified hospices are identified as voluntary or government agencies and, therefore, are considered small entities. Most of these and most of the remainder are also small hospice entities because, as noted above, their revenues fall below the SBA size thresholds.

We note that the hospice wage index methodology was previously guided by consensus, through a negotiated rulemaking committee that included representatives of national hospice associations, rural, urban, large and small hospices, multi-site hospices, and consumer groups. Based on all of the options considered, the committee agreed on the methodology described in the committee statement, and after notice and comment, it was adopted into regulation in the August 8, 1997 final rule. In developing the process for updating the hospice wage index in the 1997 final rule, we considered the impact of this methodology on small hospice entities and attempted to mitigate any potential negative effects. Small hospice entities are more likely to be in rural areas, which are less affected by the BNAF reduction than entities in urban areas. Generally, hospices in rural areas are protected by the hospice floor adjustment, which lessens the effect of the BNAF reduction.

The effects of this rule on hospices are shown in Table 1. Overall, Medicare payments to all hospices will decrease by an estimated 0.7 percent, reflecting the combined effects of the updated wage data and the 10 percent reduction in the BNAF. The combined effects of the updated wage data and the 10 percent reduction to the BNAF on small or medium sized hospices (as defined by routine home care days rather than by the SBA definition), is −0.6 or −0.7 percent, respectively. Furthermore, when including the hospital market basket update of 2.1 percent into these estimates, the combined effects on Medicare payment to all hospices would result in an estimated increase of approximately 1.4 percent. For small and medium hospices (as defined by routine home care days), the estimated effects on revenue when accounting for the updated wage data, the 10 percent BNAF reduction, and the hospital market basket update are increases in payments of 1.5 percent and 1.4 percent, respectively. Overall average hospice revenue effects will be slightly less than these estimates since according the

National Hospice and Palliative Care Organization, about 16 percent of hospice patients are non-Medicare. HHS' practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of only the updated wage data and the 10 percent reduced BNAF for all hospices is −0.7 percent. Since, by SBA's definition of ''small'' (when applied to hospices), nearly all hospices are considered to be small entities, the combined effect of only the updated wage data and the 10 percent reduced BNAF (−0.7 percent) does not exceed HHS' 3.0 percent minimum threshold. However, HHS' practice in determining ''significant economic impact'' has considered either *total* revenue or *total* costs. Total hospice revenues include the effect of the market basket update. When we consider the combined effect of the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent 2009 market basket update, the overall impact is an increase in hospice payments of 1.4 percent for FY 2010. Therefore, the Secretary has determined that this final rule does not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a metropolitan statistical area and has fewer than 100 beds. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of about $100 million or more in 1995 dollars, updated for inflation. That threshold is currently approximately $133 million in 2009. This final rule is not anticipated to have an effect on State, local, or Tribal governments or on the private sector of $133 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local, or Tribal governments.

B. Anticipated Effects

This section discusses the impact of the projected effects of the hospice wage index, including the effects of a 2.1 percent hospital market basket update that will be communicated separately through an administrative instruction. This final rule continues to use the CBSA-based pre-floor, pre-reclassified hospital wage index as a basis for the hospice wage index and continues to use the same policies for treatment of areas (rural and urban) without hospital wage data. The final FY 2010 hospice wage index is based upon the 2009 pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2008) with a 10 percent reduction in the BNAF.

For the purposes of our impacts, our baseline is estimated FY 2009 payments (without any BNAF reduction) using the 2008 pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3, Table 1) compares our baseline to estimated FY 2010 payments (holding payment rates constant) using the updated wage data (2009 pre-floor, pre-reclassified hospital wage index). Consequently, the estimated effects illustrated in column 3 of Table 1 show the distributional effects of the updated wage data only. The effects of using the updated wage data combined with the 10 percent reduction in the BNAF are illustrated in column 4 of Table 1.

We have included a comparison of the combined effects of the 10 percent BNAF reduction, the updated wage data, and a 2.1 percent hospital market basket increase for FY 2010 (Table 1, column 5). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue of the hospice wage index discussed in this rule, the BNAF phase-out, and the FY 2010 hospital market basket update. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BNAF BY 10 PERCENT AND APPLYING A 2.1 PERCENT HOSPITAL MARKET BASKET UPDATE FOR THE FY 2010 HOSPICE WAGE INDEX, COMPARED TO THE FY 2009 HOSPICE WAGE INDEX WITH NO BNAF REDUCTION

	Number of hospices*	Number of routine home care days in thousands	Percent change in hospice payments due to FY2010 wage index change	Percent change in hospice payments due to wage index change and 10% reduction in BNAF	Percent change in hospice payments due to wage index change, 10% reduction in BNAF and market basket update
	(1)	(2)	(3)	(4)	(5)
ALL HOSPICES	3,328	71,440	−0.3	−0.7	1.4
URBAN HOSPICES	2,291	61,856	−0.3	−0.7	1.4
RURAL HOSPICES	1,037	9,584	−0.3	−0.6	1.4
BY REGION—URBAN:					
NEW ENGLAND	128	2,286	−0.3	−0.8	1.3
MIDDLE ATLANTIC	226	6,479	−0.5	−0.9	1.2

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BNAF BY 10 PERCENT AND APPLYING A 2.1 PERCENT HOSPITAL MARKET BASKET UPDATE FOR THE FY 2010 HOSPICE WAGE INDEX, COMPARED TO THE FY 2009 HOSPICE WAGE INDEX WITH NO BNAF REDUCTION—Continued

	Number of hospices* (1)	Number of routine home care days in thousands (2)	Percent change in hospice payments due to FY2010 wage index change (3)	Percent change in hospice payments due to wage index change and 10% reduction in BNAF (4)	Percent change in hospice payments due to wage index change, 10% reduction in BNAF and market basket update (5)
SOUTH ATLANTIC	331	13,701	−0.7	−1.1	1.0
EAST NORTH CENTRAL	318	8,796	−0.8	−1.2	0.8
EAST SOUTH CENTRAL	176	4,459	−0.5	−0.9	1.2
WEST NORTH CENTRAL	178	4,098	0.0	−0.4	1.7
WEST SOUTH CENTRAL	431	8,181	−0.3	−0.7	1.4
MOUNTAIN	214	5,372	−0.3	−0.7	1.4
PACIFIC	253	7,315	1.1	0.7	2.8
OUTLYING	36	1,170	−1.2	−1.2	0.9
BY REGION—RURAL:					
NEW ENGLAND	26	184	0.1	−0.3	1.8
MIDDLE ATLANTIC	45	496	−0.8	−1.2	0.9
SOUTH ATLANTIC	131	1,893	−0.5	−0.9	1.2
EAST NORTH CENTRAL	146	1,592	−1.0	−1.4	0.7
EAST SOUTH CENTRAL	152	1,957	−0.5	−0.9	1.2
WEST NORTH CENTRAL	192	1,029	0.3	−0.1	2.0
WEST SOUTH CENTRAL	184	1,386	0.5	0.2	2.3
MOUNTAIN	108	610	−0.8	−1.1	0.9
PACIFIC	52	426	1.3	0.9	3.0
OUTLYING	1	11	0.0	0.0	2.1
ROUTINE HOME CARE DAYS:					
0–3499 DAYS (small)	647	1,128	−0.2	−0.6	1.5
3500–19,999 DAYS (medium)	1,616	16,297	−0.3	−0.7	1.4
20,000+ DAYS (large)	1,065	54,016	−0.3	−0.7	1.4
TYPE OF OWNERSHIP:**					
VOLUNTARY	1,190	30,071	−0.3	−0.7	1.4
PROPRIETARY	1,713	35,548	−0.3	−0.7	1.4
GOVERNMENT	425	5,822	−0.6	−0.9	1.1
HOSPICE BASE:					
FREESTANDING	2,156	54,293	−0.3	−0.7	1.4
HOME HEALTH AGENCY	595	10,195	−0.2	−0.6	1.5
HOSPITAL	559	6,714	−0.2	−0.6	1.5
SKILLED NURSING FACILITY	18	238	−0.5	−1.0	1.1

BNAF = Budget Neutrality Adjustment Factor

*OSCAR data as of January 29, 2009, for hospices with claims filed in FY 2008

**In previous years, there was also a category labeled ''Other''; these were Other Government hospices, and have been combined with the ''Government'' category.

Note: Comparison is to FY 2009 estimated payments from the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), but with no BNAF reduction.

REGION KEY: New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Middle Atlantic = Pennsylvania, New Jersey, New York; South Atlantic = Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; East North Central = Illinois, Indiana, Michigan, Ohio, Wisconsin; East South Central = Alabama, Kentucky, Mississippi, Tennessee; West North Central = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; West South Central = Arkansas, Louisiana, Oklahoma, Texas; Mountain = Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; Pacific = Alaska, California, Hawaii, Oregon, Washington; Outlying = Guam, Puerto Rico, Virgin Islands.

Table 1 shows the results of our analysis. In column 1, we indicate the number of hospices included in our analysis as of January 29, 2009 which had also filed claims in FY 2008. In column 2, we indicate the number of routine home care days that were included in our analysis, although the analysis was performed on all types of hospice care. Columns 3, 4, and 5 compare FY 2010 estimated payments with those estimated for FY 2009. The estimated FY 2009 payments incorporate a BNAF which has not been reduced. Column 3 shows the percentage change in estimated Medicare payments from FY 2009 to FY 2010 due to the effects of the updated wage data only, with estimated FY 2009 payments. Column 4 shows the percentage change in estimated hospice payments from FY 2009 to FY 2010 due to the combined effects of using the updated wage data and reducing the BNAF by 10 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2009 to FY 2010 due to the combined effects of using updated wage data, a 10 percent

BNAF reduction, and a 2.1 percent hospital market basket update.

Table 1 also categorizes hospices by various geographic and hospice characteristics. The first row of data displays the aggregate result of the impact for all Medicare-certified hospices. The second and third rows of the table categorize hospices according to their geographic location (urban and rural). Our analysis indicated that there are 2,291 hospices located in urban areas and 1,037 hospices located in rural areas. The next two row groupings in the table indicate the number of hospices by census region, also broken down by urban and rural hospices. The next grouping shows the impact on hospices based on the size of the hospice's program. We determined that the majority of hospice payments are made at the routine home care rate. Therefore, we based the size of each individual hospice's program on the number of routine home care days provided in FY 2008. The next grouping shows the impact on hospices by type of ownership. The final grouping shows the impact on hospices defined by whether they are provider-based or freestanding.

As indicated in Table 1, there are 3,328 hospices. Approximately 48.5 percent of Medicare-certified hospices are identified as voluntary (non-profit) or government agencies. Because the National Hospice and Palliative Care Organization estimates that approximately 83.6 percent of hospice patients in 2007 were Medicare beneficiaries, we have not considered other sources of revenue in this analysis.

As stated previously, the following discussions are limited to demonstrating trends rather than projected dollars. We used the pre-floor, pre-reclassified hospital wage indexes as well as the most complete claims data available (FY 2008) in developing the impact analysis. The FY 2010 payment rates will be adjusted to reflect the full hospital market basket, as required by section 1814(i)(1)(C)(ii)(VII) of the Act. As previously noted, we publish these rates through administrative instructions rather than in a proposed rule. The FY 2010 hospital market basket update is 2.1 percent. Since the inclusion of the effect of a hospital market basket increase provides a more complete picture of projected total hospice payments for FY 2010, the last column of Table 1 shows the combined impacts of the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent hospital market basket update. As discussed in the FY 2006 hospice wage index final rule (70 FR 45129), hospice agencies may use multiple hospice wage index values to compute their payments based on potentially different geographic locations. Before January 1, 2008, the location of the beneficiary was used to determine the CBSA for routine and continuous home care and the location of the hospice agency was used to determine the CBSA for respite and general inpatient care. Beginning January 1, 2008, the hospice wage index utilized is based on the location of the site of service. As the location of the beneficiary's home and the location of the facility may vary, there will still be variability in geographic location for an individual hospice. We anticipate that the location of the various sites will usually correspond with the geographic location of the hospice, and thus we will continue to use the location of the hospice for our analyses of the impact of the changes to the hospice wage index in this rule. For this analysis, we use payments to the hospice in the aggregate based on the location of the hospice.

The impact of hospice wage index changes has been analyzed according to the type of hospice, geographic location, type of ownership, hospice base, and size. Our analysis shows that most hospices are in urban areas and provide the vast majority of routine home care days. Most hospices are medium-sized followed by large hospices. Hospices are almost equal in numbers by ownership with 1,615 designated as non-profit or government hospices and 1,713 as proprietary. The vast majority of hospices are freestanding.

1. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care days. The majority of the days provided by a hospice are routine home care (RHC) days, representing about 97 percent of the services provided by a hospice. Therefore, the number of RHC days can be used as a proxy for the size of the hospice, that is, the more days of care provided, the larger the hospice. As discussed in the August 4, 2005 final rule, we currently use three size designations to present the impact analyses. The three categories are: (1) Small agencies having 0 to 3,499 RHC days; (2) medium agencies having 3,500 to 19,999 RHC days; and (3) large agencies having 20,000 or more RHC days. The FY 2010 updated wage data without any BNAF reduction are anticipated to decrease payments to small hospices by 0.2 percent, and to decrease payments to medium and large hospices by 0.3 percent (column 3); the updated wage data and the 10 percent BNAF reduction are anticipated to decrease estimated payments to small hospices by 0.6 percent, and to medium and large hospices by 0.7 percent (column 4); and finally, the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent hospital market basket update are projected to increase estimated payments by 1.5 percent for small hospices, and by 1.4 percent for medium and large hospices (column 5).

2. Geographic Location

Column 3 of Table 1 shows that the updated wage data without the BNAF reduction would result in a small reduction in estimated payments. Urban and rural hospices are both anticipated to experience a decrease of 0.3 percent. For urban hospices, an increase of 1.1 percent is anticipated to be experienced in the Pacific regions. No change in payments is anticipated for hospices in the West North Central region. The remaining urban regions are anticipated to experience a decrease ranging from 0.3 percent in the New England, West South Central, and Mountain regions to a 1.2 percent decrease in Outlying regions.

Column 3 shows that for rural hospices, Outlying regions are anticipated to experience no change. Five regions are anticipated to experience a decrease ranging from 0.5 percent in the South Atlantic and East South Central regions, to 1.0 percent in the East North Central region. The remaining regions are anticipated to experience an increase ranging from 0.1 percent in the New England region to 1.3 percent in the Pacific region.

Column 4 shows the combined effect of the updated wage data and the 10 percent BNAF reduction on estimated payments, as compared to the FY 2009 estimated payments using a BNAF with no reduction. Overall urban hospices are anticipated to experience a 0.7 percent decrease in payments, while rural hospices expect a 0.6 percent decrease. Pacific urban hospices are anticipated to see a payment increase of 0.7 percent. All other urban hospices are anticipated to experience a decrease in payment ranging from −0.4 percent in the West North Central region to 1.2 percent in the East North Central and Outlying regions.

Rural hospices are estimated to experience an increase in payments of 0.2 percent in the West South Central region and 0.9 percent in the Pacific region, while Outlying regions are estimated to experience no change in payments. The remaining rural hospices are anticipated to experience estimated decreases in payment ranging from 0.1 percent in the West North Central region

to 1.4 percent in the East North Central region.

Column 5 shows the combined effects of the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent hospital market basket update on estimated payments as compared to the estimated FY 2009 payments. Note that the FY 2009 payments had no BNAF reduction applied to them. Overall, urban and rural hospices are anticipated to experience a 1.4 percent increase in payments. Urban hospices are anticipated to experience an increase in estimated payments in every region, ranging from a 0.8 percent increase in the East North Central region to a 2.8 percent increase in the Pacific region. Rural hospices in every region are estimated to see an increase in payments ranging from 0.7 percent in the East North Central region to 3.0 percent in the Pacific region.

3. Type of Ownership

Column 3 demonstrates the effect of the updated wage data on FY 2010 estimated payments versus FY 2009 estimated payments with no BNAF reduction applied to them. We anticipate that using the updated wage data would decrease estimated payments to voluntary (non-profit) and proprietary (for-profit) hospices by 0.3 percent. We estimate a decrease in payments for government hospices of 0.6 percent.

Column 4 demonstrates the combined effects of the updated wage data and of the 10 percent BNAF reduction. Estimated payments to voluntary (non-profit) and proprietary (for-profit) hospices are anticipated to decrease by 0.7 percent, while government hospices are anticipated to experience decreases of 0.9 percent.

Column 5 shows the combined effects of the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent hospital market basket update on estimated payments, comparing FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated FY 2010 payments are anticipated to increase by 1.4 percent for voluntary (non-profit) and proprietary (for-profit) hospices, and by 1.1 percent for government hospices.

4. Hospice Base

Column 3 demonstrates the effect of using the updated wage data, comparing estimated payments for FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated payments are anticipated to decrease by 0.3 percent for freestanding facilities. Home health and hospital based facilities are anticipated to experience a 0.2 percent decrease in estimated payments. Hospices based out of skilled nursing facilities are anticipated to experience a decrease in estimated payments of 0.5 percent.

Column 4 shows the combined effects of the updated wage data and reducing the BNAF by 10 percent, comparing FY 2010 to FY 2009 (using a BNAF with no reduction) estimated payments. Skilled nursing facility based hospices are estimated to see a 1.0 percent decrease, freestanding hospices are estimated to see a 0.7 percent decrease, and hospital and home health agency based hospices are each anticipated to experience a 0.6 percent decrease in payments.

Column 5 shows the combined effects of the updated wage data, the 10 percent BNAF reduction, and the 2.1 percent hospital market basket update on estimated payments, comparing FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated payments are anticipated to increase by 1.1 percent for skilled nursing based facilities, to increase by 1.4 percent for freestanding facilities, and to increase by 1.5 percent for home health agency and hospital based facilities.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 2 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this rule. This table provides our best estimate of the decrease in Medicare payments under the hospice benefit as a result of the changes presented in this final rule on data for 3,328 hospices in our database. All expenditures are classified as transfers to Medicare providers (that is, hospices).

TABLE 2— ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2009 TO FY 2010

[in millions]

Category	Transfers
Annualized Monetized Transfers.	$ − 90
From Whom to Whom ..	Federal Government to Hospices.

*The $90 million reduction in transfers includes the 10 percent reduction in the BNAF and the updated wage data. It does not include the hospital market basket update, which is 2.1 percent.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 418

Health Facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 1. The authority citation for part 405 subpart R continues to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

Subpart R—Provider Reimbursement Determinations and Appeals

■ 2. Section 405.1803 is amended by adding paragraph (a)(3) as follows:

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

* * * * *

(a) * * *

(3) *Hospice caps.* With respect to a hospice, the reporting period for the cap calculation is the cap year; and the intermediaries' determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations, shall serve as a notice of program reimbursement. The time period for filing cap appeals begins with receipt of the determination of program reimbursement letter.

* * * * *

PART 418—HOSPICE CARE

■ 3. The authority citation for part 418 continues to read as follows:

Authority: Secs 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provision and Definitions

■ 4. Section 418.1 is amended by revising the introductory text to read as follows:

§ 418.1 Statutory basis.

This part implements section 1861(dd) of the Social Security Act (the Act). Section 1861(dd) of the Act specifies services covered as hospice care and the conditions that a hospice program must meet in order to participate in the Medicare program. Section 1861(dd) also specifies limitations on coverage of, and payment for, inpatient hospice care. The following sections of the Act are also pertinent:

* * * * *

■ 5. Section 418.2 is revised to read as follows:

§ 418.2 Scope of part.

Subpart A of this part sets forth the statutory basis and scope and defines terms used in this Part. Subpart B specifies the eligibility and election requirements and the benefit periods. Subparts C and D specify the conditions of participation for hospices. Subpart E is reserved for future use. Subparts F and G specify coverage and payment policy. Subpart H specifies coinsurance amounts applicable to hospice care.

Subpart B—Eligibility, Election and Duration of Benefits

■ 6. Section 418.22 is amended by adding a new paragraph (b)(3) to read as follows:

§ 418.22 Certification of terminal illness.

* * * * *

(b) * * *

(3) The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

(i) If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.

(ii) If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

(iii) The narrative shall include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.

(iv) The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

* * * * *

Subpart C—Conditions of Participation: Patient Care Non-Core Services

■ 7. Section 418.76 is amended by revising paragraph (f)(1) to read as follows:

§ 418.76 Condition of participation: Hospice aide and homemaker services.

(f) *Standard: Eligible competency organizations.*

* * * * *

(1) Had been out of compliance with the requirements of § 484.36(a) and § 484.36 (b) of this chapter.

* * * * *

Subpart D—Conditions of Participation: Organizational Environment

■ 8. Section 418.100 is amended by revising paragraph (f)(1)(iii) to read as follows:

§ 418.100 Condition of participation: Organization and administration of service.

* * * * *

(f) * * *

(1) * * *

(iii) The lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location which was issued the certification number.

* * * * *

§ 418.108 [Amended]

■ 9. In paragraph (b)(1)(ii), the cross reference to ''§ 418.110(f)'' is revised to read ''§ 418.110(e)''.

Subpart F—Covered Services

■ 10. Section 418.200 is revised to read as follows:

§ 418.200 Requirements for coverage.

To be covered, hospice services must meet the following requirements. They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with § 418.24. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in § 418.56. That plan of care must be established before hospice care is provided. The services provided must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in section § 418.22.

■ 11. Section § 418.202 is amended by revising paragraphs (f) and (g) to read as follows:

§ 418.202 Covered services.

* * * * *

(f) *Medical appliances and supplies, including drugs and biologicals.* Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as described in § 410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal or related conditions.

(g) *Home health or hospice aide services furnished by qualified aides as designated in § 418.94 and homemaker services.* Home health aides (also known as hospice aides) may provide personal care services as defined in § 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patients, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

* * * * *

■ 12. Section § 418.204 is amended by revising paragraph (a) to read as follows:

§ 418.204 Special coverage requirements.

(a) *Periods of crisis.* Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as

hospice aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.

* * * * *

Subpart G—Payment for Hospice Care

■ 13. Section 418.302 is amended by revising paragraphs (b)(2) and (f)(2) to read as follows:

§ 418.302 Payment procedures for hospice care.

* * * * *

(b) * * *

(2) Continuous home care day. A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in § 418.204(a) and only as necessary to maintain the terminally ill patient at home.

* * * * *

(f) * * *

(2) At the end of a cap period, the intermediary calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients. Only inpatient days that were provided and billed as general inpatient or respite days are counted as inpatient days when computing the inpatient cap.

* * * * *

■ 14. Section 418.311 is revised to read as follows:

§ 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.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 20, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 29, 2009.

Kathleen Sebelius,

Secretary.

Editor's note: The following addenda will not appear in the Code of Federal Regulations.

BILLING CODE 4120–01–P

Addendum A. Final Hospice Wage Index for Urban Areas by CBSA- FY 2010

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8547
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3909
10420	Akron, OH Portage County, OH Summit County, OH	0.9413
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9187
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9191
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9722
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8582
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	1.0027
11020	Altoona, PA Blair County, PA	0.8995
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9423
11180	Ames, IA Story County, IA	1.0014
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2594
11300	Anderson, IN Madison County, IN	0.9247
11340	Anderson, SC Anderson County, SC	1.0102
11460	Ann Arbor, MI Washtenaw County, MI	1.1026
11500	Anniston-Oxford, AL Calhoun County, AL	0.8368
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9965
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9650
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0124

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
12060	Atlanta-Sandy Springs-Marietta, GA	1.0296
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2639
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8000
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	1.0150
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	1.0066
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1811
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0614
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0740
	Penobscot County, ME	
12700	Barnstable Town, MA	1.3346
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8617
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0683
	Calhoun County, MI	
13020	Bay City, MI	0.9762
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8950
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.2287
	Whatcom County, WA	
13460	Bend, OR	1.2007
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.1134
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.9295
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.9051
	Broome County, NY	
	Tioga County, NY	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9281
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.8000
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8608
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9478
14060	Bloomington-Normal, IL McLean County, IL	0.9841
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9783
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2558
14500	Boulder, CO Boulder County, CO	1.0875
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8854
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0450
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1369
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3583
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9412
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.0099
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0067
15500	Burlington, NC Alamance County, NC	0.9222
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9769
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1702
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0921
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9333
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9918
16180	Carson City, NV Carson City, NV	1.0691
16220	Casper, WY Natrona County, WY	1.0112
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9415
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9987
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8735
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9721

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
16740	Charlotte-Gastonia-Concord, NC-SC	1.0128
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	1.0362
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.9372
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9792
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.0977
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.1503
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0226
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
17300	Clarksville, TN-KY	0.8759
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8455
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9755
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9840
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.9866
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	1.0532
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.9015
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9430
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.9225
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	1.0280
	Bartholomew County, IN	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0496
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9076
18700	Corvallis, OR Benton County, OR	1.1932
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8251
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0498
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9189
19180	Danville, IL Vermilion County, IL	0.9895
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8862
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8904
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9715
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8237
19500	Decatur, IL Macon County, IL	0.8598
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9384
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1419
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	1.0065
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0512
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8036
20100	Dover, DE Kent County, DE	1.0899
20220	Dubuque, IA Dubuque County, IA	0.8846
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0939
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0273
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0206
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1910
20940	El Centro, CA Imperial County, CA	0.9232

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8999
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0100
21300	Elmira, NY Chemung County, NY	0.8706
21340	El Paso, TX El Paso County, TX	0.9177
21500	Erie, PA Erie County, PA	0.9197
21660	Eugene-Springfield, OR Lane County, OR	1.1676
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9173
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1925
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4670
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8620
22140	Farmington, NM San Juan County, NM	0.8499
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9859
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9469
22380	Flagstaff, AZ Coconino County, AZ	1.2396
22420	Flint, MI Genesee County, MI	1.2060
22500	Florence, SC Darlington County, SC Florence County, SC	0.8582
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8309
22540	Fond du Lac, WI Fond du Lac County, WI	0.9810
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0416
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0499
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8125
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9257
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9686
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0249
23420	Fresno, CA Fresno County, CA	1.1621
23460	Gadsden, AL Etowah County, AL	0.8427
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9830
23580	Gainesville, GA Hall County, GA	0.9615
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9764
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8944
24140	Goldsboro, NC Wayne County, NC	0.9651
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8000
24300	Grand Junction, CO Mesa County, CO	1.0358

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9695
24500	Great Falls, MT Cascade County, MT	0.9272
24540	Greeley, CO Weld County, CO	1.0222
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0249
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9512
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9973
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0515
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3736
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9531
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9497
25260	Hanford-Corcoran, CA Kings County, CA	1.1474
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9662
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9388
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1684
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8000
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9475
25980	Hinesville-Fort Stewart, GA[3] Liberty County, GA Long County, GA	0.9616
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9509
26180	Honolulu, HI Honolulu County, HI	1.2468
26300	Hot Springs, AR Garland County, AR	0.9620
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8189
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0385
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9769
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9587
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9585

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
26900	Indianapolis-Carmel, IN	1.0459
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	1.0010
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	1.0149
	Tompkins County, NY	
27100	Jackson, MI	0.9827
	Jackson County, MI	
27140	Jackson, MS	0.8516
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	
27180	Jackson, TN	0.8997
	Chester County, TN	
	Madison County, TN	
27260	Jacksonville, FL	0.9499
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	Jacksonville, NC	0.8632
	Onslow County, NC	
27500	Janesville, WI	1.0199
	Rock County, WI	
27620	Jefferson City, MO	0.9263
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.8414
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8360
	Cambria County, PA	
27860	Jonesboro, AR	0.8356
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.9929
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.1402
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.1068
	Kankakee County, IL	
28140	Kansas City, MO-KS	1.0144
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Pasco-Richland, WA	1.0462
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.9252
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8173
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9896
	Ulster County, NY	
28940	Knoxville, TN	0.8319
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	0.9869

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	1.0301
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9734
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.8840
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8000
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.0967
	Lake County, IL	
	Kenosha County, WI	
29420	Lake Havasu City - Kingman, AZ	1.0342
	Mohave County, AZ	
29460	Lakeland-Winter Haven, FL	0.9004
	Polk County, FL	
29540	Lancaster, PA	0.9884
	Lancaster County, PA	
29620	Lansing-East Lansing, MI	1.0483
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	
29700	Laredo, TX	0.8831
	Webb County, TX	
29740	Las Cruces, NM	0.9425
	Dona Ana County, NM	
29820	Las Vegas-Paradise, NV	1.2637
	Clark County, NV	
29940	Lawrence, KS	0.8807
	Douglas County, KS	
30020	Lawton, OK	0.8668
	Comanche County, OK	
30140	Lebanon, PA	0.9452
	Lebanon County, PA	
30300	Lewiston, ID-WA	0.9991
	Nez Perce County, ID	
	Asotin County, WA	
30340	Lewiston-Auburn, ME	0.9712
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9616
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	
30620	Lima, OH	0.9951
	Allen County, OH	
30700	Lincoln, NE	1.0302
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock-Conway AR	0.9154
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	
	Pulaski County, AR	
	Saline County, AR	
30860	Logan, UT-ID	0.9252
	Franklin County, ID	
	Cache County, UT	
30980	Longview, TX	0.8835
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	
31020	Longview, WA	1.1830
	Cowlitz County, WA	
31084	Los Angeles-Long Beach-Santa Ana, CA	1.2887
	Los Angeles County, CA	
31140	Louisville-Jefferson County, KY-IN	0.9763
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.9216
	Crosby County, TX	
	Lubbock County, TX	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9262
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0102
31460	Madera, CA Madera County, CA	0.8380
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1577
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0935
31900	Mansfield, OH Richland County, OH	0.9849
32420	Mayaguez, PR Hormigueros Municipio, PR Mayaguez Municipio, PR	0.4531
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9510
32780	Medford, OR Jackson County, OR	1.0814
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9745
32900	Merced, CA Merced County, CA	1.2924
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0377
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9668
33260	Midland, TX Midland County, TX	1.0373
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0640
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1770
33540	Missoula, MT Missoula County, MT	0.9472
33660	Mobile, AL Mobile County, AL	0.8348
33700	Modesto, CA Stanislaus County, CA	1.2872
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8339
33780	Monroe, MI Monroe County, MI	0.9438
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8744
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.9002
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.8000
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0864
34620	Muncie, IN Delaware County, IN	0.8961
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0614
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.9133

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
	Horry County, SC	
34900	Napa, CA	1.5327
	Napa County, CA	
34940	Naples-Marco Island, FL	1.0210
	Collier County, FL	
34980	Nashville-Davidson--Murfreesboro-Franklin, TN	1.0032
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.3145
	Nassau County, NY	
	Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.2383
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	
35300	New Haven-Milford, CT	1.2395
	New Haven County, CT	
35380	New Orleans-Metairie-Kenner, LA	0.9609
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	New York-White Plains-Wayne, NY-NJ	1.3601
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	
35660	Niles-Benton Harbor, MI	0.9570
	Berrien County, MI	
35980	Norwich-New London, CT	1.2032
	New London County, CT	
36084	Oakland-Fremont-Hayward, CA	1.6987
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.8985
	Marion County, FL	
36140	Ocean City, NJ	1.2135
	Cape May County, NJ	
36220	Odessa, TX	1.0002
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9662
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	
36420	Oklahoma City, OK	0.9209
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.2178
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	0.9966
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	Orlando-Kissimmee, FL	0.9618
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	1.0001
	Winnebago County, WI	
36980	Owensboro, KY	0.9168
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2615
	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL	0.9851
	Brevard County, FL	
37380	Palm Coast, FL	0.9461
	Flagler County, FL	
37460	Panama City-Lynn Haven, FL	0.8825
	Bay County, FL	
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8304
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.8552
	George County, MS	
	Jackson County, MS	
37764	Peabody, MA	1.1345
	Essex County, MA	
37860	Pensacola-Ferry Pass-Brent, FL	0.8700
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.9540
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.1589
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0956
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.8367
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.9160
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.1026
	Berkshire County, MA	
38540	Pocatello, ID	0.9862
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.4932
	Juana Diaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0495
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.2093
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie, FL	1.0419
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1527
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	1.0789
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.1291
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	0.9903
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.9197
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9475
	Charlotte County, FL	
39540	Racine, WI	0.9557
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0363
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0132
39740	Reading, PA Berks County, PA	0.9756
39820	Redding, CA Shasta County, CA	1.4494
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0891
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9884
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2106
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9141
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1837
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9301
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0382
40484	Rockingham County, NH Strafford County, NH	1.0478
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9533
40660	Rome, GA Floyd County, GA	0.9642
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4327
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9186
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1586
41100	St. George, UT Washington County, UT	0.9523
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0957

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6392
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5469
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7038

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9507
41420	Salem, OR Marion County, OR Polk County, OR	1.1489
41500	Salinas, CA Monterey County, CA	1.5820
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9760
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9667
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8892
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9348
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2179
41780	Sandusky, OH Erie County, OH	0.9363

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.5052
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3133
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2660
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2571
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7342
42140	Santa Fe, NM Santa Fe County, NM	1.1200
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6391
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9661
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8796
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2409
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9729
43100	Sheboygan, WI Sheboygan County, WI	0.9416
43300	Sherman-Denison, TX Grayson County, TX	0.9526
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8911
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9411
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9874
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0304
43900	Spartanburg, SC Spartanburg County, SC	0.9527
44060	Spokane, WA Spokane County, WA	1.1146
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9608
44140	Springfield, MA Franklin County, MA Hampden County, MA	1.0983

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
	Hampshire County, MA	
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8892
44220	Springfield, OH Clark County, OH	0.9369
44300	State College, PA Centre County, PA	0.9434
44700	Stockton, CA San Joaquin County, CA	1.2683
44940	Sumter, SC Sumter County, SC	0.8716
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0331
45104	Tacoma, WA Pierce County, WA	1.1866
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9462
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9344
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9590
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8597
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9930
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9243
45940	Trenton-Ewing, NJ Mercer County, NJ	1.1194
46060	Tucson, AZ Pima County, AZ	0.9742
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8915
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8968
46340	Tyler, TX Smith County, TX	0.9293
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8871
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8473
46700	Vallejo-Fairfield, CA Solano County, CA	1.5157
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8576
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0942

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9378
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0708
	Tulare County, CA	
47380	Waco, TX	0.9074
	McLennan County, TX	
47580	Warner Robins, GA	0.9489
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	1.0455
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1429
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.8962
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	1.0150
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.8528
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	1.0075
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0299
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.7998
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9573
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.9323
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
48700	Williamsport, PA Lycoming County, PA	0.8546
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1291
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9594
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0346
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9517
49340	Worcester, MA Worcester County, MA	1.1438
49420	Yakima, WA Yakima County, WA	1.0501
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3947
49620	York-Hanover, PA York County, PA	1.0047
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9411
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1756
49740	Yuma, AZ Yuma County, AZ	0.9797

[1]This column lists each CBSA area name and each county or county equivalent, in the CBSA area. Counties not listed in this Table are considered to be rural areas. Wage index values for these areas are found in Addendum B.

[2]Wage index values are based on FY 2005 hospital cost report data before reclassification. These data form the basis for the pre-floor, pre-reclassified hospital wage index. The budget neutrality adjustment factor (BNAF) or the hospice floor is then applied to the pre-floor, pre-reclassified hospital wage index to derive the hospice wage index Wage index values greater than or equal to 0 8 are subject to a BNAF.

The hospice floor calculation is as follows: wage index values below 0.8 are adjusted to be the greater of a) the 10 percent reduced BNAF OR b) the minimum of the pre-floor, pre-reclassified hospital wage index value x 1.15, or 0.8000.
For the FY 2010 hospice wage index, the BNAF was reduced by 10 percent.

[3]Because there are no hospitals in this CBSA, the wage index value is calculated by taking the average of all other urban CBSAs in Georgia

Addendum B. Final Hospice Wage Index for Rural Areas by CBSA- FY 2010

State Code	Nonurban Area	Wage Index
1	Alabama	0.8009
2	Alaska	1.2560
3	Arizona	0.8923
4	Arkansas	0.8000
5	California	1.2957
6	Colorado	1.0102
7	Connecticut	1.1628
8	Delaware	1.0516
10	Florida	0.8977
11	Georgia	0.8035
12	Hawaii	1.1611
13	Idaho	0.8076
14	Illinois	0.8852
15	Indiana	0.8944
16	Iowa	0.9293
17	Kansas	0.8500
18	Kentucky	0.8237
19	Louisiana	0.8000
20	Maine	0.9125
21	Maryland	0.9377
22	Massachusetts[1]	1.2319
23	Michigan	0.9381
24	Minnesota	0.9563
25	Mississippi	0.8006

State Code	Nonurban Area	Wage Index
26	Missouri	0.8426
27	Montana	0.9139
28	Nebraska	0.9215
29	Nevada	0.9904
30	New Hampshire	1.0787
31	New Jersey[2]	------
32	New Mexico	0.9302
33	New York	0.8598
34	North Carolina	0.9053
35	North Dakota	0.8000
36	Ohio	0.9065
37	Oklahoma	0.8162
38	Oregon	1.0786
39	Pennsylvania	0.8830
40	Puerto Rico[3]	0.4654
41	Rhode Island[2]	------
42	South Carolina	0.9013
43	South Dakota	0.9081
44	Tennessee	0.8222
45	Texas	0.8333
46	Utah	0.8727
47	Vermont	1.0639
48	Virgin Islands	0.8000
49	Virginia	0.8298
50	Washington	1.0747
51	West Virginia	0.8000
52	Wisconsin	0.9894
53	Wyoming	0.9833
65	Guam	1.0145

[2] There are no hospitals in the rural areas of Massachusetts, so the wage index value used is the average of the contiguous Counties.
[3] There are no rural areas in this state.
Wage index values are obtained using the methodology described in this proposed rule.

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