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42 CFR Part 418
Medicare Program; Hospice Wage Index for Fiscal Year 2012;
Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1355–P]

RIN 0938–AQ31

Medicare Program; Hospice Wage Index for Fiscal Year 2012

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would set forth the hospice wage index for fiscal year 2012 and continue the phase-out of the wage index budget neutrality adjustment factor (BNAF), with an additional 15 percent BNAF reduction, for a total BNAF reduction in FY 2012 of 40 percent. The BNAF phase-out will continue with successive 15 percent reductions from FY 2013 through FY 2016. This proposed rule would change the hospice aggregate cap calculation methodology. This proposed rule also would revise the hospice requirement for a face-to-face encounter for recertification of a patient's terminal illness. Finally, this proposed rule would begin implementation of a hospice quality reporting program.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. eastern time on July 8, 2011.

ADDRESSES: In commenting, please refer to file code CMS–1355–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1355–P, P.O. Box 8012, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. B*y express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1355–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786 9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: For information regarding "Quality Reporting for Hospices" and "Collection of Information Requirements" sections, please contact Robin Dowell at (410) 786–0060. For information regarding "Hospice Wage Index" and "Hospice Face-to-Face Requirement" sections, please contact Anjana Patel at (410) 786–2120. For information regarding all other sections, please contact Katie Lucas at (410) 786–7723.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1355–P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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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 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

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

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. Our regulations at § 418.306(c) require each hospice's labor market to be established using the most current hospital wage data available, including any changes by the 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 Inpatient Prospective Payment System (IPPS) final rule (69 FR 48916, 49026), 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 implemented a 1-year transition policy using a 50/50 blend of the CBSA-based wage index values and the Metropolitan Statistical Area (MSA)-based wage index values for FY 2006. The one-year transition policy ended on September 30, 2006. For fiscal years 2007 and beyond, we use CBSAs.

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, comprised representatives from national hospice associations; rural, urban, large and small hospices and multi-site hospices; consumer groups; and a government representative. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee (the 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 implementing a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking committee. The Committee's 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 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 suggested by the Committee, "budget neutrality" would mean that, in a given year, estimated aggregate payments for Medicare hospice services using the updated hospice values would 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 would 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 Budget Neutrality Adjustment Factor (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 the FY 2011 Hospice Wage Index Notice with Comment Period, that meant estimating payments for FY 2011 using FY 2009 hospice claims data, and applying the FY 2011 hospice payment rates (updating the FY 2010 rates by the FY 2011 inpatient hospital market basket update). The FY 2011 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 raw 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 FY 2010 Hospice Wage Index Final Rule (74 FR 39384) finalized a provision for a 7-year phase-out of the BNAF, which is applied to the wage index values. The BNAF was reduced by 10 percent in FY 2010, an additional 15 percent in FY 2011, and will be reduced by an additional 15 percent in each of the next 5 years, for complete phase out in 2016.

The hospice wage index is updated annually. Our most recent annual hospice wage index Notice with Comment Period, published in the **Federal Register** (75 FR 42944) on July 22, 2010, set forth updates to the hospice wage index for FY 2011. As noted previously, that update included the second year of a 7-year phase-out of the BNAF, which was applied to the wage index values. The BNAF was reduced by 10 percent in FY 2010 and by an additional 15 percent in 2011, for a total FY 2011 reduction of 25 percent.

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 budget neutrality adjustment or application of the hospice floor 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 currently adjusted by a reduced BNAF. As noted above, for FY 2011, the BNAF was reduced by a cumulative total of 25 percent. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by the greater of: (1) The hospice BNAF, reduced by a total of 25 percent for FY 2011; or (2) the hospice floor (which is a 15 percent increase) subject to a maximum wage index value of 0.8. For example, if in FY 2011, County A had a pre-floor, pre-reclassified hospital wage index (raw wage index) value of 0.3994, we would perform the following calculations using the budget neutrality factor (which for this example is an unreduced BNAF of 0.060562, less 25 percent, or 0.045422) 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 25 percent reduced BNAF: ($0.3994 \times 1.045422 = 0.4175$).

Pre-floor, pre-reclassified hospital wage index value below 0.8 multiplied by the hospice floor: ($0.3994 \times 1.15 = 0.4593$).

Based on these calculations, County A's hospice wage index would be 0.4593.

The BNAF has been computed and applied annually, in full or in reduced form, 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.

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 the OMB to the definitions of MSAs, which now include CBSA designations. The August 4, 2005 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. For FY 2006, the hospice wage index consisted of a blend of 50 percent of the FY 2006 MSA-based hospice wage index and 50 percent of the FY 2006 CBSA based hospice wage index. 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.

When the raw 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 a 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. This year the only such 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 for areas lacking hospital wage data in both FY 2006 and FY 2007 for rural Massachusetts and rural Puerto Rico.

In the FY 2008 final rule (72 FR 50214, 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 through FY 2011, 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, which 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 rule (72 FR at 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 is necessary for Puerto Rico. 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 (or indices) 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 through FY 2011, we have used the most recent pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047.

5. CBSA Nomenclature Changes

The OMB regularly publishes a bulletin that updates the titles of certain CBSAs. In the FY 2008 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 raw 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 raw 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 raw 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) were 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 were located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). We are continuing to use the raw pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the use of raw pre-floor, pre-reclassified hospital (IPPS) wage data used to derive the FY 2012 hospice wage index values, reflects the application of our policy to use those data to establish the hospice wage index. The FY 2012 hospice wage index values presented in this proposed rule were computed consistent with our raw 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 implemented 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, in FY 2009 and subsequent fiscal years, hospice wage index values for the following CBSAs have been 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 market basket index, minus 1

percentage point. 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.

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 proposed rule to the labor portion of the published hospice rates. Section 3401(g) of the Affordable Care Act of 2010 requires that, in FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in Section 1814(i)(1)(C)(ii)(VII) or Section 1814(i)(1)(C)(iii) be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) of the Act. Additionally, Section 3401(g) of the Affordable Care Act requires that in FY 2013 through FY 2019, the market basket percentage update under the hospice payment system be reduced by an additional 0.3 percentage point (although the potential reduction is subject to suspension under conditions set out under new section 1814(i)(1)(C)(v) of the Act). Congress also required, in section 3004(c) of the Affordable Care Act, that hospices begin submitting quality data, based on measures to be specified by the Secretary, for FY 2014 and subsequent fiscal years. Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by 2 percentage points.

II. Summary of Cap Comments Solicited in the FY 2011 Hospice Wage Index Notice With Comment Period

Section 1814(i)(2)(A) through (C) of the Act establishes a cap on aggregate payments made to a Medicare hospice provider and prescribes a basic methodology for calculating the aggregate cap. The aggregate cap limits the total aggregate payment any individual hospice can receive in a year. A hospice's "aggregate cap" is calculated by multiplying the number of beneficiaries who have elected hospice care during an accounting year by a per-beneficiary "cap amount." The Act established the per-beneficiary cap amount and provides an annual increase to the cap amount based on the rate of increase in the medical care expenditures category of the Consumer Price Index. The 2010 per-beneficiary cap amount was $23,874.98.

A hospice's aggregate cap is compared with the total Medicare payments made to the hospice during the same accounting year. Any Medicare payments in excess of the aggregate cap are considered overpayments and must be returned to Medicare by the hospice.

CMS' contractors calculate each hospice's aggregate cap every year, and establish an overpayment for any hospice that exceeds the aggregate cap. For the aggregate cap calculation, regulations at 42 CFR 418.309 define the total number of beneficiaries as the number of individuals who have elected hospice and have not previously been included in any cap calculation, reduced to reflect the proportion of hospice care that was provided in another hospice. These regulations also define the accounting year, or cap year, as the period from November 1st to October 31st.

In the FY 2011 Hospice Wage Index Notice with Comment Period, we noted that there have been some technological advances in our data systems which we believe might enable us to modernize the aggregate cap calculation process while providing information facilitating the ability of hospices to better manage their aggregate cap. We provided details regarding policy options that we are considering for modernizing the aggregate cap calculation methodology and solicited comments on those policy options; we also solicited comments or suggestions for other possible options/alternatives to modernize the cap calculation methodology, to be considered in possible future rulemaking.

In that Notice, we described a policy option that would align the cap year with the federal fiscal year and policy options we were considering regarding how to count beneficiaries when computing the aggregate cap. We also described our plans to redesign the Provider Statistical and Reimbursement Report (PS&R) to show a beneficiary's full utilization history, and discussed having a uniform schedule for mailing cap determination letters.

The policy options we described regarding how to count beneficiaries when computing the aggregate cap were:

- *Option 1:* In this option, we described several approaches where we would apply a patient-by-patient proportional methodology to all hospices' aggregate cap calculations. Under the patient-by-patient proportional methodology, the number of patients for a given cap year and hospice would be the patient-by-patient proportional share of each patient's days in that hospice during the cap year, when considering the patient's total days of Medicare hospice care in multiple cap years and multiple hospices. One approach we described would apportion each patient across the year of election and one additional year, as our analysis showed that 99.98 percent of patients who died in hospice were admitted to hospice either in the year that they died, or in the previous year. We also described an approach where a hospice could request the Medicare contractor recalculate the hospice's aggregate cap using longer timeframes.
- *Option 2:* In this option, we described an approach which would defer across-the-board changes to the aggregate cap calculation methodology for all hospices until we implement hospice payment reform, but it would allow individual hospices to request the Medicare contractor to apply a patient-by-patient proportional methodology to its aggregate cap calculations.

For more information on future hospice payment reform, please see section IV.A of this proposed rule. For details on these options or issues, please see the July 22, 2010 Hospice Wage Index for Fiscal Year 2011 Notice with Comment Period (75 FR 42944). We received 27 public comments about the aggregate cap, with commenters expressing differing views on issues surrounding the aggregate cap. We also received several comments which were outside the scope of the solicitation.

Comment: We received public comments from 27 individuals or groups, with 1 missing an attachment, for a total of 26 comments.

Two commenters supported Option 1, with apportioning of hospice beneficiaries across 2 years; one noted that this option covers more than two 180-day periods, while providing a fixed end date. The other commenter urged us to move forward with Option 1 while additional data collection and payment reforms are pending.

More commenters suggested we choose Option 2 than any other approach. Ten commenters supported Option 2, and suggested that we defer major changes to the aggregate cap methodology until payment reform occurs, unless a hospice requests multi-year apportioning. These commenters were concerned about the burden associated with changing the aggregate cap methodology now, and preferred that we wait until broader payment reform to make a change. They noted that the majority of hospices don't exceed their aggregate cap, and therefore don't want to change. One commenter

urged CMS to retain the existing methodology, as creating a complicated, open-ended apportioning approach would disadvantage most hospices. This commenter stated that very few hospices have an aggregate cap liability, and asked that we not create an administrative burden for the vast majority of hospices that do not exceed the aggregate cap, but instead direct our aggregate cap changes to the minority of hospices that have some kind of liability.

Some felt that Option 2 was simpler and would provide flexibility for those who wanted their aggregate cap calculated using a multi-year apportionment methodology. The major hospice associations urged CMS to defer any major across-the-board changes to the cap calculation methodology until the implementation of hospice payment reform, because of concerns that any changes to the current methodology would result in additional cost and burden to hospices. One association also suggested we fully examine the cap and whether other alternatives would better address patient needs, suggesting that we address alternatives in the context of broader payment reform.

While these 10 commenters supported allowing individual hospice programs the option of requesting a recalculation of their cap determination using a multi-year apportionment methodology, some were concerned that this could have implications for hospices that had not requested a recalculation. A commenter suggested that should CMS re-open cap determinations for hospices that had not requested a recalculation, we could potentially harm hospices and ultimately risk access for patients who had been served by more than one hospice. This commenter added that CMS should 'hold harmless' hospice programs that had not requested cap recalculation against overpayments that may occur as the result of another hospice program requesting recalculation of its cap. This commenter also urged CMS to adopt policies allowing greater flexibility with respect to repayment plans for those with cap overages.

In contrast to those supporting Option 2, 9 commenters supported an open-ended multi-year apportioning approach. Many of these commenters felt that changes to the methodology should be applied to all hospices. Several of the commenters cited the lawsuits filed against the Secretary which dispute the methodology for counting beneficiaries in the aggregate cap calculation. One of these commenters supported allowing re-opening of prior years' cap reports in conjunction with a revised regulation allowing a "true" patient-by-patient proportional allocation of beneficiaries' time across all years of service. One commenter suggested we allow re-opening of any cap demand which occurred after February 13, 2008, noting that this was the first date that a court held our regulation to be unlawful. Some of these commenters requested that we suspend the use of the existing regulation. Some commenters suggested that the existing regulation disadvantages patients with non-cancer diagnoses or who are minorities.

Some of these commenters disputed the statistic that 99.98 percent of patients who died in 2007 were admitted in 2006 or 2007, and argued that increasing the time limit for a patient-by-patient proportional calculation to 2 years, as suggested in our options, would not solve the problem. These commenters, who advocated an open-ended patient-by-patient proportional calculation, suggested we focus on how many hospice patients were still alive as of the end of 2007; they stated that our statistic was based on the percentage of patients who died rather than on those who were alive at the end of 2007. These commenters suggested a larger percentage of patients were alive, and cited data for patients admitted between 2003 and 2007, who were still alive as of December 31, 2007. They believe these patients are harmed by our not using an open-ended patient-by-patient proportional allocation in computing the aggregate cap. A commenter asked that contractors perform the calculation consistently, and be instructed on how to handle its detailed mechanics when adjustments occur.

Some of these 9 commenters felt that the current Local Coverage Determinations (LCDs) were of little use in predicting patient prognoses, with one noting that the current LCDs led to appropriate but sometimes long-stay admissions, which often resulted in reimbursements that exceeded the aggregate cap. They argued that the LCDs were not evidence-based. One commenter asserted that every patient reviewed for appropriateness of admission met his contractor's LCDs, and yet these patients had long lengths of stay.

Also, several of these 9 commenters suggested we support H.R. 3454, the Medicare Hospice Reform and Savings Act of 2009, parts of which were adopted into section 3132 of the Affordable Care Act. Commenters stated that the bill would have resulted in pay-as-you-go reductions in reimbursements for patients with lengths of stay exceeding 180 days. They stated that H.R. 3454 would have abolished the cap and eliminated unintended incentives for long stays, reduced Medicare hospice costs, and reduced our administrative burden. Commenters said that this legislation would have increased hospice rates by 20 percent for the first and last five days of hospice care that ends in the death of the patient; these reductions would have been offset by another 3 percent reduction in the daily hospice rates for those patients with lengths of stay beyond 180 days. They stated that this legislation would have updated LCDs or created National Coverage Determinations which would be improved, evidence-based formulas for determining eligibility. Commenters also stated that this legislation would have paid hospices more for the first and last few days of care, and less for the interim days.

Five other commenters chose no option, or presented their own alternative approaches. One stated that the existing aggregate cap is supposed to represent the "average" cost of caring for a patient, not the maximum cost, where hospices have a mix of patients with different diagnoses and lengths of stay. This commenter felt that the current methodology forces hospices to focus on individual patients rather than on the average patient mix, and was concerned that some hospices may refuse patients with certain diagnoses to avoid exceeding their aggregate cap. This commenter also was concerned about the use of new patient elections as the methodology for counting the number of beneficiaries served in computing the aggregate cap.

Another commenter recommended that each beneficiary be counted as 1 every calendar year, because over the years, more non-cancer terminal diagnoses have appeared, with unpredictable end-of-life trajectories; the commenter stated that these non-cancer patients require higher utilization of resources. The commenter suggested that under this mentioned scenario, each patient on service would begin a new cap year every January 1 and be counted as a new patient for that year.

A different commenter suggested that we modify the aggregate cap to focus on hospices instead of beneficiaries. He suggested that we change the aggregate cap calculation to a 180-day aggregate limit per hospice, which mirrors the 6 month requirement for hospice benefits to be elected. This commenter said that by monitoring an average day limit, all of the multi-year apportioning could be discarded, and replaced with a simple

calculation. Another commenter suggested we allow hospices to carry forward to the following year any "cap cushion" remaining at the end of the year.

Several commenters supported the idea of our aligning the cap year with the federal fiscal year, with some noting that the change would be appropriate for a multi-year apportioning approach. Other commenters stated that we should not change the cap year at this time, and recommended that we wait for future payment reform to do this. Many commenters asked that cap determination letters be mailed or sent in a more timely fashion, and a few said that contractors need to calculate caps consistently.

Commenters applauded efforts by CMS to address the concerns that arise when hospices lack access to accurate and timely histories of patient care. They suggested that the new PS&R include each patient's total days of care, benefit periods by hospice, indicate the initial benefit period, and show all benefit periods that have been used. Commenters also urged that the systems be as "real-time" as possible. Another commenter stated that registration into the IVACS [sic] system (which is used to access the PS&R) was overly cumbersome, and believed that if home care is used as a marker of the success of this new registration system, only 20 percent of home health agencies are currently registered.

Those who commented on our discussion about establishing a uniform schedule for contractors' mailing cap determination letters were supportive of such a process, and felt that this would assist hospices in their planning and budgeting. One commenter asked that the cap determination letter be considered a final determination.

A commenter suggested that we factor a hospice's wage index value when computing a hospice's aggregate cap. The commenter stated that because hospice payments are adjusted by the wage index to account for geographic variances in labor costs, a hospice in an area of relatively high labor costs would have higher aggregate payments in a given cap year than a hospice in an area with relatively low labor costs. Yet, the yearly aggregate payments of both hospices are compared to the same cap amount. The commenter states that high-wage index hospices are unfairly disadvantaged by not factoring in the wage index values to their yearly cap amount, and hospices in low-wage index areas are unfairly advantaged. The commenter felt that our not wage adjusting the cap amount was contrary to the intent of Congress.

Response: We thank the commenters for their insights on these issues. We have considered the comments in developing our proposals related to changing the aggregate cap calculation methodology, which are described in section III.B in this proposed rule. We will consider other comments and suggestions for improvements in the future, as we undertake broader payment reform.

Comment: Some commenters asked for additional data collection on hospice claims or through cost reports, so that CMS will have full resource utilization data related to providing hospice care when it seeks to reform payments. Some commenters stated that they were opposed to the BNAF phase-out. Others were concerned that rural hospices had similar or greater costs than urban hospices and yet were typically paid less due to wage adjustment. A commenter said that the hospital wage index used to create the hospice wage index was not accurate, as hospital wage patterns do not mirror those of hospices; this commenter suggested that we pilot test a hospice-specific wage index. Another commenter stated her concerns regarding the wage index value for her hospice's CBSA, and said that a neighboring CBSA was much higher. The commenter asked to be included in the neighboring CBSA.

Several commenters stated that the Common Working File (CWF) is burdensome and does not provide complete data on a patient's hospice history. A commenter added that some information in CWF was pulled from hospice cost reports, and was unreliable. She added that an industry association had presented us with a prototype cost report to more accurately reflect hospice costs rather than trying to force numbers from hospices into a home care model cost report, but that CMS has been slow in adopting this software.

One commenter was concerned that CMS waived notice and comment rulemaking in our FY 2011 Hospice Wage Index Notice.

Response: We thank the commenters, but we note that these comments are outside the scope of the solicitation.

III. Provisions of the Proposed Rule

A. FY 2012 Hospice Wage Index

1. Background

As previously noted, 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 proposed rule, we used the pre-floor, pre-reclassified hospital wage index, based solely on the CBSA designations, as the basis for determining wage index values for the proposed FY 2012 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 are proposing again to 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 2012 update to the hospice wage index, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index available at the time of publication.

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 proposed 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-Fort Stewart, Georgia. We propose to continue this policy for FY 2012.

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 proposed rule. In FY 2012, Dukes and Nantucket Counties are the only areas in rural Massachusetts which are affected. We are again proposing to apply this methodology for imputing a rural pre-floor, pre-reclassified hospital wage index for those rural areas without rural hospital wage data in FY 2012.

However, as we noted section I.B.4 of this proposed rule, we do not believe that this policy is appropriate for Puerto Rico. For FY 2012, we again propose to continue 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 proposed FY 2012 hospice wage index.

3. FY 2012 Wage Index With an Additional 15 Percent Reduced Budget Neutrality Adjustment Factor (BNAF)

The hospice wage index set forth in this proposed rule would be effective October 1, 2012 through September 30, 2013. We are not proposing any modifications to the hospice wage index methodology. In accordance with our regulations and the agreement signed with other members of the Hospice Wage Index Negotiated Rulemaking Committee, we are continuing to use the most current hospital data available. For this proposed rule, the FY 2011 hospital wage index was the most current hospital wage data available for calculating the FY 2012 hospice wage index values. We used the FY 2011 pre-floor, pre-reclassified hospital wage index data for this calculation.

As noted above, for FY 2012, 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 2007 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 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384).

The August 6, 2009 FY 2010 Hospice Wage Index final rule finalized a provision to phase out the BNAF over 7 years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in FY 2011, over each of the next 5 years, with complete phase out in FY 2016. Therefore, in accordance with the August 6, 2009, FY 2010 Hospice Wage Index final rule, the BNAF for FY 2012 was reduced by an additional 15 percent for a total BNAF reduction of 40 percent (10 percent from FY 2010, additional 15 percent from FY 2011, and additional 15 percent for FY 2012).

An unreduced BNAF for FY 2012 is computed to be 0.059061 (or 5.9061 percent). A 40 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 0.035437 (or 3.5437 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 proposed hospice wage index for FY 2012 is shown in Addenda A and B. Specifically, Addendum A reflects the proposed FY 2012 wage index values for urban areas under the CBSA designations. Addendum B reflects the proposed FY 2012 wage index values for rural areas under the CBSA designations.

4. Effects of Phasing Out the BNAF

The full (unreduced) BNAF calculated for FY 2012 is 5.9061 percent. As implemented in the August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384), for FY 2012 we are reducing the BNAF by an additional 15 percent, for a total BNAF reduction of 40 percent (a 10 percent reduction in FY 2010 plus a 15 percent reduction in FY 2011 plus a 15 percent reduction in FY 2012), with additional reductions of 15 percent per year in each of the next 4 years until the BNAF is phased out in FY 2016.

For FY 2012, this is mathematically equivalent to taking 60 percent of the full BNAF value, or multiplying 0.059061 by 0.60, which equals 0.035437 (3.5437 percent). The BNAF of 3.5437 percent reflects a 40 percent reduction in the BNAF. The 40 percent reduced BNAF (3.5437 percent) was applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater in the proposed FY 2012 hospice wage index.

The hospice floor calculation would 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 proposed rule as the hospice 15 percent floor adjustment. Third, the pre-floor, pre-reclassified hospital wage index value is multiplied by the BNAF. Fourth, the greater result of either step 2 or step 3 is 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 an additional 15 percent reduction in the BNAF, for a total BNAF reduction of 40 percent, on the FY 2012 hospice wage index compared to remaining with the total 25 percent reduced BNAF which was used for the FY 2011 hospice wage index. The additional 15 percent BNAF reduction applied to the FY 2012 wage index resulted in a 0.9 percent reduction in 84.4 percent of hospice wage index values, a 0.8 percent reduction in 8.6 percent of hospice wage index values, a 0.7 percent reduction in 0.7 percent of wage index values, and no reduction in 6.3 percent of wage index values.

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 proposed 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 29 CBSAs are already protected by the hospice 15 percent floor adjustment, and are therefore completely unaffected by the BNAF reduction. There are 323 hospices in these 29 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 additional 15 percent reduction in the BNAF applied in FY 2012. Areas where the hospice floor calculation would have yielded a wage index value greater than 0.8 if the 25 percent reduction in BNAF were maintained, but which will have a final wage index value less than 0.8 after the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 40 percent) 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 additional 15 percent reduction in the

BNAF applied in FY 2012. Because of the protection given by the hospice 15 percent floor adjustment, these CBSAs will see smaller percentage decreases in their hospice wage index values than those CBSAs that are not eligible for the hospice 15 percent floor adjustment. This will affect those hospices with lower hospice wage index values, which are typically in rural areas. There are 44 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 proposed rule. Therefore, the projected reduction in payments due solely to the additional 15 percent reduction of the BNAF applied in FY 2012 is estimated to be 0.6 percent, as calculated from the difference in column 3 and column 4 of Table 1 in section VII of this proposed rule. In addition, the estimated effects of the phase-out of the BNAF will be mitigated by any inpatient hospital market basket updates in payments. The estimated inpatient hospital market basket update for FY 2012 is 2.8 percent; this 2.8 percent does not reflect the provision in the Affordable Care Act which reduces the inpatient hospital market basket update for FY 2012 by 0.1 percentage point, since that reduction does not apply to hospices. The final update will be communicated through an administrative instruction. The combined effects of the updated wage data, an additional 15 percent reduction of the BNAF, and an estimated inpatient hospital market basket update of 2.8 percent for FY 2012, are an overall estimated increase in payments to hospices in FY 2012 of 2.3 percent (column 5 of Table 1 in section VII of this proposed rule).

B. Aggregate Cap Calculation Methodology

The existing method for counting Medicare beneficiaries in 42 CFR 418.309 has been the subject of substantial litigation. Specifically, the lawsuits challenge the way CMS apportions hospice patients with care spanning more than one year when calculating the cap.

A number of district courts and two appellate courts have concluded that CMS' current methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation is not consistent with the statute. We continue to believe that the methodology set forth in § 418.309(b)(1) is consistent with the Medicare statute. Nonetheless, we have determined that it is in the best interest of CMS and the Medicare program to take action to prevent future litigation, and alleviate the litigation burden on providers, CMS, and the courts. On April 15, 2011, we issued a Ruling entitled "Medicare Program; Hospice Appeals for Review of an Overpayment Determination" (CMS–1355–R), related to the aggregate cap calculation for hospices which provided for application of a patient-by-patient proportional methodology, as defined in the Ruling, to hospices that have challenged the current methodology. Specifically, the Ruling provides that, for any hospice which has a timely-filed administrative appeal of the methodology set forth at § 418.309(b)(1) used to determine the number of Medicare beneficiaries used in the aggregate cap calculation for a cap year ending on or before October 31, 2011, the Medicare contractors will recalculate that year's cap determination using the patient-by-patient proportional methodology as set forth in the Ruling.

We are also making several proposals in this Rule that affect cap determinations from two time periods:

- Cap determinations for cap years ending on or before October 31, 2011; and
- Cap determinations for cap years ending on or after October 31, 2012.

1. Cap Determinations for Cap Years Ending on or Before October 31, 2011

By its terms, the relief provided in Ruling 1355–R applies only to those cap years for which a hospice has received an overpayment determination and filed a timely qualifying appeal. For any hospice that receives relief pursuant to Ruling 1355–R in the form of a recalculation of one or more of its cap determinations, or for any hospice that receives relief from a court after challenging the validity of the cap regulation, we propose that the hospice's cap determination for any subsequent cap year also be calculated using a patient-by-patient proportional methodology as opposed to the methodology set forth in 42 CFR 418.309(b)(1). The patient-by-patient proportional methodology is defined below in section III.B.3.

Additionally, there are hospices that have not filed an appeal of an overpayment determination challenging the validity of 42 CFR 418.309(b)(1) and which are awaiting CMS to make a cap determination in a cap year ending on or before October 31, 2011. We propose to allow any such hospice provider, as of October 1, 2011, to elect to have its final cap determination for such cap year(s), and all subsequent cap years, calculated using the patient-by-patient proportional methodology.

Finally, we recognize that most hospices have not challenged the methodology used for determining the number of beneficiaries used in the cap calculation. Therefore, we propose that those hospices which would like to continue to have the existing methodology (hereafter called the streamlined methodology) used to determine the number of beneficiaries in a given cap year would not need to take any action, and would have their cap calculated using the streamlined methodology for cap years ending on or before October 31, 2011. The streamlined methodology is defined in section III.B.4 below.

We do not see these provisions as being impermissibly retroactive in effect. To the extent that these provisions could be considered a retroactive application of a substantive change to a regulation, section 1871(e)(1)(A) of the Act permits retroactive application of a substantive change to a regulation if the Secretary determines that such retroactive application is necessary to comply with statutory requirements or that failure to apply the change retroactively would be contrary to the public interest. We determine that for providers who have successfully sought to have the existing cap methodology set aside as invalid by the courts, retroactive application of the proposed Rule would be necessary to continue to comply with the statutory requirement in section 1814(i)(2) that the Secretary apply an aggregate cap to these hospices' reimbursements. We also determine that it would be in the public interest to calculate the aggregate hospice caps for subsequent years for these providers and for other providers that have filed appeals challenging the validity of the current methodology using the patient-by-patient proportional methodology to prevent the over-counting of beneficiaries for those years and to prevent repetitive litigation. We further determine that it would be in the public interest to permit providers that have not appealed their aggregate cap determinations to elect to have the patient-by-patient proportional methodology applied to aggregate cap determinations that have not been issued as of October 1, 2011. Allowing these hospices to elect to use the patient-by-patient proportional methodology would alleviate the burden on the hospices and the agency of continued appeals and litigation regarding the validity of the aggregate hospice cap calculation.

2. Cap Determinations for Cap Years Ending on or After October 31, 2012

We continue to believe that the methodology set forth in § 418.309(b)(1) is consistent with the Medicare statute. We emphasize that nothing in our proposals in section III.B.1 above constitutes an admission as to any issue of law or fact. In light of the court decisions, however, we propose to change the hospice aggregate cap calculation methodology policy for cap determinations ending on or after October 31, 2012 (the 2012 cap year). Specifically, for the cap year ending October 31, 2012 (the 2012 cap year) and subsequent cap years, we propose to revise the methodology set forth at § 418.309(b)(1) to adopt a patient-by-patient proportional methodology when computing hospices' aggregate caps. We also propose to "grandfather" in the current streamlined methodology set forth in § 418.309(b)(1) for those hospices that elect to continue to have the current streamlined methodology used to determine the number of Medicare beneficiaries in a given cap year, for the following reasons.

As described in section II of this proposed rule, we solicited comments on modernizing the cap calculation in our FY 2011 Hospice Wage Index Notice with Comment Period. We summarized those comments in section II of this proposed rule, and noted that many commenters, including the major hospice associations, were concerned about the burden to hospices of changing the cap calculation methodology, and urged us to defer across-the-board changes to the cap methodology until we analyze the cap in the context of broader payment reform. Specifically, commenters urged CMS to retain the current methodology, as it results in a more streamlined and timely cap determination for providers as compared to other options. Also, commenters noted that once made, cap determinations usually remain final. Commenters were concerned that a proportional methodology could result in prior year cap determination revisions to account for situations in which the percentage of time a beneficiary received services in a prior cap year declines as his or her overall hospice stay continues into subsequent cap years, and these revisions may result in new overpayments for some providers. And, commenters noted that the vast majority of providers don't exceed the cap, so burdening these providers with an across-the-board change isn't justified. We also note that on January 18, 2011, President Obama issued an Executive Order entitled "Improving Regulation and Regulatory Review" (E.O. 13563), which instructs federal agencies to consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public. We believe that offering hospices the option to elect to continue to have the streamlined methodology used in calculating their caps is in keeping with this Executive Order.

For these reasons, for the cap year ending October 31, 2012 (the 2012 cap year) and subsequent cap years, we propose that the hospice aggregate cap be calculated using the patient-by-patient proportional methodology, but propose to allow hospices the option of having their cap calculated via the current streamlined methodology, as discussed below. We believe this two-pronged approach is responsive to the commenters who do not want to be burdened with a change in the cap calculation methodology at this time, while also conforming with decisional law and meeting the needs of hospices that would prefer the patient-by-patient proportional methodology of counting beneficiaries. This grandfathering proposal to allow hospices the option of having their caps calculated based on application of the current streamlined methodology only applies to currently existing hospices that have, or will have, had a cap determination calculated under the streamlined methodology. New hospices that have not had their cap determination calculated using the streamlined methodology do not fall under this proposed "grandfather" policy.

We are in the early stages of the analyses related to payment reform. As such, the role of the aggregate cap in the reformed payment system is unknown at this time. If the reformed system and statute continue to require a limitation on hospice aggregate payments, we would look to apply one aggregate cap policy consistently to all hospices, and will consider commenters' suggestions for improvements in the aggregate cap as we analyze payment reform options.

3. Patient-by-Patient Proportional Methodology

For the cap year ending October 31, 2012 (the 2012 cap year), and for all subsequent cap years (unless changed by future rulemaking), we propose that the Medicare contractors would apply the patient-by-patient proportional methodology (defined below) to a hospice's aggregate cap calculations unless the hospice elects to have its cap determination for cap years 2012 and beyond calculated using the current, streamlined methodology set forth in § 418.309(b)(1).

Under the proposed patient-by-patient proportional methodology, a hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. We propose that the whole and fractional shares of Medicare beneficiaries' time in a given cap year would then be summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year.

When a hospice's cap is calculated using the patient-by-patient proportional methodology and a beneficiary included in that calculation survives into another cap year, the contractor may need to make adjustments to prior cap determinations, subject to existing re-opening regulations.

4. Streamlined Methodology

As we described above, comments received from hospices and the major hospice associations urged CMS to defer across-the-board changes to the cap calculation methodology until we reform hospice payments. Several of these commenters feared that an across-the-board change in methodology now may disadvantage them by potentially placing them at risk for incurring new cap overpayments. Additionally, approximately 90 percent of hospices do not exceed the cap and have not objected to the current methodology, and commenters expressed concern that adapting to a process change would be costly and burdensome. In response to these concerns, we propose that a hospice may exercise a one-time election to have its cap determination for cap years 2012 and beyond calculated using the current, streamlined methodology set forth in § 418.309(b). We propose that the option to elect the continued use of the streamlined methodology for cap years 2012 and beyond would be available only to hospices that have had their cap determinations calculated using the streamlined methodology for all years prior to cap year 2012. In section III.B.5 ("Changing Methodologies") below, we describe our detailed rationale for limiting the election. Allowing hospices which, prior to cap year 2012, have their cap determination(s) calculated pursuant to a patient-by-patient proportional methodology to elect the streamlined methodology for cap years 2012 and beyond could result in over-

counting patients and introduce a program vulnerability.

Our current policy set forth in the existing § 418.309(b)(2) describes that when a beneficiary receives care from more than one hospice during a cap year or years, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice. We propose to revise the regulatory text at § 418.309(b)(2) to clarify that each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. We also propose to add language to make clear that cap determinations are subject to reopening/adjustment to account for updated data.

5. Changing Methodologies

We believe our proposed policies, described above, provide hospices with a reasonable amount of flexibility with regard to their cap calculation. However, we believe that if we allowed hospices to switch back and forth between methodologies, it would greatly complicate the cap determination calculation, would be difficult to administer, and might lead to inappropriate switching by hospices seeking merely to maximize Medicare payments. Additionally, in the year of a change in the calculation methodology, there is a potential for over-counting some beneficiaries. Allowing hospices to switch back and forth between methodologies would perpetuate the risk of over-counting beneficiaries. Therefore, we propose that:

(1) Those hospices that have their cap determination calculated using the patient-by-patient proportional methodology for any cap year prior to the 2012 cap year would continue to have their cap calculated using the patient-by-patient proportional methodology for the 2012 cap year and all subsequent cap years; and,

(2) All other hospices would have their cap determinations for the 2012 cap year and all subsequent cap years calculated using the patient-by-patient proportional methodology unless they make a one-time election to have their cap determinations for cap year 2012 and beyond calculated using the streamlined methodology.

(3) A hospice can elect the streamlined methodology no later than 60 days following the receipt of its 2012 cap determination.

(4) Hospices which elect to have their cap determination calculated using the streamlined methodology may later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:

a. Electing to change to the patient-by-patient proportional methodology; or

b. Appealing a cap determination calculated using the streamlined methodology to determine the number of Medicare beneficiaries.

(5) If a hospice elects the streamlined methodology, and changes to the patient-by-patient proportional methodology for a subsequent cap year, the hospice's aggregate cap determination for that cap year and all subsequent cap years is to be calculated using the patient-by-patient proportional methodology. As such, past cap year determinations may be adjusted to prevent the over-counting of beneficiaries, notwithstanding the ordinary limitations on reopening.

6. Other Issues

Contractors will provide hospices with instructions regarding the cap determination methodology election process. Regardless of which methodology is used, the contractor will continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. The contractor will continue to include the hospice cap determination in a letter which serves as a notice of program reimbursement under 42 CFR 405.1803(a)(3). Cap determinations are subject to the existing CMS re-opening regulations.

In our FY 2011 Hospice Wage Index Notice with Comment Period, we discussed aligning the cap year timeframe with that of the federal fiscal year. Commenters suggested we not make changes to the cap year timeframe at this time, but defer changes until broader payment reform occurs. We agree with commenters, and our cap year continues to be defined as November 1st to October 31st.

In that FY 2011 Hospice Wage Index Notice with Comment Period, we also discussed the timeframe used for counting beneficiaries under the streamlined methodology, which is September 28th to September 27th. This timeframe for counting beneficiaries was implemented because it allows those beneficiaries who elected hospice near the end of the cap year to be counted in the year when most of the services were provided. However, for those hospices whose cap determinations are calculated using a patient-by-patient proportional methodology for counting the number of beneficiaries, we propose to count beneficiaries and their associated days of care from November 1st through October 31st, to match that of the cap year. This ensures that the proportional share of each beneficiary's days in that hospice during the cap year is accurately computed.

Finally, we note that the existing regulatory text at 418.308(b)(1) refers to the timeframe for counting beneficiaries as "(1) * * * the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period)." The period beginning September 28 is actually 34 days before November 1 (the beginning of the cap year), rather than 35 days. We propose to correct this in the regulatory text, and to change references to the "cap period" to that of the "cap year" to correctly reference the time frame for cap determinations.

7. Changes to Regulatory Text

As a result of the proposals made in this section, we propose to change the regulatory text at 42 CFR 418.309 as follows:

- We propose to change the title of 418.309 from "Hospice Cap Amount" to "Hospice Aggregate Cap" to clarify what this section covers. The "cap amount" is defined as the per-beneficiary dollar amount which is updated annually, and is only one component of the aggregate cap calculation. At the beginning of the regulatory text for this section, we also propose to revise the existing language to refer to the methodologies given in (b) and (c) which follow.
- In § 418.309(b), we propose to add the title "Streamlined Methodology Defined" at the beginning of the regulatory text, and to replace "Each hospice's cap amount" with "A hospice's aggregate cap." In § 418.309(b)(1), we propose to revise the language to note that it applied to those beneficiaries who have received care from only one hospice. We also propose to correct the existing regulatory text which reads "* * * (35 days before the beginning of the cap period) * * *" to read "* * * (34 days before the beginning of the cap year) * * *" and change existing regulatory text which reads "* * * and ending on September 27 (35 days before the end of the cap period) * * *" to read "* * * and ending September 27 (35 days before the end of the cap year) * * *."
- We propose to revise § 418.309(b)(2) to describe the streamlined methodology for computing fractional shares of a beneficiary when a beneficiary has received care from more

than one hospice, and to note that the computation considers all cap years and all hospices, using the best data available at the time of the calculation. We also propose to add language that notes that the aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.

• We propose to add § 418.309(c), which would be entitled "*Patient-by-Patient Proportional Methodology Defined*." We propose that a hospice's aggregate cap would be calculated by multiplying the adjusted cap amount by the number of Medicare beneficiaries. For the purposes of the patient-by-patient proportional methodology, we propose that a hospice would include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. We propose that the total number of Medicare beneficiaries for a given hospice's cap year would be determined by summing the whole or fractional share of each Medicare beneficiary that received hospice care during the cap year, from that hospice.

Finally, we also propose that the aggregate cap calculation for a given cap year could be adjusted after the calculation for that year based on updated data.

• We propose to add paragraph (d) to section 418.309, which would be entitled "*Application of Methodologies*." We propose that for cap years ending October 31, 2011 and for prior cap years, a hospice's aggregate cap would be calculated using the streamlined methodology. However, we propose that a hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, could elect to have its final cap determination for such cap years calculated using the patient-by-patient proportional methodology. Additionally, we propose that a hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year would be deemed to have elected that its cap determination for the challenged year, and all subsequent cap years, be calculated using the patient-by-patient proportional methodology.

We also propose that for cap years ending October 31, 2012, and all subsequent cap years, a hospice's aggregate cap would be calculated using the patient-by-patient proportional methodology. We also propose that a hospice that has had its cap calculated using the patient-by-patient proportional methodology for any cap year(s) prior to the 2012 cap year would not be eligible to elect the streamlined methodology, and would have to continue to have the patient-by-patient proportional methodology used to determine the number of Medicare beneficiaries in a given cap year. We propose that a hospice that is eligible to make a one-time election to have its cap calculated using the streamlined methodology would have to make that election no later than 60 days after receipt of its 2012 cap determination. We also propose that a hospice's election to have its cap calculated using the streamlined methodology would remain in effect unless the hospice subsequently would submit a written election to change the methodology used in its cap determination to the patient-by-patient proportional methodology; or the hospice would appeal the streamlined methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation.

Finally, we propose that if a hospice that elected to have its aggregate cap calculated using the streamlined methodology subsequently elected the patient-by-patient proportional methodology or appealed the streamlined methodology, the hospice's aggregate cap determination for that cap year and all subsequent cap years would be calculated using the patient-by-patient proportional methodology. As such, we propose that past cap year determinations could be adjusted to prevent the over-counting of beneficiaries, notwithstanding the ordinary limitations on reopening.

• Throughout § 418.309 we propose to delete references to the intermediary, as this terminology is now outdated.

C. Hospice Face-to-Face Requirement

Section 3132(b) of the Affordable Care Act of 2010 (Pub. L. 111–148, enacted March 23, 2010) amended section 1814(a)(7) of the Act by adding an additional certification requirement that beginning January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with every hospice patient prior to the 180-day recertification of the patient's terminal illness to determine continued eligibility. The statute also requires that the hospice physician or NP who performs the encounter attest that such a visit took place in accordance with procedures established by the Secretary. Although the provision allows an NP to perform the face-to-face encounter and attest to it, section 1814(a)(7)(A) of the Act continues to require that a hospice physician must certify and recertify the terminal illness.

The requirement for a physician face-to-face encounter for long-stay hospice patients' was first suggested by Medicare's Payment Advisory Commission (MedPAC) in their March 2009 Report to the Congress (MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 6, March 2009, pp. 365 through 371) ("the MedPAC Report"). MedPAC recommended that a hospice physician or advance practice nurse visit hospice patients prior to the 180-day recertification of terminal illness in order to increase physician accountability in the recertification and help ensure appropriate use of the benefit.

We implemented section 1814(a)(7), as amended by section 3132(b) of the Affordable Care Act in the November 17, 2010 final rule (75 FR 70372), published in the **Federal Register**, entitled "Home Health Prospective Payment System Rate Update for CY 2011; Changes in Certification Requirements for Home Health Agencies and Hospices", hereinafter referred to as the CY 2011 HH PPS Final Rule. The statute requires that for hospice recertifications occurring on or after January 1, 2011, a face-to-face encounter take place before the 180th-day recertification. We decided that the 180th-day recertification and subsequent benefit periods corresponded to the recertification for a patient's third or subsequent benefit period.

In the CY 2011 HH PPS final rule, we describe our rationale for defining the 180th-day recertification as the recertification which occurs at the start of the third benefit period (that is, the benefit period after the second 90-day benefit period). We considered the existing language used in the statute and in our regulations, all of which is structured around the concept of benefit periods which, by statute, cannot last longer than a maximum number of days (90 days for the first two and 60 days for subsequent benefit periods). Our regulatory language at § 418.22 requires certifications at the beginning of the benefit periods. For these reasons we defined the 180th-day recertification to be the recertification which occurs at the start of the third benefit period (75 FR 70437).

These new provisions at § 418.22(a) and (b), as set out in the CY 2011 HH PPS final rule (75 FR 70463) include the following requirements:

• The encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more

than 30 calendar days prior to every subsequent benefit period thereafter.

- The hospice physician or NP who performs the encounter attests in writing that he or she had a face-to-face encounter with the patient, and includes the date of the encounter. The attestation, which includes the physician's signature and the date of the signature, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
- The physician narrative associated recertifications for the third and subsequent benefit period recertifications include an explanation of why the clinical findings of the face-to-face encounter support a prognosis that the patient has a life expectancy of 6 months or less.
- When an NP performs the encounter, the NP's attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.
- The hospice physician or the hospice NP can perform the encounter. We define a hospice physician as a physician who is employed by the hospice or working under contract with the hospice, and a hospice NP must be employed by the hospice.
- The hospice physician who performs the face-to-face encounter and attests to it must be the same physician who certifies the patient's terminal illness and composes the recertification narrative (75 FR 70445).

In this proposed rule, we would allow any hospice physician to perform the encounter and inform the certifying physician for this last requirement for the following reasons:

Since the publication of the CY 2011 HH PPS final rule, we were told of the concerns of stakeholders, such as individual hospices, major hospice associations, physicians, and patient advocacy groups regarding the hospice physician performing both the face-to-face encounter and the recertification. Most of the concerns were that this requirement could potentially result in a substantial risk of harm to terminally ill patients. We find many of these concerns compelling. Specifically, stakeholders describe the challenge rural areas and medically underserved areas have in employing hospice physicians. Often, the physicians employed are part-time, and sometimes several part-time physicians are employed by the hospice. These physicians furnish medically necessary physician services to hospice patients as a team or group practice would, communicating with each other regarding the patients' conditions and sharing responsibility for the patients' care. In requiring the same physician to perform both the face-to-face encounter and the certification, stakeholders argued that we were imposing an unnecessary complexity to the face-to-face encounter requirement which could disadvantage those patients in areas of the country whom they believed were at the greatest risk and could negatively affect access-to-care. Many hospices stated that they would not find it feasible to meet this strict implementation requirement and they would no longer be able to serve patients in the third and later benefit periods. In addition, stakeholders stated that when MedPAC recommended a face-to-face encounter for long-stay hospice patients, it also expressed a concern that the requirement could pose an access risk in rural areas (MedPAC *Report* at 366). To mitigate that risk, MedPAC recommended that NPs also be allowed to perform the encounter, and the Congress adopted that recommendation. Further, stakeholders stated that because the Congress allowed an NP to perform the encounter and inform the recertifying physician, it would be illogical for CMS to preclude another hospice physician from performing the encounter and informing the recertifying physician. The stakeholders stated that in having done so, CMS inadvertently created an access to care risk that MedPAC and the Congress had tried to prevent. Stakeholders stated that long-stay patients in rural and medically underserved areas would be denied access during a time when many are in the final stages of their disease trajectory and needed hospice care the most. Stakeholders suggested that such patients would be denied the pain and symptom management control that they require as a result of CMS's regulatory limitation. In addition, they stated that hospices in rural and medically underserved areas need the flexibility of allowing NPs and any of their hospice physicians to perform the required patient encounter in order to serve such patients.

Many stakeholders also stated that requiring the same hospice physician to perform both the face-to-face encounter and the recertification was contrary to the intent of the statute. They pointed out that the statutory language required that a hospice physician or NP perform the encounter, but the statute did not mandate that the physician who performs the encounter must be the same physician who recertifies the patient. In addition, the stakeholders observed that if the Congress had intended to require the physician who performed the encounter to be the same physician who recertified the patient, then the Congress could have included that requirement in the law.

Stakeholders also stated that MedPAC did not recommend that the physician who performed the encounter be the same physician that recertified the patient. They referred us to discussions in the MedPAC Report, which first recommended the face-to-face encounter. (MedPAC Report, 357 through 371.)

We note that some of these stakeholders were part of the technical expert panel which MedPAC convened in 2008 to develop the recommendations contained in the MedPAC Report. The report described the panel's discussions surrounding the need for more physician involvement in hospice/palliative care, and concerns regarding some hospices' practices being motivated by financial incentives (MedPAC Report, 357 through 367). The report also discussed the panel's concern that hospice medical directors could at times be influenced by such incentives and should be more accountable for eligibility determinations. However, we believe it is possible that the scenario where the hospice medical director was the certifying physician and a different hospice physician performed the encounter and informed the medical director about the patient's condition the result could be better physician accountability than if the medical director performed the encounter. The physician who performed the encounter would serve as an independent assessor of the patient's terminal condition, and would provide a check and balance to the medical director's possible financial incentive to recertify.

Stakeholders also asserted that any hospice physician who saw the patient could achieve the goals described in the MedPAC report and the statute. The report described the tension between hospice physicians and non-physician staff and how the emotional attachment to patients of non-physician staff could lead to inappropriate recertifications. Stakeholders claim that this risk could be mitigated by any hospice physician seeing the patient and informing the certifying physician. More importantly, the stakeholders referred to the MedPAC report discussion regarding concerns that a physician face-to-face encounter provision might not be feasible in rural areas where there were physician shortages. In recommending that non-

physician practitioners be allowed to perform the encounter, MedPAC identified a need to allow flexibility regarding the practitioner who performs the encounter, especially in rural areas. Commenters stated that MedPAC and the Congress intended for long-stay hospice patients to be seen by any hospice physician or NP prior to the 180-day recertification.

In this proposed rule, we propose to revise the policy finalized in the CY 2011 HH PPS final rule published on November 17, 2010.

Specifically, in the CY 2011 HH PPS final rule, we implemented section 3132(b) of the Affordable Care Act, which requires that beginning January 1, 2011, a hospice physician or NP have a face-to-face encounter with every hospice patient prior to the 180-day recertification of the patient's terminal illness to determine continued eligibility. In implementing this provision, in response to comments in the final rule, we stated that the hospice physician who performed the face-to-face encounter must be the same physician who recertifies the patient's terminal illness and composes the recertification narrative.

As a result of stakeholders concerns resulting from the final rule policy, we propose to remove this limitation in this proposed rule. We propose that any hospice physician can perform the face-to-face encounter regardless of whether that physician recertifies the patient's terminal illness and composes the recertification narrative. In keeping with this proposal, we also propose to change the regulatory text at 418.22(b)(4) to state that the attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that encounter were provided to the certifying physician, for use in determining continued eligibility for hospice. This proposal reflects the Centers for Medicare and Medicaid Services' commitment to the general principles of the President's Executive Order released January 18, 2011 entitled "Improving Regulation and Regulatory Review", as it would reduce burden to hospices and hospice physicians and increase flexibility in areas of physician shortages. We are soliciting public comments on this proposal.

D. Technical Proposals and Clarification

1. Hospice Local Coverage Determinations

In the November 17, 2010 "CY 2011 Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule", we implemented new requirements for a face-to-face encounter which were mandated by the Affordable Care Act of 2010. A commenter asked how the face-to-face encounter related to Local Coverage Determinations (LCDs), and if the expectation was that the physician would verify the patient's condition based on the LCDs. Other commenters asked for guidance regarding what the encounter should include (that is, elements that make up an encounter) for purposes of satisfying the requirement. When describing how to assess patients for recertification, our response cited the LCDs of several contractors (see 75 FR 70447–70448). The response also included common text from those LCDs related to clinical findings to use in making the assessment and determining whether a patient was terminally ill. We stated that the clinical findings should include evidence from the three following categories: (1) Decline in clinical status guidelines (for example, decline in systolic blood pressure to below 90 or progressive postural hypotension); (2) Non disease-specific base guidelines (that is, decline in functional status) as demonstrated by Karnofsky Performance Status or Palliative Performance Score and dependence in two or more activities of daily living; and (3) Co-morbidities. We would note that because the language was not mandatory, there was never any intention that this response have a legally binding effect on hospices. These are suggestions as to elements of a certification or recertification which could be deemed to be indicative of a terminal condition. However, this was not meant to be an exhaustive or exclusive list. Because there has been some confusion about the extent to which these items exclude other possible scenarios, we propose to clarify that the clinical findings included in the comment response were provided as an example of findings that can be used in determining continued medical eligibility for hospice care. The illustrative clinical findings mentioned above are not mandatory national policy. We reiterate that certification or recertification is based upon a physician's clinical judgment, and is not an exact science. Congress made this clear in section 322 of the Benefits Improvement and Protection Act of 2000 (BIPA), which says that the hospice certification of terminal illness "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

2. Definition of Hospice Employee

As noted above, in the November 17, 2010 "CY 2011 Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule," we implemented new requirements for a face-to-face encounter, which were mandated by the Affordable Care Act. As part of that implementation, we required that a hospice physician or nurse practitioner must perform the face-to-face encounters. Several commenters asked us to clarify who is considered a "hospice physician or nurse practitioner" (see 75 FR 70443–70445). We stated that a hospice physician or nurse practitioner must be employed by the hospice, and that hospice physicians could also be working under arrangement with the hospice (i.e., contracted). We added that Section 418.3 defines a hospice employee as someone who is receiving a W–2 form from the hospice or who is a volunteer. The complete definition of a hospice employee at 418.3 is as follows: "Employee means a person who: (1) Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice." We received a number of questions from the industry about the definition of an employee and whether it included personnel who were employed by an agency or organization that has a hospice subdivision and who were assigned to that hospice. We are clarifying that entire definition of employee given at 418.3 (shown above) applies. Therefore, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice is a hospice employee.

3. Timeframe for Face-to-Face Encounters

In the November 17, 2010 "CY 2011 Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule," we also implemented policies related to the timeframe for performing a face-to-face encounter. We cited the statutory language from section 3132 of the Affordable Care Act, which says that on and after January 1, 2011, a hospice physician or nurse practitioner must

have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary for hospice care prior to the 180th-day recertification and each subsequent recertification (see 75 FR 70435). We also defined the 180th-day recertification to be the recertification which occurs at the 3rd benefit period (see 75 FR 70436–70437). We implemented a requirement that the face-to-face encounter occur no more than 30 calendar days prior to the 3rd or later benefit periods, to allow hospices flexibility in scheduling the encounter (see 75 FR 70437–70439). We emphasized throughout the final rule that the encounter must occur "prior to" the 3rd benefit period recertification, and each subsequent recertification. The regulatory text associated with these changes is found at 42 CFR 418.22(a)(4), and reads, "As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the 3rd benefit period, no more than 30 calendar days prior to the 3rd benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care." We believe our final policy states clearly that the face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification and each subsequent recertification. However, we are concerned that our regulation text above could lead a hospice to believe that the face-to-face encounter could occur in an open-ended fashion after the start of a benefit period in which it is required, and that the limitation on the time-frame was only on how far in advance of the start of the benefit period that the encounter could occur. Our policy, as stated in the final rule, is that a face-to-face encounter is required prior to the 3rd benefit period recertification and each recertification thereafter (75 FR 70454). Therefore, we propose to revise the regulation text to more clearly state that the encounter is required "prior to" the 3rd benefit period recertification, and each subsequent recertification. As such, we propose to change the regulatory text to read "(4) *Face-to-face encounter.* As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to but no more than 30 calendar days prior to the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care."

4. Hospice Aide and Homemaker Services

The hospice Conditions of Participation (CoPs) were updated in 2008, after being finalized on June 5, 2008 in the Hospice Conditions of Participation Final Rule (73 FR 32088). Those revised CoPs included changing the term "home health aide" to "hospice aide". In our FY 2010 Hospice Wage Index Final Rule (74 FR 39384), we updated language in several areas of our regulatory text to use this new terminology, including at 42 CFR 418.202(g). The regulatory text at 418.202(g) describes hospice aide and homemaker services. The last sentence of the regulatory text that was finalized is about homemaker services, however the word "homemaker" was inadvertently replaced with "aide". The revised regulatory text also inadvertently deleted the sentence which read "Aide services must be provided under the supervision of a registered nurse." Finally, the title of this section of the regulatory text continues to refer to section 418.94 of the CoPs. However, section 418.94 no longer exists, and was updated in the 2008 Hospice CoP Final Rule to section 418.76. We propose to correct the regulatory text at 418.202(g) to update the CoP reference to show section 418.76, to add back the sentence about supervision which was deleted, and to correct the last sentence to refer to "homemakers" rather than "aides."

E. Quality Reporting for Hospices

1. Background and Statutory Authority

CMS seeks to promote higher quality and more efficient health care for Medicare beneficiaries. Our efforts are furthered by the quality reporting programs coupled with public reporting of that information. Such quality reporting programs exist for various settings such as the Hospital Inpatient Quality Reporting (Hospital IQR) Program. In addition, CMS has implemented quality reporting programs for hospital outpatient services, the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), and for physicians and other eligible professionals, the Physician Quality Reporting System (PQRS). CMS has also implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality improvement program that links payment to performance based on requirements in section 153(c) of the Medicare Improvement for Patients and Providers Act of 2008.

Section 3004 of the Affordable Care Act amends the Social Security Act to authorize additional quality reporting programs, including one for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent fiscal year, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that fiscal year. Depending on the amount of annual update for a particular year, a reduction of 2 percentage points may result in the annual market basket update being less than 0.0 percent for a fiscal year and may result in payment rates that are less than payment rates for the preceding fiscal year. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only with respect to the particular fiscal year involved. Any such reduction will not be cumulative and will not be taken into account in computing the payment amount for subsequent fiscal years.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Any measures selected by the Secretary must have been endorsed by the consensus-based entity which holds a contract regarding performance measurement with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, Section 1814(i)(5)(D)(ii) provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity the Secretary may specify a measure(s) that is(are) not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Under section 1814(i)(5)(D)(iii) of the Act, the Secretary must not later than October 1, 2012 publish selected measures that will be applicable with respect to FY 2014.

Section 1814(i)(5)(E) of the Act requires the Secretary to establish

procedures for making data submitted under the hospice quality reporting program available to the public. The Secretary must ensure that a hospice has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary must report quality measures that relate to hospice care provided by hospices on the Internet Web site of CMS.

2. Quality Measures for Hospice Quality Reporting Program for Payment Year FY 2014

a. Considerations in the Selection of the Proposed Quality Measures

In implementing these quality reporting programs, CMS envisions the comprehensive availability and widespread use of health care quality information for informed decision making and quality improvement. We seek to collect data in a manner that balances the need for information related to the full spectrum of quality performance and the need to minimize the burden of data collection and reporting. Our purpose is to help achieve better health care and improve health through the widespread dissemination and use of performance information. We seek to efficiently collect data using valid, reliable and relevant measures of quality and to share the information with organizations that use such performance information as well as with the public.

We also seek to align new Affordable Care Act reporting requirements with current HHS high priority conditions, topics and National Quality Strategy (NQS) goals and to ultimately provide a comprehensive assessment of the quality of health care delivered. The hospice quality reporting program will align with the HHS National Quality Strategy, particularly with the goals of ensuring person and family centered care and promoting effective communication and coordination of care. One fundamental element of hospice care is adherence to patient choice regarding such issues as desired level of treatment and location of care provision. This closely aligns with the HHS NQS goal of ensuring person and family centered care. Another fundamental element of hospice care is the use of a closely coordinated interdisciplinary team to provide the desired care. This characteristic is closely aligned with the goal of promoting effective communication and coordination of care. Patient/family preferences and coordination of care will be foci of future hospice quality measure selection. Arriving at such a comprehensive set of quality measures that reflect high priority conditions and goals of the HHS NQS will be a multi-year effort.

Other considerations in selecting measures include: Alignment with other Medicare and Medicaid quality reporting programs as well as other private sector initiatives; suggestions and input received on measures including, for example, those received during the Listening Session on the Hospice Quality Reporting Program held on November 15, 2010; seeking measures that have a low probability of causing unintended adverse consequences; and considering measures that are feasible (that is, measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analyses, and calculation of reporting and performance rates as applicable). We also considered the burden to hospices when selecting measures to propose. We considered the January 18, 2011 Executive Order entitled "Improving Regulation and Regulatory Review" (E.O. 13563), which instructs federal agencies to consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public.

In our search for measures appropriate for the first year of the Hospice Quality Reporting Program, we considered the results of our environmental scan, literature search, technical expert panel and stakeholder listening sessions that detailed measures developed by multiple stewards. Of particular interest were measures from the National Hospice and Palliative Care Organization (NHPCO), the PEACE Project conducted by The Carolinas Center for Medical Excellence 2006–2008 and the AIM Project conducted by the New York QIO, IPRO 2009–2010. Measures from these three sources can be viewed at the following Web sites: *http://ww.nhpco.org/files/public/Statistics_Research/NHPCO_research_flier.pdf, http://www.thecarolinascenter.org/default.aspx?pageid=46* and *http://www.ipro.org/index/cms-filesystem-action/hospice/1_6.pdf.*

We are investigating expanding our proposed measures to adopt some of these measures in the future. However, evaluation of these measures revealed unique measurement concerns for hospice services generally. Two major issues were identified. First, all of the measures currently available for use in measuring hospice quality of care are retrospective and have to be collected using a chart abstraction approach. This creates a burden for hospice providers. Secondly, there is no standardized vehicle for data collection or centralized structure for hospice quality reporting. We believe these issues limit our options for measure reporting in the first year of the Hospice Quality Reporting Program. Our plans to require additional measure reporting are described below under section 4. Additional Measures Under Consideration.

We considered measures currently endorsed by NQF that are applicable to hospice care. Of the nine measures listed by NQF as applicable to end of life care, seven address patients who specifically died of cancer and various situations experienced by those patients in their last days of life regardless of whether they were cared for by a hospice. These seven measures do not address the provision of hospice care or the breadth of the hospice patient population. The remaining two NQF endorsed hospice-related measures address measurement of the quality of care actually provided by hospices. One of the two hospice appropriate measures relates to pain control and is discussed below under section b. The other hospice appropriate measure, #0208: Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument requires the hospice to administer the Family Evaluation of Hospice Care (FEHC) survey to families of deceased hospice patients. The FEHC survey itself contains 54 questions to be returned to the hospice and analyzed/scored in order to produce a rating for the measure. Though the FEHC survey is available to all hospices, we are unable to determine the number of hospices that currently use this survey or the number that analyze the responses to determine scoring for this NQF endorsed measure. We believe that the efforts required for hospices to set up systems to utilize and analyze this survey tool can be burdensome for some hospices, and that the timeframe required to put the survey administration and evaluation process in place is insufficient. Therefore, while we do not propose to use this measure as a requirement for the FY 2014 payment update, this measure may be included in future quality reporting requirements because, should the level of burden prove to be acceptable, the family evaluation of hospice care is an important perspective on hospice quality. We are not aware of any other measures applicable to hospice care that have been endorsed or adopted by a consensus organization other than the NQF.

The current hospice Conditions of Participation (CoPs) at 42 CFR section 418.58 require that hospices develop,

implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement (QAPI) program and that the hospice maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS. In addition, hospices must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations as part of their QAPI Program.

Hospices have been required to have QAPI programs in place since December 2008 in order to comply with the CoPs. As a part of the QAPI regulations, since February 2, 2009, hospices have been required to develop, implement, and evaluate performance improvement projects. The regulations require that

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, reflect the scope, complexity, and past performance of the hospice's services and operations; and

(2) The hospice document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

b. Proposed Quality Measures for the Quality Reporting Program for Hospices

Proposed Quality Measures

To meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in Section 1814(i)(5) of the Act, we propose that hospices report the NQF-endorsed measure that is related to pain management, NQF #0209: The percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought under control within 48 hours. A primary goal of hospice care is to enable patients to be comfortable and free of pain, so that they may live each day as fully as possible. The provision of pain control to hospice patients is an essential function, a fundamental element of hospice care and therefore we believe the pain control measure, NQF #0209 is an important and appropriate measure for the hospice quality reporting program.

Additionally, to meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in Section 1814(i)(5) of the Act, we propose that hospices also report one structural measure that is not endorsed by NQF. Structural measures assess the characteristics and capacity of the provider to deliver quality health care. The proposed structural measure is: Participation in a Quality Assessment and Performance Improvement (QAPI) Program that Includes at Least Three Quality Indicators Related to Patient Care. We believe that participation in QAPI programs that address at least three indicators related to patient care reflects a commitment not only to assessing the quality of care provided to patients but also to identifying opportunities for improvement that pertain to the care of patients. Examples of domains of indicators related to patient care include providing care in accordance with documented patient and family goals, effective and timely symptom management, care coordination, and patient safety.

Section 1814(i)(5)(D)(ii) provides that "[i]n the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible measure has not been endorsed by an entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary." We have proposed to adopt this structural measure because we believe it is appropriate for use in evaluating the quality of care provided by hospices. As discussed above, a majority of the NQF-endorsed measures that relate to end of life care are not hospice-specific or, in the case of the FEHC survey instrument, that measure is too burdensome for hospices to implement for the FY 2014 payment determination. We are also not aware of any other measures applicable to the hospice setting that have been adopted by another consensus organization. Accordingly, we propose to adopt the structural measure under the authority in section 1814(i)(5)(D)(ii).

We propose that each hospice submit data on the proposed structural measure, including the description of each of their patient-care focused quality indicators (if applicable) to CMS by January 31, 2013 on a spreadsheet template to be prepared by CMS. Specifically, hospice programs would be required to report whether or not they have a QAPI program that addresses at least three indicators related to patient care. In addition, hospices would be required to list all of their patient care indicators. Hospice programs will be evaluated for purposes of the quality reporting program based on whether or not they respond, not on how they respond.

In addition, we propose a voluntary submission of the proposed structural measure (not for purposes of a payment determination or public reporting), including the description of each of their patient-care focused quality indicators to CMS by January 31, 2012 on a spreadsheet template to be prepared by CMS. Voluntary reporting of the structural measure data with specific quality indicators related to patient care to CMS will allow us to learn what the important patient care quality issues are for hospices and serves to provide useful information in the design and structure of the quality reporting program. Our intent is to require additional standardized and specific quality measures to be reported by hospices in subsequent years. We solicit comment on the measures proposed.

The proposed collection and submission of data on the proposed NQF-endorsed measure will be a new requirement for hospices. However, since the development, implementation and maintenance of an effective, ongoing, hospice-wide data driven quality assessment and performance improvement program have been requirements in the Medicare CoPs since 2008, we do not believe that the collection of the proposed structural measure on QAPI indicators would be considered new work. There are numerous data collection tools and quality indicators that are available to hospices through hospice industry associations and private companies. In addition to these options, hospices may choose to use the CMS-sponsored Hospice Assessment Intervention and Measurement (AIM) Project data elements, data dictionary, data collection tool, and quality indicator formulas that are freely available to all hospices, found at *http://www.ipro.org/index/hospice-aim*.

We invite comment on the proposed quality measurement approach including whether there are other quality measures currently available which may be appropriate and advisable for the hospice quality reporting program starting in FY2014. We will review and carefully consider the comments that we receive on the proposed measures for the first hospice quality reporting cycle as we prepare the final rule. We propose that hospices report the structural measure by January 2013 and the NQF measure #0209 by April 2013 in order to be used in the fiscal year 2014 payment determination. In addition, we propose that hospices voluntarily report the structural

measure by January 2012 for purposes of program development and design. It is important to note that the Affordable Care Act allows the Secretary until October 1, 2012 to publish the measures required to meet the FY 2014 reporting requirement. As such, we have the opportunity to also consider commenters' suggestions associated with this proposed rule in FY 2013 hospice rulemaking.

c. Proposed Timeline for Data Collection Under the Quality Reporting Program for Hospices

To meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in Section 1814(i)(5) of the Act, we propose that the first hospice quality reporting cycle for the proposed NQF-endorsed measure and the proposed structural measure will consist of data collected from October 1, 2012 through December 31, 2012. This timeframe will permit us to determine whether each hospice is eligible to receive the full market basket update for FY 2014 based on a full quarter of data. This also provides sufficient time after the end of the data collection period to accurately determine each hospice's market basket update for FY 2014. We propose that all subsequent hospice quality reporting cycles would be based on the calendar-year basis (e.g., January 1, 2013 through December 31, 2013 for determination of the hospice market basket update for each hospice in FY 2015, etc.). We welcome comments on the proposed reporting cycle for the hospice quality reporting program.

To voluntarily submit the structural measure, we propose that the hospice voluntary quality reporting cycle will consist of data collected from October 1, 2011 through December 31, 2011. This timeframe will permit us to analyze the data to learn what the important patient care quality issues are for hospices as we enhance the quality reporting program design to require more standardized and specific quality measures to be reported by hospices in subsequent years.

d. Data Submission Requirements

We generally propose that hospices submit data in the fiscal year prior to the payment determination. For the fiscal year 2014 payment determination, we propose that hospices submit data for the proposed NQF-endorsed measure based on the measure specifications for that measure, which can be found at *http://www.qualityforum.org,* no later than April 1, 2013. Data submission for the structural measure would include the hospices' report of whether they have a QAPI program that addresses at least three indicators related to patient care, and, if so, the subject matter of all of their patient care indicators for the period October 1, 2012 through December 31, 2012. Submission of these reports would be required by January 31, 2013.

We propose that both measures' data be submitted to CMS on a spreadsheet template to be prepared by CMS. We will announce operational details with respect to the data submission methods and format for the hospice quality data reporting program using this CMS Web site *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting* by no later than December 31, 2011 should these measures be finalized.

For the voluntary submission, we propose that hospices submit data for the proposed structural measure based on the spreadsheet template to be prepared by CMS, no later than January 31, 2012. Voluntary data submission for the structural measure would include the hospices' report of whether they have a QAPI program that addresses at least three indicators related to patient care, and, if so, the subject matter of all of their patient care indicators for the period October 1, 2011 through December 31, 2011. Submission of these reports would be required by January 31, 2012.

3. Public Availability of Data Submitted

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. Such procedures will ensure that a hospice will have the opportunity to review the data regarding the hospice's respective program before it is made public. Also, under section 1814(i)(5)(E) of the Act, the Secretary is authorized to report quality measures that relate to services furnished by a hospice on the CMS Internet Web site. At the time of the publication of this proposed rule, no date has been set for public reporting of data. We recognize that public reporting of quality data is a vital component of a robust quality reporting program and are fully committed to developing the necessary systems for public reporting of hospice quality data.

4. Additional Measures Under Consideration

As described above, we are considering expanding the proposed measures to include measures from the National Hospice and Palliative Care Organization (NHPCO), the PEACE Project and the AIM Project. While in this first year, we propose to build a foundation for quality reporting by requiring hospices to report one NQF endorsed measure and one structural measure, we seek to achieve a comprehensive set of quality measures to be available for widespread use for informed decision making and quality improvement. We expect to explore and expand the measures in various ways. Future topics under consideration for quality data reporting include patient safety, effective symptom management, patient and family experience of care, and alignment of care with patient preferences. For quality data reporting in FY2014 or FY2015, we are also particularly interested in the development of new measures related to these topics and in the further development of existing measures that can be found on the following Web sites: *http://www.nhpco.org/files/public/Statistics_Research/NHPCO_research_flier.pdf http://www.thecarolinascenter.org/default.aspx?pageid=46* and *http://www.ipro.org/index/cms-filesystem-action/hospice/1_6.pdf.*

We welcome comments on whether all, some, any, or none of these measures should be considered for future rulemaking. We also solicit comments on ways which CMS can adopt these measures in a standardized way that is not overly burdensome to hospice providers and reflects hospice patient input.

To support the standardized collection and calculation of quality measures specifically focused on hospice services, we believe the required data elements would potentially require a standardized assessment instrument.

CMS has developed an assessment instrument for the "Post-Acute Care Payment Reform Demonstration Program," as required by section 5008 of the 2005 Deficit Reduction Act (DRA). This is a standardized assessment instrument that could be used across all post-acute care sites to measure functional status and other factors during treatment and at discharge from each provider and to test the usefulness of this standardized assessment instrument (now referred to as the Continuity Assessment Record & Evaluation, CARE). We believe such an assessment instrument would be beneficial in supporting the submission of data on quality measures by requiring standardized data with regard to hospice patients, similar to the current MDS 3.0 and OASIS–C that support a variety of quality measures for nursing homes and home health agencies, respectively. The CARE data set used by hospices would require editing to

address the unique and specific assessment needs of the hospice patient population. We invite comments on the implementation of a standardized assessment instrument for hospices that would similarly support the calculation of quality measures.

We invite public comment on considering modifications to the CARE data set to capture information specifically relevant to measuring the quality of care and services delivered by hospices such as patient/family preferences and the degree to which those preferences were met for care delivery, symptom management, spiritual needs and other aspects of care pertinent to the hospice patient population. The current version of the CARE data set can be found at *www.pacdemo.rti.org*.

Finally, we are also soliciting comments on ways which CMS can expand the structural reporting measure to also include hospice performance on each QAPI indicator reported in the performance period.

IV. Updates on Issues Not Proposed for Rulemaking for FY 2012 Rulemaking

A. Update on Hospice Payment Reform and Value Based Purchasing

Section 3132 of the Affordable Care Act of 2010 (Pub. L. 111–148) authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and for other purposes. The types of data and information described in the Affordable Care Act attempt to capture resource utilization, which can be collected on claims, cost reports, and possibly other mechanisms as we determine to be appropriate. The data collected would be used to revise hospice payment methodology or routine home care rates in a budget-neutral manner no earlier than October 1, 2013. In order to determine the revised hospice payment methodology and types of data to be collected, we will consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC).

According to MedPAC's March 2011 "Report to Congress: Medicare Payment Policy" (available at *http://www.medpac.gov/chapters/Mar10_Ch02E.pdf*), Medicare expenditures for hospice services exceeded $12 billion in 2009 and the aggregate Medicare margin in 2008 was 5.1 percent. In addition, MedPAC found a 50 percent growth in the number of hospices from 2000 to 2009, of which a majority were for-profit hospices. The growth in Medicare expenditures, margins, and number of new hospices raises concern that the current hospice payment methodology may have created unintended incentives. Over the past several years, MedPAC, the Government Accountability Office (GAO), and the Office of Inspector General (OIG) all recommended that CMS collect more comprehensive data in order to better assess the utilization of the Medicare hospice benefit. MedPAC has also suggested an alternative payment model that they believe will address the vulnerabilities in the current payment system.

We are in the early stages of reform analysis. We have conducted a literature review, are in the process of conducting initial data analysis, and our contractor will convene a technical advisory panel in the spring of 2011. We are also working in collaboration with the Assistant Secretary of Planning and Evaluation to develop analysis that may be used to inform the technical advisory panel discussions. We hope to share the study design in future rulemaking to solicit public comments on the hospice payment reform methodology.

Section 10326 of the Affordable Care Act directs the Secretary to conduct a pilot program to test a value-based purchasing program for hospices no later than January 1, 2016. As described in Section III E. Quality Reporting for Hospices above, in this rule we have proposed two measures for hospices to report to CMS no later than January 31, 2013. We believe that these measures are a quality reporting foundation upon which CMS will expand. Over the course of the next few years, no later than beginning in FY 2015, CMS will require hospices to report an expanded and comprehensive set of quality measures from which CMS can select for pilot testing a value-based purchasing program. During the FY 2013, FY 2014 and FY 2015 hospice rulemaking, CMS plans to iteratively implement the expanded measures, and solicit industry comments regarding analysis and design options for a hospice value-based purchasing pilot which would improve the quality of care while reducing spending. We will also consult with stakeholders in developing the implementation plan, as well as considering the outcomes of any recent demonstration projects related to value-based purchasing which we believe might be relevant to the hospice setting. We will provide further information on the progress of our efforts in future rulemaking.

B. Update on the Redesigned Provider Statistical & Reimbursement Report (PS&R)

In our FY 2011 Hospice Wage Index Notice with Comment Period, we solicited comments on a redesigned PS&R system, which would allow hospices easy access to national hospice utilization data on their Medicare hospice beneficiaries. As described in section II of this proposed rule, some commenters were supportive of the idea, and said they needed access to each beneficiary's full utilization history to better manage their caps and to meet the new face-to-face requirements.

We are moving forward with this project, and expect the redesigned PS&R system to be able to provide complete utilization data needed for calculating hospice caps. We believe that the redesigned PS&R system will provide hospices with a greater ability to monitor their caps by providing readily accessible information on beneficiary utilization. We expect it to be available to hospices before year's end. We encourage all hospices to become familiar with the redesigned PS&R and to use the information it will make available in managing their respective caps. In the future, we may consider requiring hospices to self-report their caps, using PS&R data.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-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 each of these issues in this proposed rule.

Proposed Quality Measures for the Quality Reporting Program for Hospices

Section 1814(i)(5)(C) of the Social Security Act requires that each hospice

must submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Under section 1814(i)(5)(D)(iii) of the Act, the Secretary must not later than October 1, 2012 publish selected measures that will be applicable with respect to FY 2014.

In implementing the Hospice quality reporting program, CMS seeks to collect measure information with as little burden to the providers as possible and which reflects the full spectrum of quality performance. Our purpose in collecting this data is to help achieve better health care and improve health through the widespread dissemination and use of performance information.

A. Structural Measure: Participation in a Quality Assessment Performance Improvement Program That Includes at Least Three Indicators Related to Patient Care

Consistent with this proposed rule, hospices will voluntarily report to CMS by January 31, 2012 their participation in a QAPI program that includes the hospices' report of whether they have a QAPI program that addresses at least three indicators related to patient care, and if so, the subject matter of all of their patient care indicators during the time frame October 1 through December 31, 2011. Data submitted for the last quarter of calendar year 2011 shall be voluntary on the part of hospice providers and shall not impact their fiscal year 2014 payment determination.

The information that hospices will be required to report, in both the voluntary and mandatory phases of reporting, consists of stating whether or not they participate in a QAPI program that includes at least three indicators related to patient care and if so, the subject matter of all of their patient care indicators. Expectations of the QAPI programs are set forth in the Hospice Conditions of Participation (CoPs) at 42 CFR 418.58(a) through 418.58(e). These conditions of participation require that hospices must develop, implement, and maintain an effective, ongoing, hospice-wide, data-driven QAPI program and that the hospice must maintain documentary evidence of its QAPI programs. Hospices have been required to meet all of the standards set forth in 42 CFR 418.58(a) through 418.58(e) as a condition of participation in the Medicare and Medicaid programs since 2008. Therefore, the identification of quality indicators related to patient care, will not be considered new or additional work.

Under the proposed quality reporting program, hospices will voluntarily report to CMS by no later than January 31, 2012, data that would include whether they have a QAPI program that addresses at least three indicators related to patient care, and if so, the subject matter of all of their patient care indicators during the time frame via a CMS-prepared spreadsheet template. CMS anticipates that this reporting will take no more than 15 minutes of time to prepare the structural measure report.

Thereafter, each of the 3,531 hospices in the United States will be required to submit this structural measure information to CMS one time per year. CMS estimates that it will take approximately 15 minutes to prepare and complete the submission of this structural measure report. Therefore, the estimated number of hours spent by all hospices in the U.S. preparing and submitting such data totals 883 hours. CMS believes that the compilation and transmission of the data can be completed by data entry personnel. We have estimated a total cost impact of $18,163 to all hospices for the implementation of the hospice structural measure quality reporting program, based on 883 total hours for a billing clerk at $20.57/hour (which includes 30 percent overhead and fringe benefits, using most recent BLS wage data). We have developed an information collection request for OMB review and approval.

B. NQF Measure #0209: Percentage of Patients Who Were Uncomfortable Because of Pain on Admission to Hospice Whose Pain Was Brought Under Control Within 48 Hours

At this time, CMS has not completed development of the information collection instrument that Hospices would have to submit in order to comply with the NQF measure #0209 reporting requirements as discussed earlier in this proposed rule. Because the instrument for the reporting of this measure is still under development, we cannot assign a complete burden estimate at this time. Once the instrument is available, we will publish the required 60-day and 30-day **Federal Register** notices to solicit public comments on the data submission form and to announce the submission of the information collection request to OMB for its review and approval. The data collection of the NQF measure #0209 for the fiscal year 2014 payment determination is for the time period from October 1, 2012 to December 31, 2012.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS–1355–P, Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov.*

VI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 30, 1993, Regulatory Planning and Review), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (September 19, 1980; Pub. L. 96–354) (RFA), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has not been designated an "economically" significant rule, under section 3(f)(1) of Executive Order 12866. However, we have voluntarily prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of this proposed rule.

2. Statement of Need

This proposed rule follows § 418.306(c) which requires annual publication, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Metropolitan Statistical Areas (MSAs). Also, it implements Section 3004 of the Affordable Care Act of 2010, which directs the Secretary to specify quality measures for the hospice program. Lastly, this proposed rule includes proposed changes to the aggregate cap calculation, to requirements related to physicians who perform face-to-face encounters, and offers several clarifying technical corrections.

3. Overall Impacts

The overall impact of this proposed rule is an estimated net decrease in Federal payments to hospices of $80 million for fiscal year 2012. We estimated the impact on hospices, as a result of the changes to the FY 2012 hospice wage index and of reducing the BNAF by an additional 15 percent, for a total BNAF reduction of 40 percent (10 percent in FY 2010, 15 percent in FY 2011, and 15 percent in FY 2012). The BNAF reduction is part of a 7-year BNAF phase-out that was finalized in previous rulemaking (74 FR 39384 (August 6, 2009)), and is not a policy change.

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 2010 Hospice Wage Index final rule, which finalized a 10 percent reduced BNAF for FY 2010 as the first year of a 7-year phase-out of the BNAF, to be followed by an additional 15 percent per year reduction in the BNAF in each of the next 6 years. Total phase-out will be complete by FY 2016.

4. Detailed Economic Analysis

Column 4 of Table 1 shows the combined effects of the updated wage data (the 2011 pre-floor, pre-reclassified hospital wage index) and of the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 40 percent), comparing estimated payments for FY 2012 to estimated payments for FY 2011. The FY 2011 payments used for comparison have a 25 percent reduced BNAF applied. We estimate that the total hospice payments for FY 2012 will decrease by $80 million as a result of the application of the updated wage data ($+10 million) and the total 40 percent reduction in the BNAF ($ − 90 million). This estimate does not take into account any inpatient hospital market basket update, which is estimated to be 2.8 percent for FY 2012. This estimated 2.8 percent does not reflect the provision in the Affordable Care Act which reduces the inpatient hospital market basket update for FY 2012 by 0.1 percentage point, since that reduction does not apply to hospices. The final inpatient hospital market basket update and associated payment rates will be communicated through an administrative instruction in the summer. The effect of an estimated 2.8 percent inpatient hospital market basket update on payments to hospices is approximately $390 million. Taking into account an estimated 2.8 percent inpatient hospital market basket update (+$390 million), in addition to the updated wage data ($+10 million) and the total 40 percent reduction in the BNAF ($ − 90 million), it is estimated that hospice payments would increase by $310 million in FY 2012 ($390 million + $10 million − $90 million = $310 million). The percent change in payments to hospices due to the combined effects of the updated wage data, the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 40 percent), and the inpatient hospital market basket update of 2.8 percent is reflected in column 5 of the impact table (Table 1).

a. Effects on Hospices

This section discusses the impact of the projected effects of the hospice wage index, including the effects of an estimated 2.8 percent inpatient hospital market basket update for FY 2012 that will be communicated separately through an administrative instruction. This proposed 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 proposed FY 2012 hospice wage index is based upon the 2011 pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2009) with an additional 15 percent reduction in the BNAF (combined with the 10 percent reduction in the BNAF taken in FY 2010, and the additional 15 percent taken in 2011, for a total BNAF reduction of 40 percent in FY 2012). The BNAF reduction is part of a 7-year BNAF phase-out that was finalized in previous rulemaking, and would not be a policy change.

For the purposes of our impacts, our baseline is estimated FY 2011 payments with a 25 percent BNAF reduction, using the 2010 pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3, Table 1) compares our baseline to estimated FY 2012 payments (holding payment rates constant) using the updated wage data (2011 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 additional 15 percent reduction in the BNAF are illustrated in column 4 of Table 1.

We have included a comparison of the combined effects of the additional 15 percent BNAF reduction, the updated wage data, and an estimated 2.8 percent inpatient hospital market basket update for FY 2012 (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 proposed rule, the BNAF phase-out, and the estimated FY 2012 inpatient 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 BUDGET NEUTRALITY ADJUSTMENT FACTOR (BNAF) BY AN ADDITIONAL 15 PERCENT (FOR A TOTAL BNAF REDUCTION OF 40 PERCENT) AND APPLYING AN ESTIMATED 2.8 PERCENT † INPATIENT HOSPITAL MARKET BASKET UPDATE TO THE FY 2012 HOSPICE WAGE INDEX, COMPARED TO THE FY 2011 HOSPICE WAGE INDEX WITH A 25 PERCENT BNAF REDUCTION

	Number of hospices	Number of routine home care days in thousands	Percent change in hospice payments due to FY2012 wage index change	Percent change in hospice payments due to wage index change, and additional 15% reduction in BNAF	Percent change in hospice payments due to wage index change, additional 15% reduction in BNAF, and market basket update
	(1)	(2)	(3)	(4)	(5)
ALL HOSPICES	3,440	74,900	0.1	(0.5)	2.3
URBAN HOSPICES	2,388	64,816	0.1	(0.5)	2.3
RURAL HOSPICES	1,052	10,084	(0.2)	(0.6)	2.2
BY REGION—URBAN:					
NEW ENGLAND	133	2,425	(0.7)	(1.3)	1.5
MIDDLE ATLANTIC	239	7,131	(0.3)	(0.9)	1.9
SOUTH ATLANTIC	347	14,247	0.3	(0.3)	2.5
EAST NORTH CENTRAL	328	9,191	0.2	(0.4)	2.4
EAST SOUTH CENTRAL	177	4,420	(0.1)	(0.6)	2.2
WEST NORTH CENTRAL	180	4,280	(0.3)	(0.8)	1.9
WEST SOUTH CENTRAL	461	8,657	0.1	(0.4)	2.4
MOUNTAIN	222	5,633	(0.0)	(0.6)	2.2
PACIFIC	264	7,606	0.6	(0.0)	2.8
OUTLYING	37	1,227	(0.4)	(0.4)	2.4
BY REGION—RURAL:					
NEW ENGLAND	26	193	(0.1)	(0.6)	2.1
MIDDLE ATLANTIC	45	517	0.4	(0.2)	2.6
SOUTH ATLANTIC	136	2,106	(0.7)	(1.1)	1.6
EAST NORTH CENTRAL	147	1,706	(0.6)	(1.1)	1.6
EAST SOUTH CENTRAL	153	1,958	0.1	(0.1)	2.7
WEST NORTH CENTRAL	194	1,085	(0.5)	(0.9)	1.9
WEST SOUTH CENTRAL	189	1,498	0.8	0.4	3.2
MOUNTAIN	109	585	0.3	(0.1)	2.7
PACIFIC	52	428	(0.7)	(1.3)	1.5
OUTLYING	1	10	0.0	0.0	2.8
ROUTINE HOME CARE DAYS:					
0–3499 DAYS (small)	621	1,077	(0.1)	(0.6)	2.2
3500–19,999 DAYS (medium)	1716	17,231	(0.1)	(0.6)	2.2
20,000+ DAYS (large)	1103	56,591	0.1	(0.5)	2.3
TYPE OF OWNERSHIP:					
VOLUNTARY	1172	29,742	0.0	(0.5)	2.3
PROPRIETARY	1796	38,047	0.1	(0.4)	2.4
GOVERNMENT	472	7,111	(0.1)	(0.7)	2.1
HOSPICE BASE:					
FREESTANDING	2340	58,510	0.1	(0.5)	2.3
HOME HEALTH AGENCY	555	9,922	0.1	(0.5)	2.3
HOSPITAL	526	6,272	(0.0)	(0.6)	2.2
SKILLED NURSING FACILITY	19	196	0.2	(0.4)	2.4

BNAF = Budget Neutrality Adjustment Factor.
Comparison is to FY 2011 data with a 25 percent BNAF reduction.
* OSCAR data as of January 6, 2011 for hospices with claims filed in FY 2009.
** In previous years, there was also a category labeled "Other"; these were Other Government hospices, and have been combined with the "Government" category.
† The estimated 2.8 percent inpatient hospital market basket update for FY 2012 does not reflect the provision in the Affordable Care Act which reduces the inpatient hospital market basket update by 0.1 percentage point since that reduction does not apply to hospices.
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 6, 2011 which had also filed claims in FY 2009. 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 2012 estimated payments with those estimated for FY 2011. The estimated FY 2011 payments incorporate a BNAF which has been reduced by 25 percent. Column 3 shows the percentage change in estimated Medicare payments for FY 2012 due to the effects of the updated wage data only, compared with estimated FY 2011 payments. The effect of the updated wage data can vary from region to region depending on the fluctuations in the wage index values of the pre-floor, pre-reclassified hospital wage index. Column 4 shows the percentage change in estimated hospice payments from FY 2011 to FY 2012 due to the combined effects of using the updated wage data and reducing the BNAF by an additional 15 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2011 to FY 2012 due to the combined effects of using updated wage data, an additional 15 percent BNAF reduction, and an estimated 2.8 percent inpatient 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 2,388 hospices located in urban areas and 1,052 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 2009. 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 3,440 hospices. Approximately 48 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 percent of hospice patients in 2009 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 2009) in developing the impact analysis. The FY 2012 payment rates will be adjusted to reflect the full inpatient hospital market basket update, 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 2012 estimated inpatient hospital market basket update is 2.8 percent. This 2.8 percent does not reflect the provision in the Affordable Care Act which reduces the inpatient hospital market basket update by 0.1 percentage point since that reduction does not apply to hospices. Since the inclusion of the effect of an inpatient hospital market basket increase provides a more complete picture of projected total hospice payments for FY 2012, the last column of Table 1 shows the combined impacts of the updated wage data, the additional 15 percent BNAF reduction, and the estimated 2.8 percent inpatient 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 CBSA 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 CBSA of the various sites of service will usually correspond with the CBSA of 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 1,644 designated as non-profit or government hospices and 1,796 as proprietary. The vast majority of hospices are freestanding.

b. 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 2012 updated wage data without any BNAF reduction are anticipated to decrease payments to small and medium hospices by 0.1 percent and increase payments to large hospices by 0.1 percent (column 3); the updated wage data and the additional 15 percent BNAF reduction (for a total BNAF reduction of 40 percent) are anticipated to decrease estimated payments to small and medium hospices by 0.6 percent, and to large hospices by 0.5 percent (column 4); and finally, the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 40 percent), and the estimated 2.8 percent inpatient hospital market basket update are projected to increase estimated payments by 2.2 percent for small and medium hospices, and by 2.3 percent for large hospices (column 5).

c. Geographic Location

Column 3 of Table 1 shows updated wage data without the BNAF reduction. Urban hospices are anticipated to experience an increase of 0.1 percent, while rural hospices will experience a decrease of 0.2 percent. Urban hospices can anticipate a decrease in payments in five regions; ranging from 0.7 percent in the New England region to 0.1 percent in the East South Central region. Payments in the Mountain region are estimated to stay stable. Urban hospices are anticipated to see an increase in payments in four regions; ranging from 0.1 percent in the West South Central

region to 0.6 percent in the Pacific region.

Column 3 shows estimated percentages for rural hospices. Rural hospices are estimated to see a decrease in payments in five regions, ranging from 0.7 percent in the South Atlantic and Pacific regions to 0.1 percent in the New England region. Rural hospices can anticipate an increase in payments in four regions, ranging from 0.1 percent in the East South Central region to 0.8 percent in the West South Central region. There is no change in payments for Outlying regions due to FY 2012 Wage Index change.

Column 4 shows the combined effect of the updated wage data and the additional 15 percent BNAF reduction on estimated payments, as compared to the FY 2011 estimated payments using a BNAF with a 25 percent reduction. Overall urban are anticipated to experience a 0.5 percent decrease in payments while rural hospices are anticipated to experience a 0.6 percent decrease in payments. Nine regions in urban areas are estimated to see decreases in payments, ranging from 1.3 percent in the New England region to 0.3 percent in the South Atlantic region. Payments for the Pacific region are estimated to be relatively stable.

Rural hospices are estimated to experience a decrease in payments in eight regions, ranging from 1.3 percent in the Pacific region to 0.1 percent in the East South Central and Mountain regions. While the estimated effect of the additional 15 percent BNAF reduction decreased payments to rural hospices in the West South Central region, hospices in this region are still anticipated to experience an estimated increase in payments of 0.4 percent due to the net effect of the reduced BNAF and the updated wage index data. Payments to rural outlying regions are anticipated to remain relatively stable.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and the estimated 2.8 percent inpatient hospital market basket update on estimated payments as compared to the estimated FY 2011 payments. Note that the FY 2011 payments had a 25 percent BNAF reduction applied to them. Overall, urban hospices are anticipated to experience a 2.3 percent increase in payments and rural hospices are anticipated to experience a 2.2 percent increase in payments. Urban hospices are anticipated to experience an increase in estimated payments in every region, ranging from 1.5 percent in the New England region to 2.8 percent in the Pacific region. Rural hospices in every region are estimated to see an increase in payments, ranging from 1.5 percent in the Pacific region to 3.2 percent in the West South Central region.

d. Type of Ownership

Column 3 demonstrates the effect of the updated wage data on FY 2012 estimated payments, versus FY 2011 estimated payments. We anticipate that using the updated wage data would decrease estimated payments to government hospices by 0.1 percent and payments to voluntary (non-profit) hospices would remain relatively unchanged. We estimate an increase in payments for proprietary (for-profit) hospices of 0.1 percent.

Column 4 demonstrates the combined effects of the updated wage data and of the additional 15 percent BNAF reduction. Estimated payments to voluntary (non-profit) hospices are anticipated to decrease by 0.5 percent, while government hospices are anticipated to experience a decrease of 0.7 percent. Estimated payments to proprietary (for-profit) hospices are anticipated to decrease by 0.4 percent.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 40 percent), and an estimated 2.8 percent inpatient hospital market basket update on estimated payments, comparing FY 2012 to FY 2011 (using a BNAF with a 25 percent reduction). Estimated FY 2012 payments are anticipated to increase 2.3 percent for voluntary (non-profit), 2.1 percent for government hospices, and 2.4 percent for proprietary (for-profit) hospices.

e. Hospice Base

Column 3 demonstrates the effect of using the updated wage data, comparing estimated payments for FY 2012 to FY 2011. Estimated payments are anticipated to increase by 0.1 percent for freestanding hospices and home health agency based hospices, and 0.2 percent for hospices based out of a skilled nursing facility. Payments to hospital based hospices are estimated to remain relatively unchanged.

Column 4 shows the combined effects of the updated wage data and reducing the BNAF by an additional 15 percent, comparing estimated payments for FY 2012 to FY 2011. All hospice facilities are anticipated to experience decrease in payments ranging from 0.4 percent for skilled nursing facility based hospices, to 0.6 percent for hospital based hospices.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and an estimated 2.8 percent inpatient hospital market basket update on estimated payments, comparing FY 2012 to FY 2011. Estimated payments are anticipated to increase for all hospices, ranging from 2.2 percent for hospital based hospices to 2.4 percent for skilled nursing facility based hospices.

f. Effects on Other Providers

This proposed rule only affects Medicare hospices, and therefore has no effect on other provider types.

g. Effects on the Medicare and Medicaid Programs

This proposed rule only affects Medicare hospices, and therefore has no effect on Medicaid programs. As described previously, estimated Medicare payments to hospices in FY 2012 are anticipated to increase by $10 million due to the update in the wage index data, and to decrease by $90 million due to the total 40 percent reduction in the BNAF. However, the estimated market basket update of 2.8 percent is anticipated to increase Medicare payments by $390 million. Therefore, the total effect on Medicare hospice payments is estimated to be a $310 million increase. Note that the final market basket update and associated FY 2012 payment rates will be officially communicated this summer through an administrative instruction.

h. 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 proposed 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 proposed rule using data for 3,440 hospices in our database.

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2011 TO FY 2012

[In $millions]

Category	Transfers
Annualized Monetized Transfers.	$ − 80. *

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2011 TO FY 2012—Continued

[In $millions]

Category	Transfers
From Whom to Whom ..	Federal Government to Hospices.

*The $80 million reduction in transfers includes the additional 15 percent reduction in the BNAF and the updated wage data. It does not include the hospital market basket update, which is estimated at 2.8 percent for FY 2012. This estimated 2.8 percent does not reflect the provision in the Affordable Care Act (ACA) which reduced the hospital market basket update by 0.1 percentage point since that reduction does not apply to hospices.

i. Conclusion

In conclusion, the overall effect of this proposed rule is estimated to be the $80 million reduction in Federal payments due to the wage index changes (including the additional 15 percent reduction in the BNAF). Furthermore, the Secretary has determined that this will not have a significant impact on a substantial number of small entities, or have a significant effect relative to section 1102(b) of the Act.

B. Regulatory Flexibility Act Analysis

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. For purposes of the RFA, we estimate that almost all hospices are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of less than $7.0 million to $34.5 million in any 1 year). While the SBA does not define a size threshold in terms of annual revenues for hospices, it does define one for home health agencies ($13.5 million; see*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13*). For the purposes of this proposed 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 proposed rule has a significant impact on a substantial number of small entities (for example, hospices). Using 2009 Medicare hospice claims data, we estimate that 96 percent of hospices have Medicare revenues below $13.5 million and are considered small entities. As indicated in Table 1 below, there are 3,440 hospices with 2009 claims data as of January 6, 2011. Approximately 48 percent of those 3,440 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.

The effects of this rule on hospices are shown in Table 1. Overall, Medicare payments to all hospices would decrease by an estimated 0.5 percent over last year's payments in response to the policies that we are proposing in this NPRM, reflecting the combined effects of the updated wage data and the additional 15 percent reduction in the BNAF. The combined effects of the updated wage data and additional 15 percent reduction in the BNAF on small or medium sized hospices (as defined by routine home care days rather than by the SBA definition), is −0.6 percent. However, when including the estimated inpatient hospital market basket update of 2.8 percent into these estimates, the combined effects on Medicare payment to all hospices would result in an estimated increase of approximately 2.3 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 additional 15 percent BNAF reduction, and the estimated inpatient hospital market basket update are increases in payments of 2.2 percent. Overall average hospice revenue effects will be slightly less than these estimates since according the National Hospice and Palliative Care Organization, about 17 percent of hospice patients are non-Medicare.

HHS's 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 additional 15 percent reduced BNAF (for a total BNAF reduction of 40 percent) for all hospices is −0.5 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 additional 15 percent reduced BNAF (−0.5 percent) does not exceed HHS's 3.0 percent minimum threshold. However, HHS's 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 additional 15 percent BNAF reduction, and the estimated 2.8 percent FY 2012 inpatient hospital market basket update, the overall impact is an increase in estimated hospice payments of 2.3 percent for FY 2012. Therefore, the Secretary has determined that this proposed rule would 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 of a metropolitan statistical area and has fewer than 100 beds. This proposed rule only affects hospices. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

C. Unfunded Mandates Reform Act Analysis

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 $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. This proposed rule with comment period is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of $136 million or more.

VIII. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent 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 proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local, or tribal governments.

List of Subjects in 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 proposes to amend 42 CFR chapter IV as set forth below:

1. 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 G—Payment for Hospice Care

2. In § 418.22, paragraphs (a)(4) and (b)(4) are revised to read as follows:

§ 418.22 Certification of terminal illness.

(a) * * *

(4) *Face-to-face encounter.* As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to but no more than 30 calendar days prior to the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

(b) * * *

(4) The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

* * * * *

3. Section 418.202 (g) is revised to read:

§ 418.202 Covered services.

* * * * *

(g) *Home health or hospice aide services furnished by qualified aides as designated in § 418.76 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 patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

* * * * *

4. In § 418.309, the introductory text and paragraph (b) are revised, and new paragraphs (c) and (d) are added, to read:

§ 418.309 Hospice Aggregate Cap.

A hospice's aggregate cap is calculated by multiplying the adjusted cap amount (determined in paragraph (a) of this section) by the number of Medicare beneficiaries, as determined by one of two methodologies for determining the number of Medicare beneficiaries for a given cap year described in paragraphs (b) and (c) of this section:

* * * * *

(b) *Streamlined Methodology Defined.* A hospice's aggregate cap is calculated by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries as determined in paragraphs (b)(1) and (2) of this section. For purposes of the streamlined methodology calculation—

(1) In the case in which a beneficiary received care from only one hospice, the hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care in accordance with § 418.24 during the period beginning on September 28 (34 days before the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year), using the best data available at the time of the calculation.

(2) In the case in which a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.

(c) *Patient-by-Patient Proportional Methodology Defined.* A hospice's aggregate cap is calculated by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries as described in paragraphs (c)(1) and (2) of this section. For the purposes of the patient-by-patient proportional methodology—

(1) A hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The total number of Medicare beneficiaries for a given hospice's cap year is determined by summing the whole or fractional share of each Medicare beneficiary that received hospice care during the cap year, from that hospice.

(2) The aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.

(d) *Application of Methodologies.* (1) For cap years ending October 31, 2011 and for prior cap years, a hospice's aggregate cap is calculated using the streamlined methodology described in paragraph (b) of this section, subject to the following:

(i) A hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, may elect to have its final cap determination for such cap years calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section; or

(ii) A hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year, and all subsequent cap years, be calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section.

(2) For cap years ending October 31, 2012, and all subsequent cap years, a hospice's aggregate cap is calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section, subject to the following:

(i) A hospice that has had its cap calculated using the patient-by-patient proportional methodology for any cap year(s) prior to the 2012 cap year is not eligible to elect the streamlined methodology, and must continue to have the patient-by-patient proportional methodology used to determine the number of Medicare beneficiaries in a given cap year.

(ii) A hospice that is eligible to make a one-time election to have its cap calculated using the streamlined

methodology must make that election no later than 60 days after receipt of its 2012 cap determination. A hospice's election to have its cap calculated using the streamlined methodology would remain in effect unless:

(A) The hospice subsequently submits a written election to change the methodology used in its cap determination to the patient-by-patient proportional methodology; or

(B) The hospice appeals the streamlined methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation.

(3) If a hospice that elected to have its aggregate cap calculated using the streamlined methodology under paragraph (d)(2)(ii) of this section subsequently elects the patient-by-patient proportional methodology or appeals the streamlined methodology, under paragraph (d)(2)(ii)(A) or (B) of this section, the hospice's aggregate cap determination for that cap year and all subsequent cap years is to be calculated using the patient-by-patient proportional methodology. As such, past cap year determinations may be adjusted to prevent the over-counting of beneficiaries, notwithstanding the ordinary limitations on reopening.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 14, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 19, 2011.

Kathleen Sebelius,

Secretary.

Note: The following Addendums will not be published in the Code of Federal Regulations.

BILLING CODE 4120–01–P

ADDENDUM A: FY 2012 WAGE INDEX FOR URBAN AREAS

CBSA Code	Urban Area[1] (Constituent Counties)	Wage Index[2]
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8287
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	0.3992
10420	Akron, OH Portage County, OH Summit County, OH	0.9156
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9356
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8960
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9791
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8278
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9520
11020	Altoona, PA Blair County, PA	0.8925
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8950
11180	Ames, IA Story County, IA	1.0323
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2388
11300	Anderson, IN Madison County, IN	0.9518
11340	Anderson, SC Anderson County, SC	0.8999
11460	Ann Arbor, MI Washtenaw County, MI	1.0483
11500	Anniston-Oxford, AL Calhoun County, AL	0.8199

11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9693
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9320
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0001
12060	Atlanta-Sandy Springs-Marietta, GA 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	0.9887
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1523
12220	Auburn-Opelika, AL Lee County, AL	0.8000
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9876
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9851
12540	Bakersfield-Delano, CA Kern County, CA	1.2122
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0618
12620	Bangor, ME Penobscot County, ME	1.0123
12700	Barnstable Town, MA Barnstable County, MA	1.3277
12940	Baton Rouge, LA 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	0.8887
12980	Battle Creek, MI Calhoun County, MI	0.9998
13020	Bay City, MI Bay County, MI	0.9548
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8789

13380	Bellingham, WA Whatcom County, WA	1.1794
13460	Bend, OR Deschutes County, OR	1.1775
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0898
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8981
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9028
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	0.8916
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	0.8609
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9308
14060	Bloomington-Normal, IL McLean County, IL	0.9773
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9602
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2610
14500	Boulder, CO Boulder County, CO	1.0422
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8973
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1045
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2992
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9498
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9535
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9868
15500	Burlington, NC Alamance County, NC	0.9177
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0299
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1649
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0754
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9059
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9521
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9301
16180	Carson City, NV Carson City, NV	1.0836
16220	Casper, WY Natrona County, WY	0.9997

16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9157
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0598
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8175
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9685
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9754
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9673
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9142
16940	Cheyenne, WY Laramie County, WY	0.9725
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0968
17020	Chico, CA Butte County, CA	1.1942
17140	Cincinnati-Middletown, OH-KY-IN 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	1.0043
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8168
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8005
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9371
17660	Coeur d'Alene, ID Kootenai County, ID	0.9696

17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9928
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9817
17860	Columbia, MO Boone County, MO Howard County, MO	0.8575
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9042
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9347
18020	Columbus, IN Bartholomew County, IN	0.9768
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	1.0500
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8889
18700	Corvallis, OR Benton County, OR	1.0825
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.9155
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8476
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	1.0209
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8928
19180	Danville, IL Vermilion County, IL	1.0036
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8457
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8698
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9464
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8000
19500	Decatur, IL Macon County, IL	0.8197
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9046
19740	Denver-Aurora-Broomfield, 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	1.1098

19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9962
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0043
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8000
20100	Dover, DE Kent County, DE	1.0273
20220	Dubuque, IA Dubuque County, IA	0.9085
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0939
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0006
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9981
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1396
20940	El Centro, CA Imperial County, CA	0.9586
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8748
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9800
21300	Elmira, NY Chemung County, NY	0.8744
21340	El Paso, TX El Paso County, TX	0.8775
21500	Erie, PA Erie County, PA	0.8656
21660	Eugene-Springfield, OR Lane County, OR	1.1787
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8732
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1473
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4465
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8350
22140	Farmington, NM San Juan County, NM	0.9670
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9653
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8921
22380	Flagstaff, AZ Coconino County, AZ	1.2884
22420	Flint, MI Genesee County, MI	1.1903
22500	Florence, SC Darlington County, SC Florence County, SC	0.8544
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8433
22540	Fond du Lac, WI Fond du Lac County, WI	0.9550
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0243
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0520

22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8000
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9694
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9810
23420	Fresno, CA Fresno County, CA	1.1827
23460	Gadsden, AL Etowah County, AL	0.8000
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9485
23580	Gainesville, GA Hall County, GA	0.9550
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9406
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8808
24140	Goldsboro, NC Wayne County, NC	0.9388
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8000
24300	Grand Junction, CO Mesa County, CO	1.0199
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9494
24500	Great Falls, MT Cascade County, MT	0.8583
24540	Greeley, CO Weld County, CO	0.9833
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9926
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9197
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9702
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9986
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.4239
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9192
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9582
25260	Hanford-Corcoran, CA Kings County, CA	1.1602
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9625
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9483
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1314
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	0.9001
25980	Hinesville-Fort Stewart, GA[3] Liberty County, GA Long County, GA	0.9275
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8938
26180	Honolulu, HI Honolulu County, HI	1.2225
26300	Hot Springs, AR Garland County, AR	0.9475
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8130
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	1.0172
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9270
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9517
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	1.0005
26900	Indianapolis-Carmel, IN 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	1.0015
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9999
27060	Ithaca, NY Tompkins County, NY	1.0191
27100	Jackson, MI Jackson County, MI	0.9479
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8327
27180	Jackson, TN Chester County, TN Madison County, TN	0.8702
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9199
27340	Jacksonville, NC Onslow County, NC	0.8084
27500	Janesville, WI Rock County, WI	0.9749
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8733
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8392

27780	Johnstown, PA Cambria County, PA	0.8377
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8032
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8505
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0657
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0995
28140	Kansas City, MO-KS 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	0.9994
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0330
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9110
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8000
28740	Kingston, NY Ulster County, NY	0.9397
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8120
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9454
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0150
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9618
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8790
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8486
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1163
29420	Lake Havasu City - Kingman, AZ Mohave County, AZ	1.0598
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8746
29540	Lancaster, PA Lancaster County, PA	0.9675
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0663
29700	Laredo, TX Webb County, TX	0.8194
29740	Las Cruces, NM Dona Ana County, NM	0.9625
29820	Las Vegas-Paradise, NV Clark County, NV	1.2528
29940	Lawrence, KS Douglas County, KS	0.8835
30020	Lawton, OK Comanche County, OK	0.8579

30140	Lebanon, PA Lebanon County, PA	0.8084
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9690
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9218
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9129
30620	Lima, OH Allen County, OH	0.9600
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9958
30780	Little Rock-North Little Rock-Conway AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8849
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9106
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8866
31020	Longview, WA Cowlitz County, WA	1.0661
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2560
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9211
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9161
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9002
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9528
31460	Madera-Chowchilla, CA Madera County, CA	0.8269
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1694
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0219
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.8125
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9405

31900	Mansfield, OH Richland County, OH	0.9234
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.4186
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9150
32780	Medford, OR Jackson County, OR	1.0418
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	0.9596
32900	Merced, CA Merced County, CA	1.2797
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0487
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9806
33260	Midland, TX Midland County, TX	1.0055
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0544
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	1.1538
33540	Missoula, MT Missoula County, MT	0.9237
33660	Mobile, AL Mobile County, AL	0.8242
33700	Modesto, CA Stanislaus County, CA	1.2533
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8276
33780	Monroe, MI Monroe County, MI	0.8992
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8741
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8425
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.8000
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0730
34620	Muncie, IN Delaware County, IN	0.8497
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0157
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9048
34900	Napa, CA Napa County, CA	1.5122
34940	Naples-Marco Island, FL Collier County, FL	1.0042

34980	Nashville-Davidson--Murfreesboro-Franklin, TN 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	0.9792
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2751
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1866
35300	New Haven-Milford, CT New Haven County, CT	1.1923
35380	New Orleans-Metairie-Kenner, LA 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	0.9391
35644	New York-White Plains-Wayne, NY-NJ 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	1.3414
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9186
35840	North Port-Bradenton-Sarasota, FL Manatee County, FL Sarasota County, FL	0.9817
35980	Norwich-New London, CT New London County, CT	1.1612
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6934
36100	Ocala, FL Marion County, FL	0.8768
36140	Ocean City, NJ Cape May County, NJ	1.1265
36220	Odessa, TX Ector County, TX	0.9770
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9595
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9192
36500	Olympia, WA Thurston County, WA	1.1668
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9923
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9488
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9905

36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8667
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2816
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9537
37380	Palm Coast, FL Flagler County, FL	0.8703
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8236
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8000
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8593
37764	Peabody, MA Essex County, MA	1.1368
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8546
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9473
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1186
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.1019
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8296
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8910
38340	Pittsfield, MA Berkshire County, MA	1.0739
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9844
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4975
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0250
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1883
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.1103
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1756
39140	Prescott, AZ Yavapai County, AZ	1.2668
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1094

39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9651
39380	Pueblo, CO Pueblo County, CO	0.9030
39460	Punta Gorda, FL Charlotte County, FL	0.9069
39540	Racine, WI Racine County, WI	1.0955
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0159
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0812
39740	Reading, PA Berks County, PA	0.9220
39820	Redding, CA Shasta County, CA	1.4635
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0788
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	1.0003
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1980
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9140
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1330
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8900
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0389
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0381
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9354
40660	Rome, GA Floyd County, GA	0.8941
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4551
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9037
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1433
41100	St. George, UT Washington County, UT	0.9457

41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0667
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	0.9412
41420	Salem, OR Marion County, OR Polk County, OR	1.1528
41500	Salinas, CA Monterey County, CA	1.6242
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9324
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9594
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8597
41700	San Antonio-New Braunfels, 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	0.9317
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2403
41780	Sandusky, OH Erie County, OH	0.8994
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6291
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5244
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7295
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	0.4940

	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	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3373
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2593
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2331
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7333
42140	Santa Fe, NM Santa Fe County, NM	1.1231
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6715
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9223
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8530
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1966
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9419
43100	Sheboygan, WI Sheboygan County, WI	0.9560
43300	Sherman-Denison, TX Grayson County, TX	0.8572
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8838
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9413
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9629
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0301
43900	Spartanburg, SC Spartanburg County, SC	0.9716
44060	Spokane, WA Spokane County, WA	1.0946
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9454
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0614
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8668
44220	Springfield, OH Clark County, OH	0.9561
44300	State College, PA Centre County, PA	0.9090
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.8000

44700	Stockton, CA San Joaquin County, CA	1.3092
44940	Sumter, SC Sumter County, SC	0.8139
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0256
45104	Tacoma, WA Pierce County, WA	1.1745
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9118
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9375
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9531
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8023
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9766
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9269
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0510
46060	Tucson, AZ Pima County, AZ	0.9816
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9105
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9156
46340	Tyler, TX Smith County, TX	0.8351
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8771
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8222
46700	Vallejo-Fairfield, CA Solano County, CA	1.5460
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8510
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0907
47260	Virginia Beach-Norfolk-Newport News, VA-NC 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	0.9279

	Williamsburg City, VA	
47300	Visalia-Porterville, CA Tulare County, CA	1.1119
47380	Waco, TX McLennan County, TX	0.8701
47580	Warner Robins, GA Houston County, GA	0.8312
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9990
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV 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	1.1103
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8762
48140	Wausau, WI Marathon County, WI	0.9902
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9956
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0286
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7676
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9213
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9905

48700	Williamsport, PA Lycoming County, PA	0.8000
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0955
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9528
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0356
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9256
49340	Worcester, MA Worcester County, MA	1.1402
49420	Yakima, WA Yakima County, WA	1.0424
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4066
49620	York-Hanover, PA York County, PA	1.0337
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8931
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1434
49740	Yuma, AZ Yuma County, AZ	0.9612

[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 rural areas are found in Addendum (B).

[2]Wage index values are based on FY 2007 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 hospital 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 or a) the 40 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 2012 hospice wage index, the BNAF was reduced by a total of 40 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.

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