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Medicare Program; Hospice Wage Index for Fiscal Year 2012; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1355–F]

RIN 0938–AQ31

Medicare Program; Hospice Wage Index for Fiscal Year 2012

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

ACTION: Final rule.

SUMMARY: This final rule will set forth the hospice wage index for fiscal year (FY) 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 final rule will change the hospice aggregate cap calculation methodology. This final rule will also revise the hospice requirement for a face-to-face encounter for recertification of a patient's terminal illness. Finally, this final rule will begin implementation of a hospice quality reporting program.

DATES: *Effective Date:* These regulations are effective on October 1, 2011.

FOR FURTHER INFORMATION CONTACT:

Robin Dowell, (410) 786–0060 for questions regarding quality reporting for hospices and collection of information requirements. Anjana Patel, (410) 786–2120 for questions regarding hospice wage index and hospice face-to-face requirement.

Katie Lucas, (410) 786–7723 for questions regarding all other sections.

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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

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

B. Hospice Wage Index

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 have used CBSAs exclusively to calculate wage index values.

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). 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 Bureau of Labor Statistics (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 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 Inpatient Prospective Payment System (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. In FY 2011, the only such CBSA was 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 2011, the data collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2006 were used to compute the 2010 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 2010 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 2006) 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 final 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 final 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. Provisions of the Proposed Rule and Analysis of and Response to Public Comments

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. In the proposed rule, and in this final rule, we are using the pre-floor, pre-reclassified hospital wage index, based solely on the CBSA designations, as the basis for determining wage index values for the FY 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. In the proposed rule, and in this final rule, we are again using 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 are continuing to use the most recent pre-floor, pre-reclassified hospital wage index available at the time of publication.

We received three comments regarding the wage index.

Comment: A commenter was concerned that the wage index continues to provide a significantly lower wage index to rural counties and indicated that cuts affect rural areas more than urban areas. The commenter asked that we move to a more accurate

and fair index as recommended by the Medicare Payment Advisory Commission (MedPAC). In addition, the commenter felt that the pre-floor, pre-reclassified hospital wage index with only the hospice floor is not a good policy. The same commenter suggested that we maintain the BNAF until a more equitable wage index can be developed.

Two commenters wanted Montgomery County, Maryland to be moved from its current CBSA and placed into CBSA 47894 for number of reasons. One of the reasons a commenter described was that in FY 2012, hospices in CBSA 47894 will be paid at a rate 4.0 percent greater than the payment given to hospices in Montgomery County's current CBSA. The commenter indicated that this rate differential creates significant hardship and results in loss of revenue. The commenter also indicated that by not changing, CMS is discriminating against the Medicare beneficiaries living in Montgomery County because it is financially jeopardizing the hospices that serve them.

Response: We thank the commenters. The pre-floor, pre-reclassified hospital wage index was adopted in 1998 as the wage index from which the hospice wage index is derived by a committee of CMS (then Health Care Financing Administration) and industry representatives as part of a negotiated rulemaking effort. The Negotiated Rulemaking Committee considered several wage index options: (1) Continuing with Bureau of Labor Statistics data; (2) using updated hospital wage data; (3) using hospice-specific data; and (4) using data from the physician payment system. The Committee determined that the pre-floor, pre-reclassified hospital wage index was the best option for hospice. The pre-floor, pre-reclassified hospital wage index is updated annually, and reflects the wages of highly skilled hospital workers.

We also note that section 3137(b) of the Affordable Care Act requires us to submit to Congress a report that includes a plan to reform the hospital wage index system. This provision was enacted in response to MedPAC's suggestions, which included a suggestion that the hospital wage index minimize wage index adjustments between and within metropolitan statistical areas and statewide rural areas. The latest information on hospital wage index reform is discussed in the ''Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates'' proposed rule, published May 5, 2011 in the **Federal Register** (76 FR 25788).

In the future, when reforming the hospice payment system, we will consider wage index alternatives if alternatives are available.

Each hospice's labor market area is based on definitions of MSAs issued by the Office of Management and Budget (OMB), not CMS. For this final rule, we are using the pre-floor, pre-reclassified hospital wage index, based solely on the CBSA designations, as the basis for determining wage index values for the FY 2012 hospice wage index. In summary, we continue to believe that the pre-floor, pre-reclassified hospital wage index, which is updated yearly and is used by many other CMS payment systems, is the most appropriate method available to account for geographic variances in labor costs for hospices for FY 2012.

2. Areas Without Hospital Wage Data

In adopting the CBSA designations, we identified some geographic areas where there are no hospitals, and no hospital wage data on which to base the calculation of the hospice wage index. These areas are described in section I.B.4 of this final rule. Beginning in FY 2006, we adopted a policy that, for urban labor markets without an urban hospital from which a pre-floor, pre-reclassified hospital wage index can be derived, all of the urban CBSA pre-floor, pre-reclassified hospital wage index values within the State would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index to use as a reasonable proxy for these areas. Currently, the only CBSA that would be affected by this policy is CBSA 25980, Hinesville-Fort Stewart, Georgia. We proposed to continue this policy for FY 2012 and have applied this policy in this final rule.

Currently, the only rural areas where there are no hospitals from which to calculate a pre-floor, pre-reclassified hospital wage index are Massachusetts and Puerto Rico. In August 2007 (72 FR 50217), we adopted a methodology for imputing rural pre-floor, pre-reclassified hospital wage index values for areas where no hospital wage data are available as an acceptable proxy; that methodology is also described in section I.B.4 of this final rule. In FY 2012, Dukes and Nantucket Counties are the only areas for rural Massachusetts which are affected. We again proposed 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, and we are implementing this policy in this final rule.

However, as we noted section I.B.4 of this final rule, we do not believe that this policy is appropriate for Puerto Rico. For FY 2012, we again proposed 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 was then adjusted upward by the hospice 15 percent floor adjustment in the computing of the proposed FY 2012 hospice wage index. We are continuing to follow this policy in this final rule. We received no comments regarding continuing this policy for areas without hospital wage data.

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

The hospice wage index set forth in this final rule would be effective October 1, 2011 through September 30, 2012. We did not propose and are not finalizing any modifications to the hospice wage index methodology. For this final 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 this FY 2012 wage index final rule, the hospice wage index values are 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 seven years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in FY 2011, and additional 15 percent reductions in each of the next five 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).

For this final rule, an unreduced BNAF for FY 2012 is computed to be 0.058593 (or 5.8593 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 0.035156 (or 3.5156 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 BNAF is updated compared to the proposed rule based on availability of more complete data.

The final hospice wage index for FY 2012 is shown in Addenda A and B; the wage index values shown already have the BNAF reduction applied. Specifically, Addendum A reflects the final FY 2012 wage index values for urban areas under the CBSA designations. Addendum B reflects the final FY 2012 wage index values for rural areas under the CBSA designations.

We received five comments regarding the BNAF.

Comment: A few commenters were pleased with overall increase in the hospice payments for fiscal year 2012. Some commenters continued to voice opposition to the BNAF reduction; several were concerned about the impact of the BNAF phase-out, coupled with the productivity adjustment which begins in FY 2013. One commenter provided analysis which suggested that estimated mean hospice profit margins would decrease, and noted that many hospices can't absorb these reductions. Commenters were concerned that hospices would be forced to close, which could create access issues for patients, put at risk the quality of care, and ultimately increase Medicare costs. Several commenters noted that rate reductions disproportionately affect rural providers. One wrote that rural providers have higher costs of care than urban hospices, and yet also have a payment reduction due to lower rural wage index values. This commenter asked for a rural add-on, or at least parity. Another commenter asked that we create ''critical access'' hospices in rural areas to protect rural providers.

Response: We thank the commenters. The BNAF phase-out was finalized in the August 6, 2009 final rule. Comments opposing the BNAF reductions are outside the scope of this rule because we finalized this policy in FY 2010. Comments surrounding the productivity adjustment, which the Affordable Care Act mandates be applied beginning in fiscal year 2013, are also outside the scope of this rule. We acknowledge that there was a single erroneous reference to the BNAF reduction as a proposal; however, as noted on page 26808 of the proposed rule, and in multiple other locations throughout the proposed rule, the BNAF phase-out was already settled for the remaining years of the phase-out, as described in the FY 2010 Hospice Wage Index final rule (74 FR 39384).

However, we are sensitive to the issues raised by commenters, and to the possible effects of the BNAF reduction on access to care. We continue to monitor for unintended consequences associated with the BNAF phase-out. Our analysis reveals an overall growth in number of hospices since the start of the phase-out. Additionally, we see no data which would indicate that hospices in rural areas are closing.

We also note that the hospice wage index includes a floor calculation which benefits many rural providers. We are sensitive to concerns from rural hospices that the additional time and distance required to visit a rural patient adds significantly to their costs. We do not have the authority to change the hospice rates beyond the limits set out in the statute. We will consider the situation of rural providers in the context of broader hospice payment system reform. We appreciate the analyses shared by the commenter.

4. Effects of Phasing Out the BNAF

The full (unreduced) BNAF calculated for the FY 2012 final rule is 5.8593 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 0.58593 by 0.60, which equals 0.035156 (3.5156 percent). The BNAF of 3.5156 percent reflects a 40 percent reduction in the BNAF. The 40 percent reduced BNAF (3.5156 percent) was applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater in the final FY 2012 hospice wage index.

The hospice floor calculation still applies to any pre-floor, pre-reclassified hospital wage index values less than 0.8. The hospice floor calculation is described in section I.B.1 of this final rule. We examined the effects of an additional 15 percent reduction in the BNAF, for a total BNAF reduction of 40 percent, on the final 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 final FY 2012 wage index resulted in a (rounded) 0.9 percent reduction in wage index values in 39.7 percent of CBSAs, a 0.8 percent reduction in wage index values in 53.0 percent of CBSAs, a 0.6 or 0.7 percent reduction in wage index values in 0.7 percent of CBSAs, and no reduction in wage index values in 6.5 percent of CBSAs. Note that these are reductions in wage index values, not in payments. Please see Table 1 in section VI of this rule for the effects on payments. The wage index values in Addenda A and B already reflect the additional 15 percent BNAF reduction.

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 ongoing phase out of the BNAF. These CBSAs, which typically include rural areas, are protected by the hospice 15 percent floor adjustment. We estimate that 29 CBSAs are already protected by the hospice 15 percent floor adjustment, and are therefore completely unaffected by the BNAF reduction. There are 325 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 estimate 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 the final FY 2012 hospice wage index. 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 final 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 VI of this final 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 final inpatient hospital market basket update for FY 2012 is 3.0 percent; this 3.0 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 is communicated through an administrative instruction.

The combined estimated effects of the updated wage data, an additional 15 percent reduction of the BNAF, and the final inpatient hospital market basket update are shown in Table 1 in section VI of this final rule. The updated wage data are estimated to increase payments by 0.1 percent (column 3 of Table 1). The additional 15 percent reduction in the BNAF, which has already been applied to the wage index values shown in this final rule, is estimated to reduce payments by 0.6 percent. Therefore, the changes in the wage data and the additional 15 percent BNAF reduction reduce estimated hospice payments by 0.5 percent, when compared to FY 2011 payments (column 4 of Table 1). However, so that hospices can fully understand the total estimated effects on their revenue, we have also accounted for the 3.0 percent final market basket update for FY 2012. The net effect of that 3.0 percent increase and the 0.5 percent reduction due the updated wage data and the additional 15 percent BNAF reduction, is an estimated increase in payments to hospices in FY 2012 of 2.5 percent (column 5 of Table 1).

We received two comments regarding the combined effect of the expected market basket update, BNAF reduction and wage data updates.

Comment: Some commenters were confused about the language in the proposed rule concerning the market basket increase and the BNAF adjustment. They suggested revising the description of the BNAF reduction and the market basket increase to further describe the effect of each of the components which affect hospice rates in section II.A.4 of the final rule.

Response: We have clarified the language about the BNAF reduction and the market basket increase in this section.

B. Aggregate Cap Calculation Methodology

The existing methodology 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 14, 2011, we issued a Ruling entitled ''Medicare Program; Hospice Appeals for Review of an Overpayment Determination'' (CMS–1355–R), and also published in the **Federal Register** as CMS–1355–NR (76 FR 26731, May 9, 2011), 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.

In the proposed rule, we also made several proposals regarding 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 CMS–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 CMS–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 proposed 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 II.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 for CMS to make a cap determination for cap years ending on or before October 31, 2011. We proposed 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 proposed 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 II.B.4 below.

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 emphasized that nothing in our proposals in this section constitutes an admission as to any issue of law or fact. In light of the court decisions, however, we proposed 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 proposed 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 proposed 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 the 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 that 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 analyzed the cap in the context of broader payment reform. Specifically, commenters urged us to retain the current methodology, as it resulted in a more streamlined and timely cap determination for providers, as compared to other options. In addition, 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 declined as his or her overall hospice stay continued into subsequent cap years, and these revisions could result in new overpayments for some providers. Commenters noted that the vast majority of providers don't exceed the cap, so burdening these providers with an across-the-board change would not be justified. We also noted that on January 18, 2011, President Obama issued an Executive Order (EO) entitled ''Improving Regulation and Regulatory Review'' (EO 13563), which instructed federal agencies to consider regulatory approaches that reduced burdens and maintained 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 EO.

For these reasons, for the cap year ending October 31, 2012 (the 2012 cap year) and subsequent cap years, we proposed that the hospice aggregate cap be calculated using the patient-by-patient proportional methodology, but also proposed to allow hospices the option of having their cap calculated via the current streamlined methodology, as discussed below. We stated in the proposed rule that 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 would apply only 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 did not fall under the proposed ''grandfather'' policy. Therefore, all new hospices that are Medicare-certified after the effective date of this final rule would have their cap determinations calculated using the patient-by-patient proportional methodology.

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 proposed that the Medicare contractors would apply the patient-by-patient proportional methodology (defined below) to a hospice's aggregate cap calculations unless the hospice elected 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, for each hospice, CMS 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 proposed 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 reopening regulations.

4. Streamlined Methodology

As we described above and in the proposed rule, comments received from hospices and the major hospice associations in previous years urged us 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 could 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 proposed that a hospice could 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 proposed 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 cap years prior to cap year 2012. In section II.B.5 (''Changing Methodologies'') below, we described 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) states 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 proposed to revise the regulatory text at § 418.309(b)(2) to clarify that for each hospice, CMS 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 proposed 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 proposed 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 would be able to elect the streamlined methodology no later than 60 days following the receipt of its 2012 cap determination.

(4) Hospices which elected to have their cap determination calculated using the streamlined methodology could 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 elected the streamlined methodology, and changed to the patient-by-patient proportional methodology for a subsequent cap year, the hospice's aggregate cap determination for that cap year (*i.e.,* the cap year of the change) and all subsequent cap years would be calculated using the patient-by-patient proportional methodology. As such, past cap year determinations could 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 reopening regulations.

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 proposed to count beneficiaries and their associated days of care from November 1st through October 31st, to match that of the cap year. This would ensure that the proportional share of each beneficiary's days in that hospice during the cap year is accurately computed.

Finally, we noted 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 proposed 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. We also proposed technical corrections to the regulatory text.

The above summarizes the proposals made in our proposed rule. We are finalizing all the policies above as proposed, except as described in the following responses to comments. We received six comments related to these proposed changes.

Comment: Most commenters were supportive of our providing hospices with options regarding their cap calculation methodology; however, one suggested that we abandon the patient-by-patient proportional methodology due to the burden created by the need for adjustments to prior year cap determinations. This commenter was also concerned about the potential for increased confusion and complexity. Several commenters asked for details on how to elect a particular calculation methodology, with one commenter asking that we incorporate consistent, specific timeframes for making such an election. Another commenter suggested we send providers a form to use in making the choice. A number of commenters asked that CMS and its contractors educate providers about the election process and the cap calculation methodology options. Several also asked that all contractors use the same methodology when calculating the cap.

A commenter asked that we align the cap year and the beneficiary counting year with the federal fiscal year, to simplify the cap calculation process. A few commenters asked that contractors mail cap determination letters in a more timely and consistent fashion, with one asking that we specify timelines for contractors to follow. One commenter suggested that timely notification of cap determination letters be a performance measure for the contractors. Several commenters asked for longer, more flexible repayment timeframes, suggesting three to five years for repayment of overpayments, or longer. One commenter wrote that the cap was an outdated cost containment provision, and was concerned that it would limit access. This commenter asked that we increase the cap amount to reflect a full six months of care and wage adjust it. The commenter added that this would require study to determine the relevant methodology that would support providers in caring for all hospice patients.

Response: We appreciate commenters' support of our proposal and of the options provided to hospices regarding their aggregate cap calculations. Having two cap calculation methodologies addresses the concerns of commenters who did not want to be burdened with a change given future payment reform; those comments were described in section II of our proposed rule. Earlier in this section we also noted that there had been substantial litigation challenging the way we apportion hospice patients with care spanning more than one year when calculating

the aggregate cap. We believe it is in the best interest of CMS and the Medicare program to take action to prevent future cap litigation, and to alleviate the litigation burden on providers, CMS, and the courts. Therefore, we do not believe that we should abandon the patient-by-patient proportional methodology.

Regarding the timeframes for elections, our proposed rule addressed the issue based on two time periods:

1. *For cap years ending on or before October 31, 2011:*

We proposed that hospices that have not filed an appeal of an overpayment determination challenging the validity of 42 CFR 418.309(b)(1) and which are waiting for us to make a cap determination in a cap year ending on or before October 31, 2011 may, as of October 1, 2011, elect to have their final cap determinations for such cap year(s), and all subsequent cap years, calculated using the patient-by-patient proportional methodology. In other words, in this circumstance, the election must occur in the period beginning October 1, 2011 (the effective date of this final rule) but *before* receipt of the 2011 (or prior) cap year determination. We are finalizing this policy as proposed.

2. *For cap years ending on or after October 31, 2012:*

(a) Electing to continue using the streamlined methodology: We proposed that for cap years ending on or after October 31, 2012, hospices would have their aggregate caps calculated using the patient-by-patient proportional methodology, unless a hospice exercises a one-time election to have its aggregate cap for cap years 2012 and beyond calculated using the streamlined methodology. Those hospices that make such an election will have their cap determinations for the 2012 cap year and subsequent cap years calculated using the streamlined methodology unless they subsequently elect to have the patient-by-patient proportional methodology used, appeal the streamlined methodology (please see section II.B.5, entitled ''Changing Methodologies,'' for more details), or we implement changes through future rulemaking. This option to elect to continue with the streamlined methodology only applies to existing hospices that have had, or will have had, a cap determination calculated under the streamlined methodology. Additionally, this option to elect to continue with the streamlined methodology is not available to a hospice when its 2011 or prior cap determination(s) was calculated using the patient-by-patient proportional methodology.

The timeframe for electing to continue to have the aggregate cap calculated using the streamlined methodology is specified in the regulatory text at 42 CFR 418.309(d)(2)(ii), and requires that the election be made no later than 60 days after receipt of the 2012 cap determination. Therefore, the hospice could elect for CMS to continue using the streamlined methodology at any time between October 1, 2011 (the effective date of this final rule) and up to 60 days after receipt of its 2012 cap determination. This election to use the streamlined methodology would remain in effect unless the hospice subsequently submitted an election to change to the patient-by-patient proportional methodology or appealed the streamlined methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation. We allow this 60 days *after* receipt of the 2012 cap determination because we are concerned that a hospice that intended to continue using the streamlined methodology might fail to elect it due to an oversight, and we do not want any provider to be forced to change methodologies due to such an error. We are finalizing this policy as proposed.

(b) *Electing to change from the streamlined methodology to the patient-by-patient proportional methodology:* We proposed that if a hospice elected to have its 2012 cap determination calculated using the streamlined methodology, it could later submit a written election to change to the patient-by-patient proportional methodology. This election to change methodologies from streamlined to patient-by-patient proportional for a given cap year and all subsequent cap years must be submitted before receipt of the cap determination for that cap year. If the hospice has already received the cap determination for that cap year, and then decides it would like to change from the streamlined methodology to the patient-by-patient proportional methodology, it must file an appeal of the methodology used to determine the number of Medicare beneficiaries used in the aggregate cap calculation. We are finalizing this policy as proposed.

Contractors will provide hospices with instructions on how to elect a methodology in the coming months. In addition, we will revise the cap section of the hospice claims processing manual (Internet-only manual (IOM) 100–04, chapter 11, section 80) to reflect the policies implemented in this final rule. We will include examples to make sure the details of the calculation are clear to providers and to the contractors. There will also be a MedLearn Matters article, discussion on Open Door forums, and information on the hospice center webpage (*http://www.cms.gov/center/hospice.asp*) to further educate the industry. Additional education will come from industry associations and from contractor Web sites, reminding hospices of the procedures for electing a methodology.

In case a provider misses these educational efforts, we will also ask contractors to include language on the 2012 cap determinations which explains that the provider has up to 60 days from the date of receipt of the determination to elect to continue using the streamlined methodology. Given these efforts, we do not believe it is necessary for us to create a form and send it to all providers for choosing to continue using the streamlined methodology. To address comments related to contractor consistency in applying the cap methodologies, we also believe that clearly written manual instructions which include examples will ensure consistent application of the cap calculation procedures by all contractors.

As we noted in the proposed rule, we agree with commenters on our 2010 Hospice Wage Index Notice with Comment who asked us not to change the cap year timeframe now, but to consider that change when we undertake broader payment reform. In the proposed rule, we also stated that for purposes of applying the patient-by-patient proportional methodology, we proposed to count beneficiaries and their associated days of care from November 1 to October 31, to match the cap year timeframe. We are finalizing this policy as proposed.

Finally, several comments were outside the scope of this rule, including those related to requiring more timely and consistent mailing of cap determination letters, to extending repayment timeframes, to increasing the cap amount, and wage adjusting the cap amount. We will consider these issues, such as the wage adjustment of the cap and changing the cap amount, as we continue with hospice payment reform, to the extent that we have such authority. In its March 2010 Report to Congress (*http://www.medpac.gov/chapters/Mar10_Ch02E.pdf*), MedPAC investigated claims that the cap was creating an access problem for non-cancer patients or for racial or ethnic minorities. MedPAC found no evidence to support these claims.

Comment: A majority of commenters asked that we define the reopening time period for making adjustments to prior

year cap determinations, citing a need for hospices to manage their finances with some certainty and administrative burden. Suggested reopening timeframes ranged from 3 to 5 years. One commenter asked that we provide a manual reference for ''existing reopening regulations.'' Another commenter wrote that hospices should be afforded parallel rights, at least on a one-time basis, to request reopening of demands issued not more than 3 years ago for recalculation under the proportional methodology.

Response: Our regulations at 42 CFR 405.1803 equate the hospice cap determination letter with a Notice of Program Reimbursement (NPR). The regulations governing NPRs, which are found at 42 CFR 405.1885, have a 3-year timeframe for reopening, except in instances of fraud, where reopening is unlimited. The regulations related to reopening are described in our Paper-Based Manual 15–1, chapter 29, entitled ''Provider Payment Determination and Appeals'', available on our Web site at *http://www.cms.gov/Manuals/PBM/list.asp*. In response to concerns from multiple commenters, we are revising our proposal to make it clear that there is a 3-year timeframe for reopening, as described in 42 CFR 405.1885. We are also revising the regulatory text we proposed at 42 CFR 418.309(d)(3) to remove the language that reads ''notwithstanding the ordinary limitations on reopening'' and replacing it with ''subject to existing reopening requirements.'' These changes should satisfy commenters' concerns, and provide hospices with more certainty in managing their finances.

We do not believe that allowing us to reopen prior year cap determinations in light of a provider's decision to switch methodologies and allowing providers to request reopening of prior year cap determinations that were not timely appealed are parallel situations. If a hospice elects one methodology for determining the cap and then subsequently elects a different methodology, we believe that it might be appropriate to recalculate earlier payment/cap determinations (after the change in methodologies) in order to prevent providers from switching methodologies to gain an inappropriate benefit. This consideration does not apply in the situation where a provider did not timely appeal an earlier determination. Providers may appeal payment determinations, and we believe that, if a provider did not exercise its appeal rights in a timely manner, then subsequent developments do not warrant effectively extending the time period for appeal (unlike providers, the agency cannot ''appeal'' a payment determination for a provider reflecting that provider's election of a cap methodology within 180 days after the date of the relevant determination).

Comment: One commenter, who is counsel for a number of hospices that have brought litigation challenging the streamlined methodology, suggested that we advise hospices that ''multiple spreadsheets offered in litigation by hospices (and HHS) tend to show'' that there are ''material reductions in hospice cap liability under the proportional method.'' The commenter stated that, based on their experience, they strongly recommend that hospices opt for the proportional methodology and suggested that HHS should make the same recommendation to hospices.

Response: We note the statements and recommendations of the commenter for providers to consider, but we do not believe it is appropriate for us to make a general recommendation to hospices as to which method hospices should choose. The commenter states that ''multiple spreadsheets offered in litigation by hospices (and HHS) tend to show'' that there are ''material reductions in hospice cap liability under the proportional method.'' To the extent the commenter suggests that, as a general matter, hospices are generally likely to receive material reductions in hospice cap liability under the proportional method (relative to the streamlined method), we do not draw the same conclusions as the commenter from the spreadsheets offered in litigation by some plaintiff hospices. We acknowledge that a number of spreadsheets offered in litigation indicate that certain plaintiff hospices would likely experience a reduction (perhaps significant) in cap liability for a given year. At the same time, we believe that it is important to consider that numerous plaintiff hospices did not offer any spreadsheets in litigation indicating whether those plaintiff hospices would receive a significant reduction or any reduction in cap liability in a given year. Plaintiff hospices that did offer spreadsheets in litigation might be more likely to benefit from application of a patient-by-patient proportional methodology in a given year than other plaintiff hospices that did not offer such spreadsheets. Moreover, hospices that have brought litigation challenging the streamlined method might be more likely than other hospices to benefit from application of a patient-by-patient proportional methodology. We also note that spreadsheets offered by plaintiff hospices in litigation might have reflected incomplete data or reflected calculations that had not been verified by HHS.

It is true that a given hospice for a given year might benefit (perhaps significantly) from application of a patient-by-patient proportional methodology (resulting in a higher cap and a lower cap liability), but that same hospice might have a higher cap liability (perhaps significantly) from application of the patient-by-patient proportional methodology in a different year. In fact, some evidence offered in litigation indicated that even some plaintiff hospices were likely to have a greater cap liability using the patient-by-patient proportional methodology in a given year. The effect on a particular hospice (in a given year or in the aggregate over all years) depends on a number of factors (for example, the flow of patients in and out of the hospice, the mix of patients' lengths of stay). Therefore, while a reduction in cap liability for a hospice is certainly possible, it is not a given. Hospices that have brought litigation challenging the streamlined method and offered spreadsheets are not necessarily representative of the majority of hospices and their experience would not be generalizable to all hospices.

In any event, we do not believe it is appropriate for us to make a general recommendation to hospices regarding which method hospices should choose. Nevertheless, we note the commenter's statements and recommendations for providers to consider.

Comment: A commenter was concerned that the proposed regulatory text at 42 CFR 418.309(b) needed to be clarified. The commenter asked that we clarify the differences in the streamlined methodology calculation when a beneficiary has been in only 1 hospice versus when a beneficiary has received care from more than one hospice. The commenter also asked that we clarify 42 CFR 418.309(b)(2), which deals with applying the streamlined methodology when a beneficiary receives care from more than one hospice. The commenter wasn't clear whether the calculation of the fraction of the total days of care applies to all years of hospice care, or just to the year of initial election.

Response: The streamlined methodology requires that beneficiaries who have only been in one hospice be counted as 1 in their initial year of election, with the timeframe for counting beneficiaries running from September 28 to September 27. The beneficiary is not included in the count of beneficiaries ever again, even if he/she survives past September 27th into another beneficiary counting year. This

calculation has not changed since the hospice benefit's inception.

Under the streamlined methodology, when a beneficiary has been served by more than 1 hospice, the current regulation at 42 CFR 418.309(b)(2) says that ''In the case in which a beneficiary has elected to receive 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 stay in all hospices that was spent in that hospice.'' The streamlined methodology used when a beneficiary has been served by more than one hospice is actually a patient-by-patient proportional allocation of the beneficiary's time.

In our proposed rule, we proposed changes to the regulatory text describing how the streamlined methodology accounts for beneficiaries who are served by more than one hospice. We are finalizing those proposed changes to the regulatory text, as it makes it clear that the calculation is to occur across all years of hospice care, and not just the initial year of election. It also matches the language describing the patient-by-patient proportional methodology, and ''requires each hospice include in its count 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.'' When a beneficiary is served by more than one hospice, the calculation is a proportional one, even under the streamlined methodology.

Because the regulation refers to counting days spent in a given hospice ''in that cap year'', it also follows the same beneficiary counting timeframe that the patient-by-patient proportional methodology uses, which is the cap year timeframe (November 1 to October 31). In our proposed rule we explained that the September timeframe for counting beneficiaries was implemented in 1983 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 expected to be provided. However, for a patient-by-patient proportional calculation, there is no need to make such an adjustment, and therefore we are using the cap year timeframe when counting beneficiaries.

In other words, the streamlined methodology is identical to the patient-by-patient proportional methodology when counting beneficiaries who have been served by more than one hospice. As such, the difference between the streamlined methodology and the patient-by-patient proportional methodology is only evident when a beneficiary receives hospice care from a single hospice. We are finalizing the regulatory text at 42 CFR 418.309(b) as proposed.

Comment: Several commenters suggested that we allow calculation of a total cap across all provider numbers belonging to a common owner. One commenter suggested that in the situation where one hospice acquires another hospice, hospices operating under the proportional methodology should have the option of switching to the streamlined methodology for consistency.

Response: There are several issues we must address to fully respond to this comment: (1) Whether the aggregate cap calculation can be consolidated for all providers of a common owner, such as for hospices that are part of a chain; (2) which calculation methodology to allow when there is a change of ownership with assignment of provider agreements; and (3) which calculation methodology to allow when there is an acquisition with rejection of assignment of provider agreements. All three issues hinge on the Medicare provider agreement for each participating hospice and its unique provider number. The unique provider number is the administrative method used by Medicare to track each Medicare provider agreement. A unique provider number is assigned to a hospice program which is certified as meeting the conditions to participate in the Medicare program defined in section 1861(dd) of the Act.

To address the first issue, longstanding policy has not permitted consolidation of separate Medicare certified hospice providers with a common owner when computing the aggregate cap; instead, a separate cap calculation occurs for each Medicare certified hospice program defined by its unique provider number. Our regulations at 42 CFR 418.308 and 42 CFR 418.309 describe the aggregate cap calculation in terms of an individual hospice, rather than in terms of a hospice chain or a common owner.

To address the second issue, when one hospice acquires another, one needs to consider the unique provider number of the hospice(s) which provided care to each patient. For example, hospice A, which has opted for CMS to use the streamlined methodology in its cap calculation, acquires hospice B, which has its cap calculated using the patient-by-patient proportional methodology. When a change of ownership occurs with assignment of provider agreements, and the acquiring hospice chooses to consolidate the operations, the unique provider number of hospice B is retired, and hospice B comes under hospice A's Medicare provider agreement and unique provider number. Hospice B is consolidated into hospice A. In this case the beneficiaries who were in hospice B are now in hospice A. From the standpoint of the cap, those beneficiaries are considered to have been served by more than one hospice. As noted previously in this section, the streamlined and patient-by-patient proportional methodologies are identical when a beneficiary is served by more than one hospice, following the patient-by-patient proportional methodology. Therefore hospice A's use of the streamlined methodology does not create any inconsistency when accounting for hospice B's beneficiaries in its aggregate cap.

In another example, if hospice A acquires hospice B with rejection of assignment of provider agreements, but wants to operate hospice B as a separate entity, hospice B's existing Medicare provider agreement and unique provider number would be terminated. Hospice B would have to meet all requirements to be certified to participate in the Medicare program, and would be given a new provider agreement and unique provider number upon approval. Therefore, hospice A and B continue to have separate unique provider numbers. As such, separate cap calculations are performed for hospice A and hospice B, since our longstanding policy is to calculate the cap by provider (defined as having a unique provider number), rather than by owner or by chain.

Because hospice B has a new Medicare provider agreement (with a new unique provider number), it is considered a new provider for purposes of applying the aggregate cap. As such, all its cap calculations would be made using the patient-by-patient proportional methodology; new providers are not eligible for the grandfathering described in the proposed rule, which allows hospices to elect to continue using the streamlined methodology.

We continue to believe that there would be a program vulnerability if we allowed providers to switch back and forth between cap calculation methodologies. As such, we proposed that a provider whose cap is calculated using the proportional methodology may not later decide to have its cap calculated using the streamlined methodology. We proposed an exception to this policy for the 2012 cap year, when all aggregate caps will be computed using the proportional methodology, unless an eligible provider makes a one-time election to continue using the streamlined

methodology. The exception allows eligible providers that intended to continue using the streamlined methodology but which failed to elect the streamlined methodology to make that one-time election during the 60-day period following receipt of the 2012 cap determination notice.

The above examples regarding changes in ownership are consistent with our policy of defining hospices by their unique provider numbers and consistent with our proposal to preclude switching calculation methodologies.

In summary, we are finalizing the proposals related to the aggregate cap as proposed, except to clarify that the timeframe for reopening cap determinations is 3 years (except in the case of fraud).

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.

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.

These 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 with recertifications for the third and subsequent benefit period recertifications includes 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 as an NP who is 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).

As a result of stakeholders' concerns regarding access risks resulting from the final rule policy, we proposed 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. Additionally, we also proposed to change the regulatory text at 42 CFR 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 our commitment to the general principles of the President's EO 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 received 15 comments related to these proposed changes.

Comment: Commenters expressed appreciation of CMS' efforts to address concerns regarding implementation of the face-to-face encounter for hospice eligibility certification and recertification, including the three-month enforcement delay provided for in early 2011.

All 15 commenters supported the proposal to allow any hospice physician to perform the face-to-face encounter regardless of whether the physician recertifies the patient's terminal illness and composes the recertification narrative. While commenters supported the less restrictive policy, they made suggestions to add additional practitioners such as Physician Assistants (PA) and Clinical Nurse Specialists (CNS) to the list of healthcare professionals that would be allowed to conduct the face-to-face encounter. These commenters described the shortage of nurse practitioners and physicians in some areas of the country, especially small and rural areas. Another commenter, also citing physician and NP shortages in rural areas, suggested that community physicians and nurse practitioners should be able to conduct the face-to-face encounter and report their findings to a physician employed by the hospice. Another commenter strongly encouraged CMS to allow any physician to certify and recertify a patient for hospice. The commenter described the situation when caring for the imminently dying patient at an emergency department; a non-hospice physician cannot certify the patient for hospice services without a hospice physician certification. The commenter indicated that the patient should not have to wait for the hospice physician to certify the patient in a situation when the patient is imminently dying. The commenter supported efforts in Congress to change the statute about this change.

Commenters were concerned that hospices are facing a large increase in administrative costs to provide care to hospice patients without getting additional reimbursement as a result of the new face-to-face requirement. Commenters indicated that unreimbursed face-to-face visits are costly in terms of time, travel and salaries, and the visits cause patients and families to be anxious that the patient may be discharged.

Response: We thank the commenters for their support of our clarification in allowing any hospice physician to

perform face-to-face encounters regardless of whether that same physician recertifies the patient's terminal illness and composes the recertification narrative and of the three-month delay provided early in 2011. We are finalizing the policy to allow any hospice physician to perform the face-to-face encounter regardless of whether that same physician recertifies the patient's terminal illness and composes the recertification narrative.

The statutory language in section 1814(a)(7) of the Act limits the disciplines of those who can provide a hospice face-to-face encounter. PAs and CNSs are not authorized by the Affordable Care Act to perform the face-to-face visit. Therefore, without a change in the law, we cannot adopt a policy to allow PAs and CNSs to perform the face-to-face encounter. In addition, a statutory change to section 1814(a)(7) of the Act would also be required to change the requirements regarding the physicians who must certify and recertify a patient's terminal illness.

Similarly, allowing community physicians and NPs to conduct the face-to-face encounter and report their findings to a physician employed by the hospice would also require a statutory change. The Act requires that the physician or NP conducting the face-to-face encounter must be a hospice physician or NP. A ''hospice physician'' is a physician either employed by or working under arrangement with a hospice (*i.e.,* contracted). The complete definition of a hospice employee at 42 CFR 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 appreciate the commenters concerns about the financial effects of the face-to-face requirements. We expect most face-to-face encounters would be satisfied in conjunction with a medically reasonable and necessary physician service. Hospices can bill for that portion of the visit where medically reasonable and necessary physician services were provided to the patient by the hospice physician or hospice attending NP in conjunction with a face-to-face encounter. We will continue to monitor for any unintended consequences associated with this provision.

Comment: A commenter asked us to consider the concept of ''advanced disease management.'' A commenter noted that many patients are legitimately certified at admission but their condition actually improves with hospice care. The commenter also suggested that Medicare benefit be modified in ways that will encourage more comprehensive, continuing care management for those in the advanced stages of incurable illnesses.

Response: We appreciate the comment; however, it is outside the scope of this rule. We may consider such suggestions in the future in the context of broader analysis surrounding palliative care.

Comment: A commenter supported the change in regulatory text that states an NP or a non-certifying hospice physician may convey their clinical findings from the face-to-face visit to the certifying physician.

Response: We thank the commenter for his or her support.

Comment: A commenter requested that we make every effort to ensure that the clarification provided in the proposed rule about the face-to-face requirement is applied as if incorporated in the final rule issued November 17, 2010.

Response: Thank you for your comment. We note that the effective date of the provisions in this final rule is October 1, 2011. We direct providers to the Hospice Benefit Policy Manual (IOM 100–02, chapter 9), section 20.1 for up-to-date and comprehensive guidance on our face-to-face encounter policy. In summary, we are finalizing the proposed policy to allow any hospice physician to perform the face-to-face encounter regardless of whether that same physician recertifies the patient's terminal illness and composes the recertification narrative.

D. Technical Proposals and Clarification

1. Hospice Local Coverage Determinations

In section II.H of the November 17, 2010 CY 2011 HH PPS Final Rule, we implemented new requirements for a hospice 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 noted 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 considered during 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 proposed 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. In this final rule we are clarifying that the clinical findings included in the comment response discussed above were provided as an example, and are not 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, 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.'' We received four comments about this clarification.

Comment: Commenters appreciated the clarification and our reiterating existing policy that the certification and recertification are based upon the clinical judgment of the physician. One commenter wrote that their hospice physician occasionally discharges a patient who is not longer eligible for the benefit, and asked how the hospice should handle a situation in which the

Quality Improvement Organization (QIO) later overrules the physician.

Response: We appreciate the commenters' support for our clarification and for the existing policy that certification and recertification are based upon the clinical judgment of the physician. We again note the response we gave to the same question in the CY 2011 HH PPS final rule. We wrote ''If a patient appeals a pending discharge to the QIO, the QIO decision is binding; a hospice could not discharge a patient as ineligible if the QIO deems that patient to be eligible. The provider is required to continue to provide services for the patient. In the QIO response, the QIO should advise the provider as to why it disagrees with the hospice, which should help the provider to re-evaluate the discharge decision. If at another point in time the hospice feels that the patient is no longer hospice eligible, the provider should give timely notice to the patient of its decision to discharge. The patient could again appeal to the QIO, and the hospice and patient would await a new determination from the QIO based on the situation at that time'' (75 FR 70448).

2. Definition of Hospice Employee

As noted above, in section II.H of the November 17, 2010 CY 2011 HH PPS Final Rule, we implemented new requirements for a hospice 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 42 CFR 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 42 CFR § 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. In the proposed rule, we clarified that entire definition of employee given at 42 CFR 418.3 (shown above) applies. In this final rule, we continue to clarify that the entire definition of employee given at 42 CFR 418.3 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. We received seven comments on this section.

Comment: Several commenters wrote that they appreciated our clarifying that the entire definition of employee given in the existing regulation at 42 CFR 418.3 applies when considering who is a hospice employee. Two commenters sought further clarification. One asked if a hospice that issues W–2s for its direct employees is also part of a commonly controlled health system, could it use NPs employed by that health system and assigned to the hospice to perform face-to-face encounters. Another asked that we clarify further what it means to be ''assigned to a hospice.'' A third commenter felt that the clarification gives a competitive advantage to hospices that are part of a larger system, and noted the shortage of NPs. This commenter added that in rural areas, NPs are often working under contracts with exclusivity rights, which do not permit them to work for others.

Response: We thank commenters for their support of our clarification. An NP employed by a health care system and assigned to the hospice would be considered a direct employee and could perform face-to-face encounters. ''Assigned to the hospice'' means that the health care system has allotted a position for a specific employee to work at that specific hospice. This would be the employee's regular place of employment. An NP can be assigned to more than one hospice, in which case the NP would have more than one regular place of employment.

Our clarification did not change or add to existing policy regarding the definition of an employee, but simply noted the complete definition of employee given at 42 CFR 418.3. Hospices face different operational challenges depending on the specific business model their operators have chosen. We appreciate the difficulties created by a shortage of NPs in some areas; however, we do not have the authority to regulate the contractual provisions of an employer and an employee, and such contractual relationships are, therefore, not within the scope of this rule.

3. Timeframe for Face-to-Face Encounters

In section II.H of the November 17, 2010 CY 2011 HH PPS Final Rule, we also implemented policies related to the timeframe for performing a hospice 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 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 proposed 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 proposed 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.'' Based on the comments received, we are implementing this change as proposed. We received 10 comments related to these proposed changes.

Comment: Commenters supported clarification regarding the timing of the face-to-face encounter; however, they asked for more flexibility in the timeframe that CMS mandated. A few commenters urged CMS to consider alternatives to discharging and readmitting patients when a face-to-face encounter is not timely.

Commenters appreciated our effort to incorporate ''exceptional circumstances'' as part of the manual instructions governing the hospice face-to-face requirement. While commenters found these instructions helpful, they urged that we expand the current two-day grace period to seven days for all new 3rd benefit period and later readmissions and include transfer patients. Commenters believed that allowance of only two days is not sufficient and may still result in delayed delivery of needed services. A commenter also said that allowing seven days will avoid delays in admissions without creating staffing burdens where there is a shortage in MD/NPs. Commenters indicated that hospice physicians may have unavoidable circumstances such as becoming ill, taking vacations, and resigning suddenly, which the commenter indicated could potentially leave the hospice in the unforeseeable position of having to discharge a patient because the face-to-face encounter was not completed prior to the start of the benefit period. A commenter believed a seven-day window would allow for emergency patient admissions and address potential staffing issues.

Another commenter recommended that we allow the encounter to occur up to five days after the start of the 3rd or later benefit period in exceptional circumstances, such as in a situation in which a transfer occurs immediately prior to a three-day weekend. Moreover, commenters requested that we include additional circumstances under which the grace period may be allowed, such as for providers in rural and large service areas and those in medically underserved areas. In addition, a commenter indicated that contractors should be instructed to use reasonable discretion when implementing application of ''exceptional circumstances.''

A commenter suggested a statutory change to require that the face-to-face encounter occur every six months instead of every new benefit period. A commenter stated that we should not require a hospice to discharge and readmit the patient if a face-to-face encounter does not occur prior to the 3rd benefit period recertification as it imposes a needless complication on the process, and it is an unnecessary burden on the patient and family for a mistake made by the hospice. The same commenter suggested other alternatives to penalize the hospice for its mistake without causing any problems to the patient. The commenter indicated that prior to the face-to-face requirement, hospices could use occurrence code 77 to represent the non-billable days if certification criteria were not documented in a timely fashion. The commenter asked to allow the use of the billing code subsequent to implementation of the face-to-face requirement. The commenter also suggested that hospices should not be able to submit claims until the certification is complete.

The same commenter stated that the main goal of the face-to-face encounter requirement was to increase hospice accountability; this commenter felt that a financial consequence to the hospice for an untimely face-to-face encounter is a logical and justified way to meet this goal. The commenter stated that in stark contrast, there is no justifiable purpose for an overly strict implementation requirement when actively dying patients need to go through a formal discharge process and re-complete admission paperwork and assessments because of a technical error made by hospice. A commenter suggested that we act to prevent a negative impact on hospice patients and families by recognizing that human error can occur. In addition, the commenter suggested that we limit consequences such that they impact the hospice alone, rather than patients and their families.

A commenter indicated that the existing regulations allow two days after the beginning of the certification period to get a Certification of Terminal Illness signed; therefore, this commenter urged us to permit this two-day extended period for the face-to-face encounter for all 3rd and later benefit periods, not just new admissions.

A commenter suggested that we ''hold harmless'' those who miscalculate the correct date for the recertification when they demonstrate compliance in terms of submitting information.

Response: We thank the commenters for their support of the clarification of the regulation text regarding the timing of the face-to-face encounter. Based on the comments we received, we are finalizing the policy as clarified in the proposed rule.

The remaining comments described in the comment summary are beyond the scope of the clarification which we proposed, including the comment that suggested that we ''hold harmless'' those who miscalculate the correct date for the recertification when they demonstrate compliance in terms of submitting information. However, we will briefly address some of them to ensure that the policy is clear. We appreciate commenters support regarding the manual instructions. We note that the flexibility adopted in the manual instructions applies only to new admissions which occur at the 3rd or later benefit period. We allow this flexibility because we are convinced that in cases where a hospice newly admits a patient who is in the third or later benefit period, a face-to-face encounter prior to the start of the benefit period may not be possible. The manual provides some examples, but these examples are not intended to be all-inclusive. We believe that any additional flexibility would require a statutory change.

We also note that if the face-to-face encounter requirements are not met, the beneficiary is no longer certified as terminally ill, and consequently is not eligible for the Medicare hospice benefit. Therefore, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient signs a new election form and all other new election criteria are met. If they choose to do so, hospices can provide care to these patients in the interim at the hospice's own expense until eligibility is re-established, but that care must occur outside of the Medicare hospice benefit.

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 42 CFR 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 42 CFR 418.94 of the CoPs. However, 42 CFR 418.94 no longer exists, and it was updated in the 2008 Hospice CoP Final Rule to 42 CFR 418.76. We propose to correct the regulatory text at 42 CFR 418.202(g) to update the CoP reference to show 42 CFR § 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.'' We received one comment on this section, and are implementing this change as proposed.

Comment: A commenter wrote in support of this change.

Response: We appreciate the commenter's support.

Comment: A commenter had concerns that hospice patients could not fully access occupational therapy services. The commenter asked us to provide education to providers, especially physicians, about the benefits and improved quality of life that occupational therapy services can provide to hospice patients.

Response: We appreciate this comment, but it is outside the scope of this rule.

E. Quality Reporting for Hospices

1. Background and Statutory Authority

The 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 Reporting Program (OQR), 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 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 FY, the Secretary shall reduce the market basket update by two 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 two percentage points may result in the annual market basket update being less than 0.0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. 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 FYs.

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) of the Act 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 are 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 CMS Internet Web site.

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, we envision 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 issues such as the desired level of treatment and the location of care. 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 our 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 EO 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 (Prepare. Embrace. Attend. Communicate. Empower.) Project conducted by The Carolinas Center for Medical Excellence 2006–2008 and the Assessment Intervention and Measurement (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://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 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 the NQF that are applicable to hospice care. Of the nine measures listed by the NQF as applicable to care provided at this stage of life, 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 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 is available to all hospices and contains 54 questions to be returned to the hospice and analyzed/scored in order to produce ratings for the measure. A composite score derived from 17 items on the survey and a global score based on the overall rating question on the survey are included in the measure. Although in the proposed rule we stated that we were uncertain of 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 estimate that one-third of hospices participate in the NHPCO data collection effort (the NHPCO is the developer of the FEHC survey measure). Although we did not propose to include the FEHC survey measure in the 2014 hospice quality reporting program, we are now considering whether to propose to adopt this measure in next year's rule. 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 CoPs at 42 CFR 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 us. 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.

Comment: CMS appreciates comments received about the potential use of measures calculated using data from the Family Evaluation of Hospice Care (FEHC) Survey. The FEHC was recognized by commenters as a well-known and widely used instrument and received support from some commenters. However, other commenters raised concerns about the use of the FEHC survey including the burden on providers and the potential for bias during data entry and analysis if the survey is not administered by a third party (rather than hospices themselves).

Response: Measurement of patient/family experience of hospice care is a high priority for CMS. The NQF Web site now contains updated information regarding the endorsed FEHC measure

#0208, which includes a composite score and a global score. Details on the measure can be found at: *http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=456#k=0208&e=1&st=&sd=&s=n&so=a&p=1&mt=&cs=.* We recognize that many (approximately one-third) of all hospices do participate in the NHPCO sponsored data collection and analysis of the FEHC survey. We are also aware of limitations of the FEHC survey, some of which may be addressed in the near future through updates to the survey. Ensuring patient and family centered care continues to be a priority for CMS. Therefore, we are considering this measure for inclusion in next year's rule for data collection beginning October 2012 for the FY 2014 program, or for data collection beginning in January 2013 for the FY 2015 program. We will also consider the comments received in making decisions about future measure development.

b. Quality Measures for 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 proposed 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 to a comfortable level 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; 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 proposed 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) of the Act 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 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 in this category are not hospice-specific or, in the case of the FEHC survey instrument, that measure may be 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 proposed to adopt the structural measure under the authority in section 1814(i)(5)(D)(ii) of the Act.

We proposed that each hospice submit data on the proposed structural measure, including the description of each of its patient-care focused quality indicators (if applicable) to us by January 31, 2013 on a spreadsheet template to be prepared by us. 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 would be evaluated for purposes of the quality reporting program based on whether or not they respond, not on how they respond.

In addition, we proposed 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 us by January 31, 2012 on a spreadsheet template to be prepared by us. Voluntary reporting of the structural measure data with specific quality indicators related to patient care to us would allow us to learn what the important patient care quality issues are for hospices and would serve 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.

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 proposed that hospices report the structural measure by January 2013 and the NQF measure #0209 by April 2013 in order to be used in the FY 2014 payment determination. We are requiring two different reporting dates in order for details on the QAPI data to be useful in rulemaking that would impact FY 2014 and to allow hospices sufficient time to extract, calculate and report the pain measure data collected through December 31, 2012. In addition, we proposed 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 final rule in FY 2013 hospice rulemaking.

Comment: Most commenters supported use of the NQF#0209 measure overall, and pointed out that many hospices already track this measure, and that it is practical. However, some expressed concerns about complexities with respect to pain management in hospice, about the exclusion of non-verbal patients, and

about whether this measure would require risk adjustment. The commenters stated the need for a quality measure that would take these challenges into consideration, and provides very specific definitions and specifications in how to collect the data needed to calculate the measure. One commenter expressed concern that it is premature to collect an outcome pain management measure and suggested a process measure instead.

Response: We appreciate the positive feedback. We are finalizing our proposal to require 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 to a comfortable level within 48 hours. The data for this measure are collected at the patient level, but are reported in the aggregate for all patients cared for within the reporting period. The patient's definition of ''comfort'' is used in this measure; there is no set numeric value on a standardized assessment that's used to quantify ''comfort.'' The measure is designed to capture information on each patient's overall experience of pain. The measure is not limited to asking the patient about one specific pain site; rather it is a reflection of the patient's overall experience of pain. There is no assumption that every patient's pain will be managed to a ''comfortable'' level within 48 hours. The measure reflects the opinions of experienced hospice professionals that, in the aggregate, most patients admitted in pain can and should be more comfortable within 48 hours of admission. The measure allows for the fact that some patients will not achieve a comfortable level because of complications like those suggested by commenters. This measure was tested in two studies during its initial development, and it has been collected on a voluntary basis by hospices for many years. We will consider the use of process measures related to pain management and will consider all comments we receive as we continue to evaluate additional measures for use in the hospice quality reporting program.

Comment: We received several comments in support of the requirement that hospices report the structural measure: Participation in a Quality Assessment and Performance Improvement (QAPI) Program that Includes at Least Three Quality Indicators Related to Patient Care. We also received a few comments indicating a need for clarification about this measure for both the voluntary and mandatory reporting periods.

Response: We appreciate the supportive comments. In response to requests for clarification, we note that the description of the proposed measure was accurately described in section II.E.2.b. ''Proposed Quality Measures'' and that the proposed measure was subsequently inaccurately summarized in section II.E.2.d ''Data Submission Requirements.'' We are clarifying that the structural measure is designed to obtain two pieces of information from hospices during both the voluntary reporting period and the mandatory period. Hospices will indicate whether their QAPI program includes at least three patient care related indicators, and will also list all their patient related indicators along with specific information about those indicators. Information requested includes: name and description of indicator, domain of care the indicator addresses, description (not the numeric values) of the numerator and denominator if available, and data source (for example, electronic medical record, paper medical record, adverse events log). Hospices will *not* be asked to report their level of performance on these patient care related indicators at this time. The information being gathered will be used by CMS to ascertain the breadth and content of existing hospice QAPI programs. This stakeholder input will help inform future measure development. Based on the comments we received, we are therefore finalizing our adoption of the structural measure: Participation in a Quality Assessment and Performance Improvement (QAPI) Program that Includes at Least Three Quality Indicators Related to Patient Care. Hospices will be required to submit data on the structural measure, including the description of each of their patient-care focused quality indicators.

Comment: Commenters expressed support of and pledged participation in the voluntary data reporting period. Some commenters questioned how the voluntary data collected about hospices' QAPI programs would be used by CMS, and cautioned that the data would likely not be comprehensive or generalizable. In addition, commenters expressed concerns regarding the need for standardization of patient outcome definitions when soliciting data. Finally, a few commenters urged CMS to make available as soon as possible the standardized voluntary data collection form along with training and education to ensure a smooth process for the voluntary data submission period.

Response: We are finalizing our proposed voluntary submission of the structural measure (not for purposes of a payment determination or public reporting), including the description of each hospice's patient-care focused quality indicators to CMS by January 31, 2012. We acknowledge and appreciate commenters' support of, and their pledging participation in, the voluntary data reporting period. The voluntary data reporting we proposed is designed to obtain specific information about hospice organizations' existing QAPI programs, including specifics about patient care related indicators the hospices monitor as part of their QAPI program. Hospices will be invited to provide us a list of their QAPI indicators along with specific information about each indicator. The information being gathered will be used by us to ascertain the breadth and content of existing hospice QAPI programs. This will help inform future measure development. We recognize that not all hospices will choose to participate in the voluntary data submission, and that information obtained will not necessarily be generalizable. We also recognize that information obtained during the voluntary period will not necessarily be representative of all hospices' QAPI programs.

The data collection form will be made available, along with education in the form of webinars, data dictionary, and other supporting documents, before the voluntary data submission date.

Comment: Commenters supported the use of an electronic spreadsheet as a temporary approach to data submission for the voluntary and mandatory data reporting period, but urged the creation of a more user friendly and less labor intensive approach in the future, including approaches that use data from Electronic Health Records. Commenters also expressed an eagerness to see the data collection template as soon as possible.

Response: We are finalizing our proposal to provide a spreadsheet template to hospices as a temporary means of data submission. To maximize the security of transmission of data from hospices to us, and to reduce data errors and streamline analysis, we are investigating the feasibility of a Web interface for the data collection. The spreadsheet template will be part of this web interface for the data entry. Hospices will be asked to provide identifying information, and then complete a Web based data entry that contains four questions. Hospices would report whether they have a QAPI program that includes at least three patient care related indicators and

hospices would be asked to enter information about all of their patient care related indicators including name of indicator, domain of care, description (not the numeric values) of the numerator and denominator if available, and data source (for example, electronic medical record, paper medical record, adverse events log) using a spreadsheet format. Training for use of this Web based data submission tool will be provided to hospices through webinars and other downloadable materials. A call-in help line will also be established and staffed, should hospices have specific questions requiring immediate assistance. For hospices that cannot complete the Web based data entry, a downloadable data entry form will be available.

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 proposed that the first hospice quality reporting cycle for the proposed NQF-endorsed measure and the proposed structural measure would consist of data collected from October 1, 2012 through December 31, 2012. This timeframe would permit us to determine whether each hospice was 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 proposed that all subsequent hospice quality reporting cycles be based on the calendar-year basis (for example, January 1, 2013 through December 31, 2013 for determination of the hospice market basket update for each hospice in FY 2015, etc.).

To voluntarily submit the structural measure, we proposed that the hospice voluntary quality reporting cycle would consist of data collected from October 1, 2011 through December 31, 2011. This timeframe would permit us to analyze the data to learn what the important patient care quality issues were 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.

Comment: We received minimal yet supportive comments on the proposed data collection timeframes. One commenter questioned why data would be required so early for the FY 2014 payment determination and requested further clarification.

Response: We are finalizing our proposal that the first hospice quality mandatory reporting cycle for the proposed NQF-endorsed measure and the proposed structural measure consist of data collected from October 1, 2012 through December 31, 2012. We are also finalizing our proposal that all subsequent hospice quality reporting cycles be based on a calendar-year (for example, January 1, 2013 through December 31, 2013 for determination of the hospice market basket update for each hospice in FY 2015, *etc.*). Hospices will report their data for the structural measure by January 2013 and data for NQF #0209 by April 2013 to allow ample time for analysis of data and subsequent impact on hospices' annual payment updates in advance of the start of FY 2014 (10/1/2013–9/30/2014). This timeframe will also be necessary in future years where analysis will be required in advance of any public reporting of data.

We are also finalizing our proposal that the hospice voluntary quality reporting cycle consist of data collected from October 1, 2011 through December 31, 2011.

d. Data Submission Requirements

We generally proposed that hospices submit data in the fiscal year prior to the payment determination. For the fiscal year 2014 payment determination, we proposed 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 (1) Whether they have a QAPI program that addresses at least three indicators related to patient care, and (2) 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 proposed that both measures' data be submitted to us on a spreadsheet template to be prepared by us. We would 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.

For the voluntary submission, we proposed that hospices submit data for the proposed structural measure based on the spreadsheet template to be prepared by us, no later than January 31, 2012. Voluntary data submission for the structural measure would include the hospices' report of (1) Whether they have a QAPI program that addresses at least three indicators related to patient care, and (2) 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.

Comment: Commenters supported the use of an electronic spreadsheet as a temporary approach to data submission for the voluntary and mandatory data reporting period, but urged the creation of a more user friendly and less labor intensive approach in the future, including approaches that use data from EHRs. Commenters also expressed an eagerness to see the data collection template as soon as possible.

Response: We are finalizing our proposal that hospices submit data in the FY prior to the payment determination. For the FY 2014 payment determination, hospices will be required to submit data for the NQF-endorsed measure no later than April 1, 2013. Data submission for the structural measure will include the hospices' report of (1) Whether they have a QAPI program that addresses at least three indicators related to patient care, and (2) the subject matter of all of their patient care indicators for the period October 1, 2012 through December 31, 2012. Submission of these reports will be required by January 31, 2013.

The proposed rule stated that we would provide a spreadsheet template to hospices as a temporary means of data submission. To maximize the security of transmission of data from hospices to us, and to reduce data errors and streamline analysis, we are investigating the feasibility of a Web interface for the data collection. The spreadsheet template will be part of this Web interface for the data entry. Hospices will be asked to provide identifying information, and then complete a Web based data entry that contains four questions. Hospices would report they have a QAPI program that includes at least three patient care-related indicators and all hospices would be asked to enter information about all of their patient care indicators including name of indicator, domain of care, description (not the numeric values) of the numerator and denominator if available, and data source (for example, electronic medical record, paper medical record, adverse events log) using a spreadsheet format. Training for use of this Web based data submission tool would be provided to hospices through webinars and other downloadable materials. A call-in help line would also be established and

staffed, should hospices have specific questions requiring immediate assistance. For hospices that cannot complete the Web based data entry, a downloadable data entry form would be available. We are finalizing all of these proposals. We would announce further operational details with respect to the data submission methods and format for the mandatory hospice quality data reporting program using the CMS Web site *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting* no later than December 31, 2011 and for the voluntary reporting cycle by November 2011.

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 its program before it is made public. In addition, 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 final 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.

Comment: Commenters supported our development of systems for future public reporting and provided input on that process. Commenters suggested we gain a clear understanding of what is important to consumers when discriminating between providers. A few commenters also urged us to involve broad representation from stakeholders in development of future public reporting. Commenters also indicated that some states already have public reporting, and that where possible, CMS-required reporting should not result in duplication of efforts.

Response: We appreciate comments received indicating support for the development of systems for future public reporting, and willingness to provide input. We are taking into consideration the body of literature related to consumer perceptions of what is important to them during the measure development process. In addition, we are aware of state-based quality reporting initiatives, and plan to take these into consideration as well. Finally, the measure development process used includes a variety of ways in which we obtain stakeholder input, including Listening Sessions, Technical Expert Panels, and public comment periods. Stakeholder input is critical to the process, and we value it highly.

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 will 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 welcomed comments on whether all, some, any, or none of these measures should be considered for future rulemaking. We also solicited comments on ways by which we 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.

We have developed an assessment instrument for the ''Post-Acute Care Payment Reform Demonstration Program,'' as required by section 5008 of the 2005 Deficit Reduction Act. 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 invited comments on the implementation of a standardized assessment instrument for hospices that would similarly support the calculation of quality measures.

We invited 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 *http://www.pacdemo.rti.org.*

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

Comment: We received many comments about the need for future measures to reflect the full range of hospice practice and approach to care. Commenters pointed out that measures need to include domains of care including psychosocial and spiritual to fully reflect hospice quality of care. In addition, commenters indicated that measures needed to reflect patient preference and refusal of treatment. Finally, commenters pointed out that measures needed to be very specific with regard to definitions, and easy to extract from medical records (paper or electronic). We received numerous and detailed comments related to the PEACE, AIM and NHPCO measures, including measures calculated from the collection of data using the Family Evaluation of Hospice Care (FEHC). While commenters were supportive of future measure development, a few commenters cautioned against implementing future measures for which evidence of validity is not fully established.

Response: We appreciate the specific and insightful analyses provided and will carefully consider this input as we continue to develop the hospice quality reporting program. Future measures will be proposed after being selected through our measure development process. This process is designed to prevent implementation of measures without sufficient evidence for use in care settings. We will consider the comments received in making decisions about future measure development.

Comment: Comments were also received about the development of a standardized tool, such as the CARE tool, as an instrument to gather standardized data items. Commenters voiced general support of the idea of developing a data tool specifically for hospice and offered specific ideas on domains of hospice patient care that are missing from the current tool. Some commenters advised against adopting existing tools that were developed for other settings and other commenters offered suggestions for additions to the tool that would make it appropriate for hospice patients.

Response: We appreciate the comments submitted about a future standardized data set for use in hospice. We recognize the tension between the desire for a tool to standardize data elements collected that would enable comparison of hospices ''apples to apples'' and the need for development of evidence for quality measures in certain domains of care. We also recognize that the CARE in its current form would not meet the needs of hospice patients or providers, and that revisions including the addition of care domains and items would be required to make CARE hospice-appropriate.

Comment: We received one comment in response to our request for input about future expansion of the structural measure to include hospice performance on each QAPI indicator. The commenter did not support the expansion of the structural measure in the future, stating that the data would not be usable unless we know the definitions, specifications, and data dictionaries used by each hospice, or would have to standardize the measure. The commenter also was unsure what use the measure would be.

Response: We appreciate the comment received, and understand the limitations of the QAPI program structural measure. We will consider this comment, along with data from the voluntary data collection period to inform future decisions.

III. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule without changes. Those provisions of this final rule that differ from the proposed rule are as follows:

- In section II.B, Aggregate Cap Calculation Methodology, we are clarifying that the reopening period is three years (except in cases of fraud, where it is unlimited), in accordance with existing regulations. We are changing proposed regulatory text at 418.309(d)(3) to indicate that adjustment of prior year cap determinations is subject to existing reopening regulations.
- In section II.E, Quality Reporting for Hospices, the proposed rule stated that CMS would provide a spreadsheet template to hospices as a temporary means of data submission. To maximize the security of transmission of data from hospices to CMS, and to reduce data errors and streamline analysis, CMS is investigating the feasibility of a Web interface for the data collection. The spreadsheet template will be part of this Web interface for the data entry. In response to comments, we have also clarified the description of the structural measure which is designed to obtain two pieces of information from hospices during both the voluntary reporting period and the mandatory period. Hospices will indicate whether their QAPI program includes at least three patient care related measures, and will also list all their patient related indicators along with specific information about those indicators. We are finalizing our adoption of this measure.

We are implementing all other provisions in the proposed rule as proposed.

IV. Updates on Issues Not Proposed 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 for routine home care rates (in a budget-neutral manner in the first year), no earlier than October 1, 2013. In order to determine the revised hospice payment methodology, we will consult with hospice programs and MedPAC.

According to MedPAC's March 2011 ''Report to Congress: Medicare Payment Policy'' (available at *http://www.medpac.gov/chapters/Mar11_Ch11.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. Finally, MedPAC noted a change in patient case-mix from predominantly cancer diagnoses to non-cancer diagnoses. The growth in Medicare expenditures, margins, and number of new hospices, and the change in patient case-mix, raise concern that the current hospice payment methodology may have created unintended incentives and may not reflect the resource usage associated with the current mix of hospice patients. Over the past several years, MedPAC, the Government Accounting Office, and the Office of Inspector General all recommended that we 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 convened a technical advisory panel in June 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 our reform efforts. We will continue to update stakeholders on our progress.

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 II.E. ''Quality Reporting for Hospices'' above, we finalized two measures for hospices to report to us, with one measure (the QAPI measure) to be reported no later than January 2013 and the other measure (the pain measure) to be reported by April 2013. We believe that these measures are a quality reporting foundation upon which we will expand. Over the course of the next few years, no later than beginning in FY 2015, we expect to require hospices to report an expanded and comprehensive set of quality measures from which we can select for pilot testing a value-based purchasing program. During the FY 2013, FY 2014 and FY 2015 hospice rulemaking, we

plan 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.

We did not solicit comments on this section, but we received three comments.

Comment: Some commenters noted that the hospice payment system is based upon the benefit as it was in the early 1980's, and that the benefit has changed considerably. While they agree that the payment system needs to be updated, they suggested that we not make piecemeal changes, and that we accumulate the necessary data to overhaul the system. A few commenters wrote that payment reform should not be undertaken without compelling reasons, and that the changes made must reflect the cost of services provided. One commenter urged us to work with a national industry association in reforming the payment system. Commenters suggested that we pilot any payment system changes through a demonstration project, which would help overcome a lack of reliable data to evaluate payment methodologies, would allow for testing to assess the impact of the reformed model on beneficiary access, and would help ensure a smoother transition.

Response: We appreciate the commenters' input, and will consider these suggestions as we move forward with payment reform. We reiterate that the Affordable Care Act calls for us to work with MedPAC and the industry in reforming the payment system.

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 the 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.

While we did not solicit comments on this section, we received 1 comment.

Comment: A commenter looks forward to the redesigned PS&R, and asked to give input before the newly designed PS&R report is finalized.

Response: We appreciate the commenter's support for the PS&R redesign; the PS&R redesign was undertaken in consultation with contractors, and with input previously solicited from the industry in prior rulemaking (see our FY 2011 Hospice Wage Index Notice with Comment, 75 FR 42950, dated July 22, 2010). We expect more information on the PS&R redesign to be forthcoming, and will keep the industry up-to-date through Open Door Forums, list-serves, and the hospice center webpage (*http://www.cms.gov/center/hospice.asp*).

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995(PRA), 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 PRA 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 solicited public comment on each of these issues in the proposed rule.

Quality Measures for the Quality Reporting Program for Hospices

Section 1814(i)(5)(C) of the 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, we seek 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 these 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 final rule, hospices will voluntarily report to us 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 (1) Whether or not they participate in a QAPI program that includes at least three indicators related to patient care and (2) 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 quality reporting program, hospices will voluntarily report to us by no later than January 31, 2012, data that would include (1) Whether they have a QAPI program that addresses at least three indicators related to patient care, and (2) the subject matter of all of their patient care indicators during the time frame via a CMS-prepared spreadsheet template. We anticipate 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 us one time per year. We estimate 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. We believe 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. Outcome Measure: 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, we have 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 final 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 FY 2014 payment determination is for the time period from October 1, 2012 to December 31, 2012.

We did not receive any public comments on this collection of information section.

VI. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this proposed rule as required by EO 12866 (September 30, 1993, Regulatory Planning and Review), EO 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), EO 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 EO 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 final rule follows 42 CFR 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 MSAs. In addition, 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 final rule implements 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 final rule is an estimated net decrease in Federal payments to hospices of $80 million for FY 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 six 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 additional 15 percent reduction in the BNAF ($ − 90 million). This estimate does not take into account any inpatient hospital market basket update, which is 3.0 percent for FY 2012. This 3.0 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 are communicated through an administrative instruction in the summer. The estimated effect of 3.0 percent inpatient hospital market basket update on payments to hospices is approximately $420 million. Taking into account 3.0 percent inpatient hospital market basket update (+$420 million), in addition to the updated wage data ($+10 million) and the additional 15 percent reduction in the BNAF ($ − 90

million), it is estimated that hospice payments would increase by $340 million in FY 2012 ($420 million + $10 million −$90 million = $340 million). The percent change in estimated 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 3.0 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 a 3.0 percent inpatient hospital market basket update for FY 2012 that is communicated separately through an administrative instruction. This final rule continues to use the CBSA-based pre-floor, pre-reclassified hospital wage index as a basis for the hospice wage index and continues to use the same policies for treatment of areas (rural and urban) without hospital wage data. The final FY 2012 hospice wage index is based upon the 2011 pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2010) 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 is not 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 a 3.0 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 final 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 A 3.0 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 FY 2012 wage index change	Percent change in hospice payments due to wage index change, 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	3,552	79,509	0.1%	(0.5%)	2.5%
URBAN HOSPICES	2,494	69,238	0.1%	(0.5%)	2.5%
RURAL HOSPICES	1,058	10,272	(0.2%)	(0.6%)	2.3%
BY REGION—URBAN:					
NEW ENGLAND	134	2,527	(0.7%)	(1.3%)	1.7%
MIDDLE ATLANTIC	244	7,488	(0.4%)	(0.9%)	2.0%
SOUTH ATLANTIC	359	15,713	0.3%	(0.3%)	2.7%
EAST NORTH CENTRAL	336	10,058	0.2%	(0.4%)	2.6%
EAST SOUTH CENTRAL	177	4,456	(0.1%)	(0.6%)	2.4%
WEST NORTH CENTRAL	189	4,482	(0.3%)	(0.9%)	2.1%
WEST SOUTH CENTRAL	485	9,249	0.1%	(0.4%)	2.6%
MOUNTAIN	234	5,818	(0.0%)	(0.6%)	2.4%
PACIFIC	299	8,070	0.6%	(0.0%)	3.0%
OUTLYING	37	1,377	(0.4%)	(0.4%)	2.6%
BY REGION—RURAL:					
NEW ENGLAND	26	200	(0.1%)	(0.7%)	2.3%
MIDDLE ATLANTIC	45	517	0.4%	(0.2%)	2.8%
SOUTH ATLANTIC	139	2,176	(0.8%)	(1.2%)	1.8%
EAST NORTH CENTRAL	147	1,779	(0.6%)	(1.1%)	1.8%
EAST SOUTH CENTRAL	154	1,794	0.1%	(0.1%)	2.9%
WEST NORTH CENTRAL	196	1,122	(0.5%)	(0.9%)	2.0%
WEST SOUTH CENTRAL	189	1,574	0.8%	0.3%	3.3%
MOUNTAIN	109	648	0.3%	(0.1%)	2.9%
PACIFIC	52	450	(0.7%)	(1.3%)	1.6%
OUTLYING	1	13	0.0%	0.0%	3.0%

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 A 3.0 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—Continued

	Number of hospices * (1)	Number of routine home care days in thousands (2)	Percent change in hospice payments due to FY 2012 wage index change (3)	Percent change in hospice payments due to wage index change, additional 15% reduction in BNAF (4)	Percent change in hospice payments due to wage index change, additional 15% reduction in BNAF, and market basket update† (5)
BY SIZE/DAYS:					
0–3,499 DAYS (small)	649	1,083	(0.0%)	(0.5%)	2.4%
3,500–19,999 DAYS (medium)	1,767	17,897	(0.1%)	(0.6%)	2.4%
20,000+ DAYS (large)	1,136	60,530	0.1%	(0.5%)	2.5%
TYPE OF OWNERSHIP:					
VOLUNTARY	1,170	31,470	0.0%	(0.5%)	2.5%
PROPRIETARY	1,895	40,587	0.1%	(0.4%)	2.6%
GOVERNMENT **	487	7,452	(0.1%)	(0.7%)	2.3%
HOSPICE BASE:					
FREESTANDING HOME HEALTH	2,448	62,588	0.1%	(0.5%)	2.5%
AGENCY	571	10,441	0.1%	(0.5%)	2.5%
HOSPITAL	513	6,274	(0.1%)	(0.6%)	2.3%
SKILLED NURSING FACILITY	20	206	0.3%	(0.3%)	2.7%

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 2010.

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

† The 3.0 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 2010. 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 a 3.0 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 2,494 hospices located in urban areas and 1,058 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 3,552 hospices. Approximately 47 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 2010) 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 final inpatient hospital market basket update is 3.0 percent. This 3.0 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 3.0 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 hospice 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 1,657 designated as non-profit or government hospices and 1,895 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 medium hospices by 0.1 percent and increase payments to large hospices by 0.1 percent; small hospices are anticipated to be unchanged (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 large hospices by 0.5 percent, and to medium hospices by 0.6 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 final 3.0 percent inpatient hospital market basket update are projected to increase estimated payments by 2.4 percent for small and medium hospices, and by 2.5 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 are anticipated to 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 0.8 percent in the South Atlantic 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 anticipated 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 hospices 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 0.3 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 final 3.0 percent inpatient hospital market basket update on estimated FY 2012 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 2.5 percent increase in payments and rural hospices are anticipated to experience a 2.3 percent increase in payments. Urban hospices are anticipated to experience an increase in estimated payments in every region, ranging from 1.7 percent in the New England region to 3.0 percent in the Pacific region. Rural hospices in every region are estimated to see an increase in payments, ranging from 1.6 percent in the Pacific region to 3.3

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 a final 3.0 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 2.5 percent for voluntary (non-profit), 2.3 percent for government hospices, and 2.6 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 0.3 percent for hospices based out of a skilled nursing facility. Payments to hospital based hospices are estimated to decrease by 0.1 percent.

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 0.3 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 a final 3.0 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 2.3 percent for hospital based hospices to 2.7 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 additional 15 percent reduction in the BNAF (for a of total 40 percent reduction in the BNAF). However, the final market basket update of 3.0 percent is anticipated to increase Medicare payments by $420 million. Therefore, the total effect on Medicare hospice payments is estimated to be a $340 million increase. Note that the final market basket update and associated FY 2012 payment rates is 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 this final 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 3,552 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.*
From Whom to Whom	Federal Government to Hospices.

*The $80 million estimated reduction in transfers includes the additional 15 percent reduction in the BNAF and the updated wage data. It does not include the final hospital market basket update, which is 3.0 percent for FY 2012. This final 3.0 percent does not reflect the provision in the Affordable Care Act 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 final 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 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 final rule, because the hospice benefit is a home-based benefit, we are applying the SBA definition of ''small'' for home health agencies to hospices; we will use this definition of ''small'' in determining if this final rule has a significant impact on a substantial number of small entities (for example, hospices). Using CY 2009 Medicare hospice data from the Health Care Information System (HCIS), we estimate that 96 percent of hospices

have Medicare revenues below $13.5 million and therefore are considered small entities.

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 finalizing in this final rule, 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 and large sized hospices (as defined by routine home care days rather than by the SBA definition), is an estimated reduction of 0.5 percent. Medium sized hospices are anticipated to experience an estimated reduction in payments of 0.6 percent as a result of the updated wage data and the additional 15 percent reduction in the BNAF. Furthermore, when examining the distributional effects of the updated wage data combined with the additional 15 percent BNAF reduction, the highest estimated reductions in payments are experienced by the urban New England and rural Pacific areas with each reflecting a 1.3 percent reduction.

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 an estimated reduction of 0.5 percent. Furthermore, since HHS's practice in determining ''significant economic impact'' considers either total revenue or total costs, it is necessary for total hospice revenues to include the effect of the market basket update of 3.0 percent. As a result, we consider the combined effect of the updated wage data, the additional 15 percent BNAF reduction, and the final 3.0 percent FY 2012 inpatient hospital market basket update inclusive of the overall impact, thereby reflecting an aggregate increase in estimated hospice payments of 2.5 percent for FY 2012. 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 final inpatient hospital market basket update reflect increases in payments of 2.4 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. Therefore, the Secretary has determined that this final 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 final rule only affects hospices. Therefore, the Secretary has determined that this final 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 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 final rule 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.

VII. 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 final rule under the threshold criteria of EO 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 amends 42 CFR chapter IV as set forth below:

PART 418—HOSPICE CARE

■ 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 B—Eligibility, Election and Duration of Benefits

■ 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.

* * * * *

Subpart F—Covered Services

■ 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.

* * * * *

Subpart G—Payment for Hospice Care

■ 4. In § 418.309, the section heading, 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, subject to existing reopening regulations.

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

Dated: July 21, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 27, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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

ADDENDUM A: FY 2012 Final 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	0.8284
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	0.9154
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9354
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8957
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9788
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8276
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9517
11020	Altoona, PA Blair County, PA	0.8923
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8948
11180	Ames, IA Story County, IA	1.0321
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2385
11300	Anderson, IN Madison County, IN	0.9515
11340	Anderson, SC Anderson County, SC	0.8997
11460	Ann Arbor, MI Washtenaw County, MI	1.0480
11500	Anniston-Oxford, AL Calhoun County, AL	0.8196
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9690
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9317
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9999

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	0.9885
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1520
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	0.9873
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9848
12540	Bakersfield-Delano, CA Kern County, CA	1.2119
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	1.0616
12620	Bangor, ME Penobscot County, ME	1.0121
12700	Barnstable Town, MA Barnstable County, MA	1.3274
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	0.8885
12980	Battle Creek, MI Calhoun County, MI	0.9995
13020	Bay City, MI Bay County, MI	0.9545
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8786
13380	Bellingham, WA Whatcom County, WA	1.1790
13460	Bend, OR Deschutes County, OR	1.1772

13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0895
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8979
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9026
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	0.8914
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	0.8606
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9305
14060	Bloomington-Normal, IL McLean County, IL	0.9771
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9599
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2606
14500	Boulder, CO Boulder County, CO	1.0419
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8971
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1042
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2988
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9495
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9533
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9865
15500	Burlington, NC Alamance County, NC	0.9175
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0297
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1646
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0751
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9057
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9518
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9299
16180	Carson City, NV Carson City, NV	1.0833
16220	Casper, WY Natrona County, WY	0.9994

16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9155
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0595
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8173
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9683
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	0.9751
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9670
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9139
16940	Cheyenne, WY Laramie County, WY	0.9722
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	1.0965
17020	Chico, CA Butte County, CA	1.1938
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	1.0040
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8165
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8003
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9368
17660	Coeur d'Alene, ID Kootenai County, ID	0.9693

17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9925
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9814
17860	Columbia, MO Boone County, MO Howard County, MO	0.8573
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9040
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9344
18020	Columbus, IN Bartholomew County, IN	0.9766
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	1.0498
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8887
18700	Corvallis, OR Benton County, OR	1.0823
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.9153
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8474
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	1.0207
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8925
19180	Danville, IL Vermilion County, IL	1.0034
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8455
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8695
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9461
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8000
19500	Decatur, IL Macon County, IL	0.8194
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9043

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	1.1095
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9959
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0040
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8000
20100	Dover, DE Kent County, DE	1.0270
20220	Dubuque, IA Dubuque County, IA	0.9082
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0936
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0004
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9978
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1393
20940	El Centro, CA Imperial County, CA	0.9583
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8746
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9798
21300	Elmira, NY Chemung County, NY	0.8742
21340	El Paso, TX El Paso County, TX	0.8773
21500	Erie, PA Erie County, PA	0.8654
21660	Eugene-Springfield, OR Lane County, OR	1.1784
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8729
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1470
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4465
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8347
22140	Farmington, NM San Juan County, NM	0.9667
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9651
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8919

22380	Flagstaff, AZ Coconino County, AZ	1.2880
22420	Flint, MI Genesee County, MI	1.1900
22500	Florence, SC Darlington County, SC Florence County, SC	0.8542
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8430
22540	Fond du Lac, WI Fond du Lac County, WI	0.9547
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0240
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach,FL Broward County, FL	1.0517
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	0.9691
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9807
23420	Fresno, CA Fresno County, CA	1.1824
23460	Gadsden, AL Etowah County, AL	0.8000
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9482
23580	Gainesville, GA Hall County, GA	0.9547
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9403
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8806
24140	Goldsboro, NC Wayne County, NC	0.9386
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8000
24300	Grand Junction, CO Mesa County, CO	1.0196
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9491
24500	Great Falls, MT Cascade County, MT	0.8580
24540	Greeley, CO Weld County, CO	0.9830
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9923
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9194
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9699
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9983
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	0.9189
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9579
25260	Hanford-Corcoran, CA Kings County, CA	1.1599
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9623
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9480
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1311
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	0.8999
25980	Hinesville-Fort Stewart, GA[3] Liberty County, GA Long County, GA	0.9273
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8935
26180	Honolulu, HI Honolulu County, HI	1.2222
26300	Hot Springs, AR Garland County, AR	0.9473
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8128
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	1.0169
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9268
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9514
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	1.0003
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	1.0012
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9997
27060	Ithaca, NY Tompkins County, NY	1.0188
27100	Jackson, MI Jackson County, MI	0.9477

27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8325
27180	Jackson, TN Chester County, TN Madison County, TN	0.8699
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9196
27340	Jacksonville, NC Onslow County, NC	0.8081
27500	Janesville, WI Rock County, WI	0.9746
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8731
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8390
27780	Johnstown, PA Cambria County, PA	0.8374
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8030
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8503
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0654
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0992
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	0.9991
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0327
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9107
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	0.9394
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8118
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9451
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0148

29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9616
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8787
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8484
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1160
29420	Lake Havasu City - Kingman, AZ Mohave County, AZ	1.0595
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8744
29540	Lancaster, PA Lancaster County, PA	0.9672
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0660
29700	Laredo, TX Webb County, TX	0.8192
29740	Las Cruces, NM Dona Ana County, NM	0.9623
29820	Las Vegas-Paradise, NV Clark County, NV	1.2524
29940	Lawrence, KS Douglas County, KS	0.8833
30020	Lawton, OK Comanche County, OK	0.8576
30140	Lebanon, PA Lebanon County, PA	0.8081
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9687
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9216
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9127
30620	Lima, OH Allen County, OH	0.9597
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9955
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	0.8846
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9103
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8864
31020	Longview, WA Cowlitz County, WA	1.0658
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2556
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	0.9209

	Trimble County, KY	
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9158
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9000
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9526
31460	Madera-Chowchilla, CA Madera County, CA	0.8267
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1691
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0216
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.8123
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9402
31900	Mansfield, OH Richland County, OH	0.9232
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.4186
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9148
32780	Medford, OR Jackson County, OR	1.0415
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	0.9594
32900	Merced, CA Merced County, CA	1.2793
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0484
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9803
33260	Midland, TX Midland County, TX	1.0052
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0541
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	1.1535
33540	Missoula, MT Missoula County, MT	0.9235
33660	Mobile, AL Mobile County, AL	0.8240
33700	Modesto, CA Stanislaus County, CA	1.2530

33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8274
33780	Monroe, MI Monroe County, MI	0.8989
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8739
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8423
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.8000
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0727
34620	Muncie, IN Delaware County, IN	0.8494
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0154
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9045
34900	Napa, CA Napa County, CA	1.5117
34940	Naples-Marco Island, FL Collier County, FL	1.0039
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	0.9789
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2748
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1863
35300	New Haven-Milford, CT New Haven County, CT	1.1920
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	0.9389
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	1.3410
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9184
35840	North Port-Bradenton-Sarasota,FL Manatee County, FL Sarasota County, FL	0.9814
35980	Norwich-New London, CT New London County, CT	1.1609
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6929
36100	Ocala, FL	0.8766

	Marion County, FL	
36140	Ocean City, NJ Cape May County, NJ	1.1261
36220	Odessa, TX Ector County, TX	0.9768
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9593
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	0.9189
36500	Olympia, WA Thurston County, WA	1.1665
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	0.9920
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9485
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9902
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8664
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2812
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9535
37380	Palm Coast, FL Flagler County, FL	0.8700
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8234
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	0.8591
37764	Peabody, MA Essex County, MA	1.1365
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8544
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9471
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1183
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.1016
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8294
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA	0.8908

	Westmoreland County, PA	
38340	Pittsfield, MA Berkshire County, MA	1.0736
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9841
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	1.0247
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	1.1879
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.1100
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1753
39140	Prescott, AZ Yavapai County, AZ	1.2664
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	1.1091
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9649
39380	Pueblo, CO Pueblo County, CO	0.9028
39460	Punta Gorda, FL Charlotte County, FL	0.9067
39540	Racine, WI Racine County, WI	1.0952
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0156
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0809
39740	Reading, PA Berks County, PA	0.9217
39820	Redding, CA Shasta County, CA	1.4631
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0785
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	1.0001
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1977

40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9137
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1327
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8897
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0386
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0378
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9352
40660	Rome, GA Floyd County, GA	0.8939
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4547
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9035
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1430
41100	St. George, UT Washington County, UT	0.9454
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0664
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	0.9410
41420	Salem, OR Marion County, OR Polk County, OR	1.1524
41500	Salinas, CA Monterey County, CA	1.6237
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9322
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9592
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8595

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	0.9314
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2400
41780	Sandusky, OH Erie County, OH	0.8991
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6286
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	1.7290
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4940
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3369
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2590
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2328
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7329
42140	Santa Fe, NM Santa Fe County, NM	1.1228
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6711
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9220
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA	0.8528

	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1962
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9417
43100	Sheboygan, WI Sheboygan County, WI	0.9558
43300	Sherman-Denison, TX Grayson County, TX	0.8570
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8836
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9411
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9626
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0298
43900	Spartanburg, SC Spartanburg County, SC	0.9713
44060	Spokane, WA Spokane County, WA	1.0943
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9451
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0611
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8665
44220	Springfield, OH Clark County, OH	0.9559
44300	State College, PA Centre County, PA	0.9088
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.8000
44700	Stockton, CA San Joaquin County, CA	1.3089
44940	Sumter, SC Sumter County, SC	0.8136
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0253
45104	Tacoma, WA Pierce County, WA	1.1742
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9116
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9372
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9529
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8020

45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9764
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9267
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0507
46060	Tucson, AZ Pima County, AZ	0.9813
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9102
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9154
46340	Tyler, TX Smith County, TX	0.8349
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8769
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8220
46700	Vallejo-Fairfield, CA Solano County, CA	1.5456
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8508
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0904
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 Williamsburg City, VA	0.9276
47300	Visalia-Porterville, CA Tulare County, CA	1.1116
47380	Waco, TX McLennan County, TX	0.8698
47580	Warner Robins, GA Houston County, GA	0.8310
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9987

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	1.1100
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8759
48140	Wausau, WI Marathon County, WI	0.9899
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9953
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0283
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	0.9211
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9902
48700	Williamsport, PA Lycoming County, PA	0.8000
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0952
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9526
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0354
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9253
49340	Worcester, MA Worcester County, MA	1.1399
49420	Yakima, WA Yakima County, WA	1.0421
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4066
49620	York-Hanover, PA York County, PA	1.0334
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8928
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1431
49740	Yuma, AZ Yuma County, AZ	0.9609

[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 by the greater of a) the 40 percent reduced BNAF, OR b) 15 percent, subject to a maximum adjusted wage index value of 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.

ADDENDUM B: FY 2012 Final Wage Index for Rural Areas

State Code	Nonurban Area	Wage Index
1	Alabama	0.8000
2	Alaska	1.3070
3	Arizona	0.9415
4	Arkansas	0.8000
5	California	1.2480
6	Colorado	1.0282
7	Connecticut	1.1519
8	Delaware	1.0100
9	District of Columbia[1]	------
10	Florida	0.8705
11	Georgia	0.8000
12	Hawaii	1.1582
13	Idaho	0.8000
14	Illinois	0.8636
15	Indiana	0.8686
16	Iowa	0.8845
17	Kansas	0.8262
18	Kentucky	0.8105
19	Louisiana	0.8000
20	Maine	0.8890
21	Maryland	0.9498
22	Massachusetts[2]	1.2183
23	Michigan	0.8856
24	Minnesota	0.9356
25	Mississippi	0.8000
26	Missouri	0.8000
27	Montana	0.8816
28	Nebraska	0.9224
29	Nevada	0.9679
30	New Hampshire	1.0566
31	New Jersey[1]	------
32	New Mexico	0.9224
33	New York	0.8473
34	North Carolina	0.8653
35	North Dakota	0.7856
36	Ohio	0.8862
37	Oklahoma	0.8136
38	Oregon	1.0382
39	Pennsylvania	0.8778
40	Puerto Rico[3]	0.4654
41	Rhode Island[1]	------
42	South Carolina	0.8709
43	South Dakota	0.8836
44	Tennessee	0.8163
45	Texas	0.8080
46	Utah	0.8953
47	Vermont	0.9928
48	Virgin Islands	0.8274
49	Virginia	0.8117
50	Washington	1.0542
51	West Virginia	0.8000
52	Wisconsin	0.9509
53	Wyoming	0.9863
65	Guam	0.9949

[1]There are no rural areas in this State or District.

[2]There are no hospitals in the rural areas of Massachusetts, so the wage index value used is the average of the contiguous Counties.

[3]Wage index values are obtained using the methodology described in this final rule.

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