DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405 and 418

[CMS–1420–P]

RIN 0938–AP45

Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2010

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

ACTION: Proposed rule; request for comments.

SUMMARY: This proposed rule would set forth the hospice wage index for fiscal year 2010. The proposed rule would adopt a MedPAC recommendation regarding a process for certification and recertification of terminal illness. This proposed rule would also continue the phase-out of the wage index budget neutrality adjustment factor (BNAF), which will conclude in 2011. In addition, we are requesting comments on a suggestion to require recertification visits by physicians or advanced practice nurses, and on issues of payment reform for use in possible future policy development. Finally, the proposed rule would make several technical and clarifying changes to the regulatory text.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 22, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1420–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1420–P, P.O. Box 8012, Baltimore, MD 21244–8012.

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

3. *By express or overnight mail*. You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1420–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. For delivery in Baltimore, MD—7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Randy Throndset (410) 786–0131.

Katie Lucas (410) 786–7723.

SUPPLEMENTARY INFORMATION:

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

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

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I. Background

A. General

1. Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses

an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible. Counseling services and inpatient respite services are available to the family of the hospice patient. Hospice programs consider both the patient and the family as a unit of care. Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Section 1814(i) of the Act provides payment for Medicare participating hospices.

2. Medicare Payment for Hospice Care

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

B. Hospice Wage Index

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

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

In the August 8, 1997 **Federal Register** (62 FR 42860), we published a final rule implementing a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking Committee, using a hospital wage index rather than continuing to use the Bureau of Labor Statistics (BLS) data. The committee statement was included in the appendix of that final rule (62 FR 42883). The reduction in overall Medicare payments if a new wage index were adopted was noted in the November 29, 1995 notice transmitting the recommendations of the negotiated rulemaking committee (60 FR 61264). Therefore, the Committee also decided that for each year in updating the hospice wage index, aggregate Medicare payments to hospices would remain budget neutral to payments as if the 1983 wage index had been used.

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

The BNAF is calculated by computing estimated payments using the most recent completed year of hospice claims data. The units (days or hours) from those claims are multiplied by the updated hospice payment rates to calculate estimated payments. For this proposed rule, that means estimating payments for FY 2010 using FY 2007 hospice claims data, and applying the estimated FY 2010 hospice payment rates (updating the FY 2009 rates by the FY 2010 estimated hospital market basket update). The FY 2010 hospice wage index values are then applied to the labor portion of the payment rates only. The procedure is repeated using the same claims data and payment rates, but using the 1983 BLS-based wage index instead of the updated 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 hospice wage index is updated annually. Our most recent update, published in the **Federal Register** (73 FR 46464) on August 8, 2008, set forth updates to the hospice wage index for FY 2009. That update also finalized a provision for a 3-year phase-out of the BNAF, which was applied to the wage index values. As discussed in detail below, the update was later revised with the February 17, 2009 passage of the American Recovery and Reinvestment Act (ARRA), which eliminated the BNAF phase-out for FY 2009.

1. Raw Wage Index Values (Pre-Floor, Pre-Reclassified Hospital Wage Index)

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

Pre-floor, pre-reclassified hospital wage index values of 0.8 or greater are adjusted by the BNAF. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by the greater of:

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

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

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

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

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

The August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464) implemented a phase-out of the hospice BNAF over 3 years, beginning with a 25 percent reduction in the BNAF in FY 2009, an additional 50 percent reduction for a total of 75 percent in FY 2010, and complete phase out of the BNAF in FY 2011. However, subsequent to the publication of the above rule, the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (ARRA) eliminated the BNAF phase-out for FY 2009. Specifically, division B, section 4301(a) of ARRA prohibited the Secretary from phasing out or eliminating the BNAF in the Medicare hospice wage index before October 1, 2009, and instructed the Secretary to recompute and apply the final Medicare hospice wage index for FY 2009 as if there had been no reduction in the BNAF. We have done so in an administrative instruction to our intermediaries, which was issued as Change Request (CR) #6418 (Transmittal #1701, dated 3/13/2009).

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

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

The annual update to the hospice wage index is published in the **Federal Register** and is based on the most current available hospital wage data, as well as any changes by OMB to the definitions of MSAs, which now include CBSA designations. The August 4, 2005 hospice wage index final rule (70 FR 45130) set forth the adoption of the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Micropolitan Statistical Areas and the creation of MSAs and Combined Statistical Areas. In adopting the OMB CBSA geographic designations, we provided for a 1-year transition with a blended hospice wage index for all hospices for FY 2006. Subsequent fiscal years have used the full CBSA-based hospice wage index.

3. Definition of Rural and Urban Areas

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

In the August 22, 2007 FY 2008 Inpatient Prospective Payment System (IPPS) final rule with comment period (72 FR 47130), § 412.64(b)(1)(ii)(B) was revised such that the two ''New England deemed Counties'' that had been considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH) but deemed urban, were no longer considered urban effective for discharges occurring on or after October 1, 2007. Therefore, these two counties are considered rural in accordance with § 412.64(b)(1)(ii)(C).

The recommendations to adjust payments to reflect local differences in wages are codified in § 418.306(c) of our regulations; however there had been no explicit reference to § 412.64 in § 418.306(c) before implementation of the August 8, 2008 FY 2009 Hospice Wage Index final rule. Although § 412.64 had not been explicitly referred to, the hospice program has used the definition of urban in § 412.64(b)(1)(ii)(A) and (b)(1)(ii)(B), and the definition of rural as any area outside of an urban area in § 412.64(b)(1)(ii)(C). With the implementation of the August 8, 2008 FY 2009 Wage Index final rule, we now explicitly refer to those provisions in § 412.64 to make it absolutely clear how we define urban and rural for purposes of the hospice wage index.

Litchfield County, CT and Merrimack County, NH are considered rural areas for hospital IPPS purposes in accordance with § 412.64. Effective October 1, 2008, Litchfield County, CT was no longer considered part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and Merrimack County, NH was no longer considered part of urban CBSA 31700 (Manchester-Nashua, NH). Rather, these counties are now considered to be rural areas within their respective States under the hospice payment system. When the raw pre-floor, pre-reclassified hospital wage index was adopted for use in deriving the hospice wage index, it was decided not to take into account IPPS geographic reclassifications. This policy of following OMB designations of rural or urban, rather than considering some counties to be ''deemed'' urban, is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the hospice wage index.

4. Areas Without Hospital Wage Data

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data on which to base the calculation of the hospice wage index. Beginning in FY 2006, we adopted a policy to use the FY 2005 pre-floor, pre-reclassified hospital wage index value for rural areas when no hospital wage data were available. We also adopted the policy that for urban labor markets without a hospital from

which hospital wage index data could be derived, all of the CBSAs within the State would be used to calculate a Statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. Consequently, in subsequent fiscal years, we applied the average pre-floor, pre-reclassified hospital wage index data from all urban areas in that state, to urban areas without a hospital. The only affected CBSA is 25980, Hinesville-Fort Stewart, Georgia.

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

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

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

We also noted that we do not believe that this policy would be appropriate for Puerto Rico, as there are sufficient economic differences between hospitals in the United States and those in Puerto Rico, including the payment of hospitals in Puerto Rico using blended Federal/Commonwealth-specific rates. Therefore, we believe that a separate and distinct policy for Puerto Rico is necessary. Any alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico would need to take into account the economic differences between hospitals in the United States and those in Puerto Rico. Our policy of imputing a rural pre-floor, pre-reclassified hospital wage index based on the pre-floor, pre-reclassified hospital wage index(es) of CBSAs contiguous to the rural area in question does not recognize the unique circumstances of Puerto Rico. While we have not yet identified an alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico, we will continue to evaluate the feasibility of using existing hospital wage data and, possibly, wage data from other sources. For FY 2008 and FY 2009, we used the most recent pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047.

5. CBSA Nomenclature Changes

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

6. Wage Data From Multi-Campus Hospitals

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

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

Beginning in FY 2008, the IPPS apportioned the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period 72 FR 47317 through 47320). We are continuing to use the raw pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values for FY 2010 because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the use of raw pre-floor, pre-reclassified hospital (IPPS) wage data, used to derive the FY 2010 hospice wage index values, reflects the application of our policy to use that data to establish the hospice wage index. The FY 2010 hospice wage index values presented in this notice were computed consistent with our 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, the FY 2009 hospice wage index values for the following CBSAs were affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI–MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974), and Lake County-Kenosha County, IL–WI (CBSA 29404).

7. Hospice Payment Rates

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended section 1814(i)(1)(C)(ii) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the hospital market basket index, minus 1 percentage point. However, neither the BBA nor subsequent legislation specified alteration to the hospital market basket adjustment to be used to compute hospice payment for fiscal years beyond 2002. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent fiscal years will be the market basket percentage for the fiscal year. It has been longstanding practice to use the inpatient hospital market basket as a proxy for a hospice market basket.

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

II. Provisions of the Proposed Rule

A. FY 2010 Proposed Hospice Wage Index

1. Background

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

As noted above, our hospice payment rules utilize the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. We are proposing again to use the pre-floor and pre-reclassified hospital wage index data as the basis to determine the hospice wage index, which is then used to adjust the labor portion of the hospice payment rates based on the geographic area where the beneficiary receives hospice care. We believe the use of the pre-floor, pre-reclassified hospital wage index data, as a basis for the hospice wage index, results in the appropriate adjustment to the labor portion of the costs. For the FY 2010 update to the hospice wage index, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index available at the time of publication.

2. Areas Without Hospital Wage Data

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

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

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

3. FY 2010 Wage Index With 75 Percent Reduced Budget Neutrality Adjustment Factor (BNAF)

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

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

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

the August 8, 2008 FY 2009 Hospice Wage Index final rule.

While ARRA eliminated the BNAF phase-out for FY 2009, it did not change the 75 percent reduction in the BNAF for FY 2010, or the elimination of the BNAF in FY 2011 that was previously implemented in the August 8, 2008 FY 2009 Hospice Wage Index final rule. The provision in ARRA that eliminated the FY 2009 BNAF reduction provided the hospice industry additional time to prepare for the FY 2010 75 percent BNAF reduction and the FY 2011 BNAF elimination. Therefore, in accordance with the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), the rationale presented in that final rule, and consistent with the section 4301(a) of ARRA, we plan to reduce the BNAF for FY 2010 by 75 percent, and ultimately eliminate the BNAF in FY 2011. We are accepting comments on the BNAF reductions.

An unreduced BNAF for FY 2010 is computed to be 0.067845 (or 6.7845 percent). A 75 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 0.016961 (or 1.6961 percent). Pre-floor, pre-reclassified hospital wage index values, which are less than 0.8, are subject to the hospice floor calculation; that calculation is described in section I.B.1.

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

4. Effects of Phasing Out the BNAF

The full (unreduced) BNAF calculated for FY 2010 is 6.7845 percent. As implemented in the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), we are reducing the BNAF by 75 percent for FY 2010, and eliminating it altogether for FY 2011 and beyond.

For FY 2010, this is mathematically equivalent to taking 25 percent of the full BNAF value, or multiplying 0.067845 by 0.25, which equals 0.016961 (1.6961 percent). The BNAF of 1.6961 percent reflects a 75 percent reduction in the BNAF. The 75 percent reduced BNAF (1.6961 percent) would be applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater in the proposed FY 2010 hospice wage index.

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

We examined the effects of a 75 percent reduction in the BNAF versus using the full BNAF of 6.7845 percent on the proposed FY 2010 hospice wage index. The FY 2010 BNAF reduction of 75 percent resulted in approximately a 4.76 to 4.77 percent reduction in most hospice wage index values. The elimination of the BNAF in FY 2011 would result in an estimated final reduction of the FY 2011 hospice wage index values of approximately 1.66 to 1.67 percent compared to FY 2010 hospice wage index values.

Those CBSAs whose pre-floor, pre-reclassified hospital wage index values had the hospice 15 percent floor adjustment applied before the BNAF reduction would not be affected by this proposed phase out of the BNAF. These CBSAs, which typically include rural areas, are protected by the hospice 15 percent floor adjustment. We have estimated that 17 CBSAs are already protected by the hospice 15 percent floor adjustment, and are therefore completely unaffected by the BNAF reduction. There are over 100 hospices in these 17 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 75 percent reduced BNAF. Areas where the hospice floor calculation would have yielded a wage index value greater than 0.8 if the full BNAF were applied, but which will have a final wage index value less than 0.8 after the 75 percent reduced BNAF is applied, will now be eligible for the hospice 15 percent floor adjustment. These CBSAs will see a smaller reduction in their hospice wage index values since the hospice 15 percent floor adjustment will apply. We have estimated that 18 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 75 percent reduction in the BNAF. 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 over 300 hospices located in these 18 CBSAs.

Finally, the hospice wage index values only apply to the labor portion of the payment rates; the labor portion is described in section I.B.1 of this proposed rule. Therefore the projected reduction in payments due to the 75 percent reduction of the BNAF will be an estimated 3.2 percent, as described in column 4 of Table 1 in section VI of this proposed rule. In addition, the estimated effects of the phase-out of the BNAF will be mitigated by any hospital market basket updates in payments. We will not have the final market basket update for FY 2010 until the summer. However, the current estimate of the hospital market basket update for FY 2010 is 2.1 percent. The final update will be communicated through an administrative instruction. The combined effects of a 75 percent reduction of the BNAF and an estimated hospital market basket update of 2.1 percent for FY 2010 is an overall estimated decrease in payments to hospices in FY 2010 of 1.1 percent (column 5 of Table 1 in section VI of this proposed rule).

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

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

indicate that the patient's life expectancy is 6 months or less if the illness runs its normal course, and must be signed by the physician. The medical record must include documentation that supports the terminal prognosis.

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

The expert panel noted that there were several reasons for the variation in compliance. First, they noted that in some cases there was limited medical director engagement in the certification or recertification process. Physicians had delegated this responsibility to the staff involved with patients' day-to-day care, and simply signed off on the paperwork. Second, inadequate charting of the patient's condition or a lack of staff training had led some physicians to certify patients who were not truly eligible for Medicare's hospice benefit. Finally, some panelists cited financial incentives associated with long-stay patients. The panelists mentioned anecdotal reports of hospices using questionable marketing strategies to recruit patients without mentioning the terminal illness requirement, and of hospices failing to discharge patients who had improved or enrolling patients who had already been discharged or turned away from other hospices. Consensus emerged among the panelists that more accountability and oversight of certification and recertification are needed. See, *http://www.medpac.gov/transcripts/20081104_Hospice_final_public.pdf* and *http://www.medpac.gov/transcripts/1106–1107MedPAC%20final.pdf.*

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

To increase accountability related to the physician certification and recertification process, we are proposing a change to § 418.22. Specifically, we propose to add a new paragraph (b)(3) to § 418.22 to require that physicians that certify or recertify hospice patients as being terminally ill include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less. This brief narrative should be written or typed on the certification form itself. We do not believe that an attachment should be permissible because an attachment could easily be prepared by someone other than the physician. We seek comments on whether this proposed requirement would increase physician engagement in the certification and recertification process.

C. Proposed Update of Covered Services, § 418.202

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

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

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

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

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

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

Currently, hospices that exceed either the inpatient cap or the aggregate cap are sent a letter by their contractor (regional home health and hospice intermediary (RHHI) or fiscal intermediary (FI)), detailing the cap results, along with a demand for repayment. As described in an administrative instruction (CR 6400, Transmittal 1708, issued April 3, 2009) effective July 1, 2009, this letter of determination of program reimbursement will be sent to every hospice provider, regardless of whether or not the hospice has exceeded the cap. A demand for repayment will be included for those hospices which have exceeded either cap. If a hospice disagrees with the contractor's cap calculations, the hospice has appeal rights which are set out at 42 CFR § 418.311 and Part 405, Subpart R. The letter of determination of program

reimbursement shall include language describing the hospice's appeal rights. We are proposing to clarify the language at § 405.1803(a) to note that for the purposes of hospice, the determination of program reimbursement letter sent by the contractors serves as the written notice reflecting the intermediary's determination of the total amount of reimbursement due the hospice, which is commonly called a Notice of Program Reimbursement or NPR. Additionally, we are proposing to clarify § 405.1803(a)(1)(i) to note that in the case of hospice, the reporting period covered by the determination of program reimbursement letter is the hospice cap year and the bases for the letter are the cap calculations rather than reasonable cost from cost report data.

F. Proposed Technical and Clarifying Changes

In addition to the proposals and solicitation of comments discussed above, we are proposing to make the following technical changes to clarify existing regulations text, correct errors that we have identified in the regulations, remove obsolete cross references, or to ensure consistent use of terminology in our regulations.

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

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

2. Proposed Update of the Scope of Part, § 418.2

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

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

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

4. Proposed Clarification of Hospice Multiple Location, § 418.100

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

5. Proposed Revision to Short Term Inpatient Care, § 418.108

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

6. Proposed Clarification of the Requirements for Coverage, § 418.200

Section 418.200 describes the requirements for coverage for Medicare hospice services, and references § 418.58 (''Conditions of Participation plan of care''). This cross reference is no longer accurate as § 418.58 was updated with the publication of the new CoPs in 2008. We propose to detail the requirements for coverage related to the plan of care rather than cross refer to the CoPs regulations. This revision would avoid the need to make updates to this section each time the CoPs are changed.

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

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

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

8. Proposed Clarification of Administrative Appeals, § 418.311

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

We propose to clarify the last sentence of this section, which currently notes that ''the methods and standards for the calculation of the payment rates by CMS are not subject to appeal.'' The payment rates referred to are the national rates which are set by statute, and updated according to the statute using the hospital market basket (unless Congress has instructed us to update the rates differently). To ensure better understanding of what is not subject to

appeal, we propose to revise § 418.311 to provide that methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal.

III. Request for Comments on Other Policy Issues

A. Recertification Visits, § 418.22

As noted earlier, MedPAC convened an expert panel from the hospice industry in late 2008. That panel noted that some hospices are enrolling and recertifying patients who are not eligible for hospice care under the Medicare benefit, and consensus emerged that greater accountability and oversight are needed in the certification and recertification process. To further increase accountability in the recertification process, several of the panelists suggested to MedPAC that an additional policy change be made to the recertification process. Several panelists supported a requirement that a hospice physician or advanced practice nurse visit the patient at the time of the 180-day recertification to assess continued eligibility, and at every certification thereafter. MedPAC recommended that the physician or advanced practice nurse be required to attest that the visit took place. See, *http://www.medpac.gov/transcripts/20081104_Hospice_final_public.pdf* and *http://www.medpac.gov/transcripts/1106-1107MedPAC%20final.pdf*.

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

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

B. Hospice Aggregate Cap Calculation

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

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

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

As stated above, in our current hospice aggregate cap calculation methodology, the intermediary calculates each hospice's aggregate cap amount by multiplying the per-beneficiary cap amount by the number of Medicare beneficiaries counted in

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

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

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

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

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

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

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

this approach, contractors would still verify the reported cap.

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

C. Hospice Payment Reform

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

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

Medicare spending for hospice is rapidly growing, more than tripling between 2000 and 2007. In fiscal year (FY) 1998, expenditures for the Medicare hospice benefit were $2.2 billion, while in FY 2007, expenditures for the Medicare hospice benefit were $10.6 billion, more than the Medicare program spends on inpatient rehabilitation hospitals, critical access hospitals, long term care hospitals, or psychiatric hospitals. Medicare hospice spending is expected to more than double in the next 10 years and will account for roughly 2.3 percent of overall Medicare spending in FY 2009.

The number of hospice agencies has also grown by over 70 percent since 1997. The growth is overwhelmingly in the for-profit category. In 1997, there were 1,834 hospices, about 20 percent of which were for-profit and 80 percent were non-profit. In 2008, there were over 3,200 hospices, and 51 percent of these are for-profit entities. Since 2000, nearly all hospices newly participating in Medicare are for-profit entities. MedPAC reports that the newly participating hospices have margins five to six times higher than more established hospices. MedPAC estimates that, on average, hospice Medicare margins were approximately 3.4 percent in 2005. However, the for-profit hospices are estimated to have margins ranging from 15.9 percent in 2003 to 11.8 percent in 2005.

In their analyses of the hospice benefit in their June 2008 ''Report to the Congress,'' MedPAC found that hospice care is more costly at the beginning and end of an episode of hospice care, because of the intensity of services provided during those times. Hospices provide more visits to a patient right after a patient elects hospice and in the time shortly before death, than they provide during the middle of the episode. In its November 6, 2008 public meeting, MedPAC suggested that payments to hospices should decline as the beneficiary's length of stay increases, thus better reflecting intensity and frequency of the hospice services provided over the course of treatment. MedPAC also suggested that payment to hospices should increase during the period just prior to the patient's death to reflect the higher resource usage during this time [see, *http://www.medpac.gov/transcripts/20081104_Hospice_final_public.pdf* and *http://www.medpac.gov/transcripts/1106-1107MedPAC%20final.pdf*.]. MedPAC believes this payment structure would better reflect hospice patient resource usage and hospice costs, and would encourage hospices to admit patients at the time in their illness which provides the most benefit to the patient.

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

IV. Update on Additional Hospice Data Collection

Over the past several years MedPAC, the GAO, and the Office of the Inspector General have all recommended that CMS collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit. We have been phasing in this process to collect more comprehensive data on hospice claims. We also began collecting additional data on hospice claims beginning in January 2007 through an administrative instruction (CR 5245, Transmittal 1011, issued July 28, 2006), when we started required reporting of a HCPCS code on the claim to describe the location where services were provided (Phase 1). In addition, we issued an administrative instruction (CR 5567, Transmittal 1494, issued April 29, 2008) requiring Medicare hospices to provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. The start date of this mandatory CR 5567 reporting requirement was July 2008 (Phase 2).

On several occasions, industry representatives have communicated to CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care. A major concern was that CMS was not requiring reporting of the visit intensity. As a result of these concerns, we committed to working with the industry to expand the data collection requirements. In October 2008, we solicited comments via a posting on CMS' hospice center Web site (*http://www.cms.hhs.gov/center/hospice.asp*) on an approach to collecting additional data about hospice resource use. We asked about data collection using hospice claims, along with data collection using hospice cost reports. This proposed rule provides an update on the additional data collection which is in process.

Based on the feedback received from our October 2008 web posting, we have revised our plans for Phase 3 of the claims data collection. Those plans are currently being developed and will be implemented through an administrative instruction.

Phase 3 will involve collecting new data on hospice claims. In addition to the existing visit reporting requirement, we anticipate requiring visit time reporting in 15 minute increments for nurses, social workers, and aides. We anticipate requiring visit and visit time reporting in 15 minute increments from physical therapists, occupational therapists, and speech language therapists. We also anticipate requiring reporting of some social worker phone calls and their associated time, within certain limits. Specifically, we anticipate requiring the reporting of social worker calls that are necessary for the palliation and management of the

terminal illness and related conditions as described in the patient's plan of care (for example, counseling, speaking with a patient's family, or arranging for a placement). Furthermore, we anticipate that only social worker phone calls related to providing and/or coordinating care to the patient and family, and documented as such in the clinical records, would be reported. We anticipate that visit and time data collection for respite and general inpatient care provided by non-hospice staff in contract facilities would be exempt from the reporting requirement. Finally, we anticipate that travel time, documentation time, and interdisciplinary group time would not be included in the time reporting. These changes would necessitate line-item billing on hospice claims.

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

We also note that this additional data collection uses existing revenue codes and existing UB–04 and 837I claim forms. Those claims forms were previously approved by the OMB under control number #0938–0997.

As stated above, these changes will be forthcoming through an administrative instruction, and are not to be considered as proposals in this rule; that instruction will be issued some time this spring or summer.

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

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

We are soliciting public comment on the issue for the following section of this document that contains information collection requirements.

Section 418.22 Certification of terminal illness.

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

The burden associated with this requirement is the time and effort put forth by the physician to include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less. We estimate it would take a physician 5 minutes to meet this requirement. We also estimate that a narrative would be provided on 1,534,388 certifications or recertifications annually. Therefore, the total annual burden associated with this requirement is 127,866 hours. The current requirements for § 418.22 are approved under OMB# 0938–0302 with an expiration date of 8/31/2009. We will revise the currently approved PRA package to reflect any changes in burden.

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

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

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer,

Fax: (202) 395–7245; or

E-mail: *OIRA_submission@omb.eop.gov*.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). We estimated the impact on hospices, as a result of the changes to the proposed FY 2010 hospice wage index and of reducing the BNAF by 75 percent.

As discussed previously, the methodology for computing the hospice wage index was determined through a negotiated rulemaking committee and implemented in the August 8, 1997 hospice wage index final rule (62 FR 42860). The BNAF, which was implemented in the August 8, 1997 rule, is being phased out. This rule proposes updates to the hospice wage index in accordance with the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), which originally implemented a 75 percent reduced BNAF for FY 2010 as the second year of a 3-year phase-out of the BNAF.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this proposed rule is an economically significant rule under this Executive Order.

Column 4 of Table 1 shows the combined effects of the 75 percent reduction in the BNAF and of the updated wage data, comparing estimated payments for FY 2010 to estimated payments for FY 2009. In keeping with the American Recovery and Reinvestment Act (ARRA) mentioned earlier in this proposed rule, the FY 2009 payments used for comparison have a full (unreduced) BNAF applied. We estimate that the total hospice payments for FY 2010 will decrease by $340 million as a result of the application of the 75 percent reduction in the BNAF and the updated wage data. This estimate does not take into account any hospital market basket update, which is currently estimated to be about 2.1 percent for FY 2010. The final hospital market basket update will not be available until sometime later this year and will be communicated through an administrative instruction. The effect of an estimated 2.1 percent hospital market basket update on payments to hospices is approximately

$240 million. Taking into account an estimated 2.1 percent hospital market basket update, in addition to the 75 percent reduction in the BNAF and the updated wage data, it is estimated that hospice payments would decrease by $100 million in FY 2010 ($340 million − $240 million = $100 million). The percent change in payments to hospices due to the combined effects of the 75 percent reduction in the BNAF, the updated wage data, and the estimated hospital market basket update of 2.1 percent is reflected in column 5 of the impact table (Table 1).

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

As indicated in Table 1 below, there are 3,206 hospices as of January 29, 2009. Approximately 49.8 percent of Medicare certified hospices are identified as voluntary or government agencies and, therefore, are considered small entities. Most of these and most of the remainder are also small hospice entities because, as noted above, their revenues fall below the SBA size thresholds.

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

The effects of this rule on hospices are shown in Table 1. Overall, Medicare payments to all hospices will decrease by an estimated 3.2 percent, reflecting the combined effects of the 75 percent reduction in the BNAF and the updated wage data. However, when we consider the combined effects of the 75 percent reduction to the BNAF and the updated wage data on small or medium sized hospices, as defined by routine home care days rather than by the SBA definition, the effect is –2.9 percent. Furthermore, when including the estimated hospital market basket update of 2.1 percent into these estimates, the combined effects on Medicare payment to all hospices would result in an estimated decrease of approximately 1.1 percent. For small to medium hospices (as defined by routine home care days), the effects on revenue when accounting for the updated wage data, the 75 percent BNAF reduction, and the estimated hospital market basket update are –0.8 percent and –0.9 percent, respectively. Overall average hospice revenue effects will be slightly less than these estimates since according the National Hospice and Palliative Care Organization, about 16 percent of hospice patients are non-Medicare. HHS practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of only the updated wage data and the 75 percent reduced BNAF for all hospices (large and small) is 3.2 percent. Since, by SBA's definition of ''small'' (when applied to hospices), nearly all hospices are considered to be small entities, the combined effect of only the updated wage data and the 75 percent reduced BNAF (3.2 percent) exceeds HHS' 3.0 percent minimum threshold. However, HHS' practice in determining ''significant economic impact'' has considered either *total* revenue or *total* costs. Total hospice revenues include the effect of the market basket update. When we consider the combined effect of the updated wage data, the 75 percent BNAF reduction, and the estimated 2.1 percent 2009 market basket update, the overall impact is a decrease in hospice payments of 1.1 percent for FY 2010. Therefore, the Secretary has determined that this proposed rule does not create a significant economic impact on a substantial number of small entities.

In the August 8, 2008 FY 2009 Hospice Wage Index final rule, we implemented a 3-year phase-out of the BNAF. The BNAF was to be reduced by 25 percent in FY 2009, by an additional 50 percent for a total of 75 percent in FY 2010, and by a final 25 percent, for complete elimination in FY 2011. This phased approach to eliminating the BNAF was estimated to reduce payments by 1.1 percent in FY 2009, an additional 2 percent in FY 2010, and an additional 1 percent in FY 2011. As originally implemented, the phase out of the BNAF would not have a significant economic impact on small entities because in any of the 3 fiscal years, the estimated reduction in payments was less than 3 percent. However, on February 17, 2009, ARRA eliminated the phase-out for FY 2009, but left intact the BNAF reductions implemented in the August 8, 2008 FY 2009 Hospice Wage Index final rule for FY 2010 and FY 2011. While we are still using a phased approach to eliminating the BNAF, the phase-out is now occurring over 2 years rather than over 3 years. There is a greater impact on hospices in FY 2010 since hospices move from having a full (unreduced) BNAF in FY 2009 to a 75 percent reduced BNAF in FY 2010.

The hospice floor calculation gives some relief to hospices with pre-floor, pre-reclassified wage index values less than 0.8. Hospices which are eligible for the hospice floor calculation will either be totally unaffected by the BNAF phase-out, or will be less affected by the phase-out. As noted in section II.A.4 of this proposed rule, there are just over 100 hospices that will be totally unaffected by the BNAF phase-out and just over 300 hospices which will be less affected by the BNAF phase-out, due to the hospice floor calculation.

Hospices do not need to take any action for the BNAF phase-out to be effective. The FY 2010 wage index includes the 75 percent reduced BNAF, and that wage index is applied to hospice payments automatically by the claims processing contractors, thereby relieving hospices of the responsibility of having to implement the change.

We are taking a number of actions to provide information to hospices to help them prepare for the BNAF phase-out. First, this phase-out was originally

implemented in the August 8, 2008 FY 2009 Hospice Wage Index final rule. With the passage of ARRA, hospices have been given additional time to prepare for the FY 2010 BNAF reduction, and the ultimate elimination of the BNAF in FY 2011. Second, we continue to publicize information about the BNAF phase-out on our hospice Web site. The hospice center page at *http://www.cms.hhs.gov/center/hospice.asp* provides information about the BNAF phase-out and links to related documents. Third, we are publicizing the information about the BNAF phase-out through other avenues (for example, through Open Door Forums). All of these efforts should provide information to hospices to help them prepare for the BNAF phase-out.

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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a metropolitan statistical area and has fewer than 100 beds. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

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

B. Anticipated Effects

This section discusses the impact of the projected effects of the proposed hospice wage index, including the effects of an estimated 2.1 percent hospital market basket update that will be communicated separately through an administrative instruction. The proposed provisions include continuing to use the CBSA-based pre-floor, pre-reclassified hospital wage index as a basis for the hospice wage index and continuing to use the same policies for treatment of areas (rural and urban) without hospital wage data. In FY 2010, we are continuing with the 75 percent reduction of the BNAF which, in the August 8, 2008 FY 2009 Hospice Wage Index final rule (73 FR 46464), was originally implemented as the second year of a 3-year phase-out of the BNAF. The proposed FY 2010 hospice wage index is based upon the 2009 pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2007) with a 75 percent reduction in the BNAF.

For the purposes of our impacts, our baseline is estimated FY 2009 payments (without any BNAF reduction) using the 2008 pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3, Table 1) compares our baseline to estimated FY 2010 payments (holding payment rates constant) using the updated wage data (2009 pre-floor, pre-reclassified hospital wage index). Consequently, the estimated effects illustrated in column 3 of Table 1 show the distributional effects of the updated wage data only. The effects of using the updated pre-floor, pre-reclassified hospital wage index data combined with the 75 percent reduction in the BNAF are illustrated in column 4 of Table 1.

We have included a comparison of the combined effects of the 75 percent BNAF reduction, the updated pre-floor, pre-reclassified hospital wage index, and an estimated 2.1 percent hospital market basket increase for FY 2010 (Table 1, column 5). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue of the proposed hospice wage index discussed in this rule, the BNAF phase-out, and the estimated FY 2010 hospital market basket update. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BNAF BY 75 PERCENT AND APPLYING AN ESTIMATED 2.1 PERCENT HOSPITAL MARKET BASKET UPDATE FOR THE FY 2010 PROPOSED HOSPICE WAGE INDEX, COMPARED TO THE FY 2009 HOSPICE WAGE INDEX WITH NO BNAF REDUCTION

	Number of hospices *	Number of routine home care days in thousands	Percent change in hospice payments due to FY 2010 wage index change	Percent change in hospice payments due to wage index change and 75% reduction in BNAF	Percent change in hospice payments due to wage index change, 75% reduction in BNAF and estimated hospital market basket update
	(1)	(2)	(3)	(4)	(5)
ALL HOSPICES	3,206	67,763	(0.0)	(3.2)	(1.1)
URBAN HOSPICES	2,184	58,428	(0.1)	(3.3)	(1.2)
RURAL HOSPICES	1,022	9,336	0.1	(2.3)	(0.3)
BY REGION—URBAN:					

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BNAF BY 75 PERCENT AND APPLYING AN ESTIMATED 2.1 PERCENT HOSPITAL MARKET BASKET UPDATE FOR THE FY 2010 PROPOSED HOSPICE WAGE INDEX, COMPARED TO THE FY 2009 HOSPICE WAGE INDEX WITH NO BNAF REDUCTION—Continued

	Number of hospices * (1)	Number of routine home care days in thousands (2)	Percent change in hospice payments due to FY 2010 wage index change (3)	Percent change in hospice payments due to wage index change and 75% reduction in BNAF (4)	Percent change in hospice payments due to wage index change, 75% reduction in BNAF and estimated hospital market basket update (5)
NEW ENGLAND	121	2,092	0.0	(3.4)	(1.4)
MIDDLE ATLANTIC	209	5,971	(0.1)	(3.4)	(1.4)
SOUTH ATLANTIC	314	12,988	(0.8)	(4.0)	(1.9)
EAST NORTH CENTRAL	307	8,318	(0.5)	(3.7)	(1.7)
EAST SOUTH CENTRAL	171	4,512	(0.0)	(2.9)	(0.9)
WEST NORTH CENTRAL	169	3,860	0.4	(2.9)	(0.8)
WEST SOUTH CENTRAL	410	7,949	0.0	(3.1)	(1.1)
MOUNTAIN	203	5,065	0.1	(3.2)	(1.2)
PACIFIC	245	6,702	1.6	(2.0)	0.1
OUTLYING **	35	972	(1.2)	(1.2)	0.9
BY REGION—RURAL:					
NEW ENGLAND	26	175	0.6	(2.7)	(0.7)
MIDDLE ATLANTIC	44	462	(0.4)	(3.5)	(1.5)
SOUTH ATLANTIC	128	1,915	(0.1)	(2.7)	(0.7)
EAST NORTH CENTRAL	145	1,354	(0.6)	(3.8)	(1.8)
EAST SOUTH CENTRAL	152	2,051	(0.1)	(1.3)	0.8
WEST NORTH CENTRAL	192	965	0.7	(2.4)	(0.4)
WEST SOUTH CENTRAL	176	1,406	0.9	(0.9)	1.2
MOUNTAIN	106	601	(0.4)	(3.2)	(1.2)
PACIFIC	52	397	1.7	(1.7)	0.3
OUTLYING	1	9	0.0	0.0	2.1
ROUTINE HOME CARE DAYS:					
0–3499 DAYS (small)	663	1,103	0.1	(2.9)	(0.8)
3500–19,999 DAYS (medium)	1,537	15,311	0.1	(2.9)	(0.9)
20,000+ DAYS (large)	1,006	51,350	(0.1)	(3.2)	(1.2)
TYPE OF OWNERSHIP: †					
VOLUNTARY (Non-Profit)	1,187	29,043	(0.1)	(3.3)	(1.3)
PROPRIETARY (For Profit)	1,608	33,275	0.1	(3.0)	(1.0)
GOVERNMENT	411	5,446	(0.1)	(3.3)	(1.3)
HOSPICE BASE:					
FREESTANDING	2,028	51,413	(0.1)	(3.2)	(1.2)
HOME HEALTH AGENCY	601	9,509	0.2	(3.1)	(1.1)
HOSPITAL	561	6,627	0.2	(3.0)	(0.9)
SKILLED NURSING FACILITY	16	214	(0.1)	(3.5)	(1.5)

BNAF = Budget Neutrality Adjustment Factor.

* As of January 29, 2009; Source: OSCAR database.

** Guam, Puerto Rico, Virgin Islands.

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

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

Table 1 shows the results of our analysis. In column 1, we indicate the number of hospices included in our analysis as of January 29, 2009. In column 2, we indicate the number of routine home care days that were included in our analysis, although the analysis was performed on all types of hospice care. Columns 3, 4, and 5 compare FY 2010 estimated payments with those estimated for FY 2009. The estimated FY 2009 payments incorporate a BNAF which has not been reduced. Column 3 shows the percentage change in estimated Medicare payments from FY 2009 to FY 2010 due to the effects of the updated wage data only, with estimated FY 2009 payments. Column 4 shows the percentage change in estimated hospice payments from FY 2009 to FY 2010 due to the combined effects of using the 2009 pre-floor, pre-reclassified hospital wage index and reducing the BNAF by 75 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2009 to FY 2010 due to the combined effects of using updated wage data, a 75 percent BNAF

reduction, and a 2.1 percent estimated 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 2,184 hospices located in urban areas and 1,022 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 2007. 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 3,206 hospices. Approximately 49.8 percent of Medicare-certified hospices are identified as voluntary (non-profit) or government agencies. Because the National Hospice and Palliative Care Organization estimates that approximately 83.6 percent of hospice patients in 2007 were Medicare beneficiaries, we have not considered other sources of revenue in this analysis.

As stated previously, the following discussions are limited to demonstrating trends rather than projected dollars. We used the pre-floor, pre-reclassified hospital wage indexes as well as the most complete claims data available (FY 2007) in developing the impact analysis. The FY 2010 payment rates will be adjusted to reflect the full hospital market basket, as required by section 1814(i)(1)(C)(ii)(VII) of the Act. As previously noted, we publish these rates through administrative instructions rather than in a proposed rule. Currently the FY 2010 hospital market basket update is estimated to be 2.1 percent; however this figure is subject to change. Since the inclusion of the effect of an estimated hospital market basket increase provides a more complete picture of projected total hospice payments for FY 2010, the last column of Table 1 shows the combined impacts of the updated wage index, the 75 percent BNAF reduction, and an estimated 2.1 percent hospital market basket update factor.

As discussed in the FY 2006 hospice wage index final rule (70 FR 45129), hospice agencies may use multiple hospice wage index values to compute their payments based on potentially different geographic locations. Before January 1, 2008, the location of the beneficiary was used to determine the CBSA for routine and continuous home care and the location of the hospice agency was used to determine the CBSA for respite and general inpatient care. Beginning January 1, 2008, the hospice wage index utilized is based on the location of the site of service. As the location of the beneficiary's home and the location of the facility may vary, there will still be variability in geographic location for an individual hospice. We anticipate that the location of the various sites will usually correspond with the geographic location of the hospice, and thus we will continue to use the location of the hospice for our analyses of the impact of the proposed 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 1,598 designated as non-profit and 1,608 as proprietary. The vast majority of hospices are freestanding.

1. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care days. The majority of the days provided by a hospice are routine home care (RHC) days, representing about 97 percent of the services provided by a hospice. Therefore, the number of RHC days can be used as a proxy for the size of the hospice, that is, the more days of care provided, the larger the hospice. As discussed in the August 4, 2005 final rule, we currently use three size designations to present the impact analyses. The three categories are: (1) Small agencies having 0 to 3,499 RHC days; (2) medium agencies having 3,500 to 19,999 RHC days; and (3) large agencies having 20,000 or more RHC days. The updated FY 2010 wage index values without any BNAF reduction are anticipated to increase payments to small and medium hospices by 0.1 percent, and to decrease payments to large hospices by 0.1 percent (column 3); the FY 2010 wage index values using the updated wage data and the 75 percent BNAF reduction that was finalized in the FY 2009 final rule, published August 2008 (73 FR 46464), are anticipated to decrease estimated payments to small and to medium hospices by 2.9 percent each, and to large hospices by 3.2 percent (column 4); and finally, the FY 2010 wage index values with the updated wage data, the 75 percent BNAF reduction which was finalized in the FY 2009 final rule, published in August 2008 (73 FR 46464), and the estimated 2.1 percent hospital market basket update are projected to decrease estimated payments by 0.8 percent for small hospices, by 0.9 percent for medium hospices, and to decrease estimated payments by 1.2 percent for large hospices (column 5).

2. Geographic Location

Column 3 of Table 1 shows that FY 2010 wage index values without the BNAF reduction would result in little change in estimated payments. Urban hospices are anticipated to experience a slight decrease of 0.1 percent while rural hospices are anticipated to have a slight increase of 0.1 percent. For urban hospices, the greatest increase of 1.6 percent is anticipated to be experienced by the Pacific regions, followed by an increase for West North Central regions of 0.4 percent, an increase for Mountain regions of 0.1 percent, and no change for the West South Central or New England regions. The remaining urban regions are anticipated to experience a decrease ranging from 0.1 percent in the Middle Atlantic region to a 1.2 percent decrease for Outlying regions. East South Central is anticipated to see a slight decrease which rounds to a 0.0 percent change.

Column 3 shows that for rural hospices, Outlying regions are anticipated to experience no change. Five regions are anticipated to experience a decrease ranging from 0.1 percent for the South Atlantic and East South Central regions to 0.6 percent for the East North Central region. The remaining regions are anticipated to experience an increase ranging from 0.6 percent for the New England region to 1.7 percent for the Pacific region.

Column 4 shows the combined effect of the 75 percent BNAF reduction and the updated pre-floor, pre-reclassified hospital wage index values on estimated payments, as compared to the FY 2009 estimated payments using a BNAF with no reduction. Overall urban hospices are anticipated to experience a 3.3 percent decrease in payments, while

rural hospices expect a 2.3 percent decrease. The estimated percent decrease in payment for urban hospices ranged from 1.2 percent for Outlying hospices to 4.0 percent for South Atlantic hospices.

The estimated percent decrease in payment for rural hospices ranged from 0.9 percent for West South Central hospices to 3.8 percent for East North Central hospices. Rural Outlying estimated payments were unaffected.

Column 5 shows the combined effects of the proposed FY 2010 wage index values with the updated wage data, the 75 percent BNAF reduction which was finalized in the FY 2009 final rule, published in August 2008 (73 FR 46464), and the estimated 2.1 percent hospital market basket update on estimated payments as compared to the estimated FY 2009 payments. Note that the FY 2009 payments had no BNAF reduction applied to them. Overall, urban hospices are anticipated to experience a 1.2 percent decrease in payments while rural hospices should experience a 0.3 percent decrease in payments. Urban hospices are anticipated to experience a decrease in estimated payments in 8 regions, ranging from a 0.8 percent decrease for the West North Central region to a 1.9 percent decrease for South Atlantic hospices. Urban hospices in 2 regions are anticipated to see an increase in estimated payments of 0.1 percent for the Pacific region and 0.9 percent for Outlying regions. Rural hospices in 6 regions are estimated to see a decrease in payments ranging from 0.4 percent for the West North Central region to 1.8 percent for the East North Central region. Rural hospices in 4 regions are anticipated to see an increase in payments ranging from 0.3 percent for the Pacific region to 2.1 percent for the Outlying regions.

3. Type of Ownership

Column 3 demonstrates the effect of the updated pre-floor, pre-reclassified hospital wage index on FY 2010 estimated payments versus FY 2009 estimated payments with no BNAF reduction applied to them. We anticipate that using the updated pre-floor, pre-reclassified hospital wage index data would increase estimated payments to proprietary (for-profit) hospices by 0.1 percent. We estimate a slight decrease in payments for voluntary (non-profit) and government hospices of 0.1 percent each.

Column 4 demonstrates the combined effects of using updated pre-floor, pre-reclassified hospital wage index data and of incorporating a 75 percent BNAF reduction. Estimated payments to proprietary (for-profit) hospices are anticipated to decrease by 3.0 percent, while voluntary (non-profit) and government hospices are each anticipated to experience decreases of 3.3 percent.

Column 5 shows the combined effects of the updated pre-floor, pre-reclassified hospital wage index values with the updated wage data, the 75 percent BNAF reduction, and the estimated 2.1 percent hospital market basket update on estimated payments, comparing FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated FY 2010 payments are anticipated to decrease by 1.0 percent for proprietary (for-profit) hospices, and by 1.3 percent for both voluntary (non-profit) and government hospices.

4. Hospice Base

Column 3 demonstrates the effect of using the updated pre-floor, pre-reclassified hospital wage index values, comparing estimated payments for FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated payments are anticipated to decrease by 0.1 percent each for freestanding facilities and for hospices based out of skilled nursing facilities. Home health and hospital based facilities are anticipated to experience a 0.2 percent increase in estimated payments.

Column 4 shows the combined effects of updating the pre-floor, pre-reclassified hospital wage index values and reducing the BNAF by 75 percent (as finalized in the FY 2009 final rule, published August 2008, 73 FR 46464), comparing FY 2010 to FY 2009 (using a BNAF with no reduction) estimated payments. Skilled nursing facility based hospices are estimated to see a 3.5 percent decrease, freestanding hospices are estimated to see a 3.2 percent decrease, home health agency based hospices are anticipated to experience a 3.1 percent decrease in payments, and hospital-based hospices are anticipated to experience a 3.0 percent decrease in payments.

Column 5 shows the combined effects of the updated pre-floor, pre-reclassified hospital wage index, the 75 percent BNAF reduction which was finalized in FY 2009 hospice wage index final rule (73 FR 46464), and the estimated 2.1 percent hospital market basket update on estimated payments, comparing FY 2010 to FY 2009 (using a BNAF with no reduction). Estimated payments are anticipated to decrease by 0.9 percent for hospital based hospices, by 1.1 percent for home health agency based hospices, and by 1.2 percent and by 1.5 percent for freestanding hospices and skilled nursing facility based hospices, respectively.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 2 below, we have prepared an accounting statement showing the classification of the expenditures associated with the proposed provisions of this rule. This table provides our best estimate of the decrease in Medicare payments under the hospice benefit as a result of the changes presented in this proposed rule on data for 3,206 hospices in our database. All expenditures are classified as transfers to Medicare providers (that is, hospices).

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

[In millions]

Category	Transfers
Annualized Monetized Transfers.	$ − 340.
From Whom to Whom	Federal Government to Hospices.

Note: The $340 million reduction in transfers includes the 75 percent reduction in the BNAF and the updated wage data. It does not include the estimated hospital market basket update, which is currently forecast to be about 2.1 percent.

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

List of Subjects

42 CFR Part 405

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

42 CFR Part 418

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

For the reasons set forth in the preamble, the Centers for Medicare and Medicare Services propose to amend 42 CFR chapter IV as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

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

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

Subpart R—Provider Reimbursement Determinations and Appeals

2. Section 405.1803 is amended by revising paragraph (a) introductory text and paragraph (a)(1) to read as follows:

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

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (as described in § 405.1835(a)(3)(ii)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. For the purposes of hospice, the intermediaries' determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations, shall serve as a notice of program reimbursement. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report, or in the case of hospice, on the basis of the cap calculations for the reporting period that is the cap year; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

* * * * *

PART 418—HOSPICE CARE

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

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

Subpart A—General Provision and Definitions

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

§ 418.1 Statutory basis.

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

* * * * *

5. Section 418.2 is revised to read as follows:

§ 418.2 Scope of part.

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

Subpart B—Eligibility, Election and Duration of Benefits

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

§ 418.22 Certification of terminal illness.

* * * * *

(b) * * *

(3) The physician must include on the certification a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.

* * * * *

Subpart C—Conditions of Participation: Patient Care

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

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

* * * * *

(f) * * *

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

* * * * *

Subpart D—Conditions of Participation: Organizational Environment

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

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

* * * * *

(f) * * *

(1) * * *

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

* * * * *

§ 418.108 [Amended]

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

Subpart F—Covered Services

10. Section 418.200 is revised to read as follows:

§ 418.200 Requirements for coverage.

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

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

§ 418.202 Covered Services.

* * * * *

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

(g) Home health or hospice aide services furnished by qualified aides as designated in § 418.94 and homemaker services. Home health aides (also known

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

* * * * *

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

§ 418.204 Special coverage requirements.

(a) *Periods of crisis.* Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as hospice aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.

* * * * *

Subpart G—Payment for Hospice Care

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

§ 418.302 Payment procedures for hospice care.

* * * * *

(b) * * *

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

* * * * *

(f) * * *

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

* * * * *

14. Section 418.311 is revised to read as follows:

§ 418.311 Administrative appeals.

A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least $1,000 or $10,000, respectively. In such a case, the procedure in 42 CFR part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under § 405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal.

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

Dated: March 30, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 15, 2009.

Charles E. Johnson,

Acting Secretary.

BILLING CODE 4120–01–P

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

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8234
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3909
10420	Akron, OH Portage County, OH Summit County, OH	0.9068
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8851
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8855
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9366
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8268
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9660

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
11020	Altoona, PA Blair County, PA	0.8666
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9078
11180	Ames, IA Story County, IA	0.9648
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2133
11300	Anderson, IN Madison County, IN	0.8909
11340	Anderson, SC Anderson County, SC	0.9732
11460	Ann Arbor, MI Washtenaw County, MI	1.0622
11500	Anniston-Oxford, AL Calhoun County, AL	0.8061
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9600
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9297
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9754

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
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	0.9919
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.2176
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	0.9778

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9698
12540	Bakersfield, CA Kern County, CA	1.1379
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	1.0226
12620	Bangor, ME Penobscot County, ME	1.0347
12700	Barnstable Town, MA Barnstable County, MA	1.2857
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	0.8301
12980	Battle Creek, MI Calhoun County, MI	1.0292
13020	Bay City, MI Bay County, MI	0.9405
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8623
13380	Bellingham, WA Whatcom County, WA	1.1837
13460	Bend, OR Deschutes County, OR	1.1568

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0727
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8954
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8719
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	0.8941
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	0.8293
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9131
14060	Bloomington-Normal, IL McLean County, IL	0.9481
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9425
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2099
14500	Boulder, CO Boulder County, CO	1.0477

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8530
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0068
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0953
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3086
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9067
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9729
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9699
15500	Burlington, NC Alamance County, NC	0.8884
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9411
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1274
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0521
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8991
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9555
16180	Carson City, NV Carson City, NV	1.0300
16220	Casper, WY Natrona County, WY	0.9741
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9070

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9621
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8415
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9365
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9758
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9982
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9029
16940	Cheyenne, WY Laramie County, WY	0.9433
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL	1.0575

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Will County, IL	
17020	Chico, CA Butte County, CA	1.1082
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	0.9851
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8439
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8146
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9398
17660	Coeur d'Alene, ID Kootenai County, ID	0.9480

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9505
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0146
17860	Columbia, MO Boone County, MO Howard County, MO	0.8685
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9085
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8887
18020	Columbus, IN Bartholomew County, IN	0.9904
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	1.0112
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8744
18700	Corvallis, OR Benton County, OR	1.1496
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8000

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
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	1.0114
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8853
19180	Danville, IL Vermilion County, IL	0.9533
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8537
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8578
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9359
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8000
19500	Decatur, IL Macon County, IL	0.8283
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9041
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO	1.1001

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Park County, CO	
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9697
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0127
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8000
20100	Dover, DE Kent County, DE	1.0500
20220	Dubuque, IA Dubuque County, IA	0.8522
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0539
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9897
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9832
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1474
20940	El Centro, CA Imperial County, CA	0.8894
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8670
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9730
21300	Elmira, NY Chemung County, NY	0.8387
21340	El Paso, TX	0.8841

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	El Paso County, TX	
21500	Erie, PA Erie County, PA	0.8861
21660	Eugene-Springfield, OR Lane County, OR	1.1249
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8837
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1489
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4670
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8305
22140	Farmington, NM San Juan County, NM	0.8188
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9498
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9122
22380	Flagstaff, AZ Coconino County, AZ	1.1942
22420	Flint, MI Genesee County, MI	1.1619
22500	Florence, SC Darlington County, SC Florence County, SC	0.8268
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8005
22540	Fond du Lac, WI Fond du Lac County, WI	0.9451

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0034
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0115
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8000
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8918
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9332
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9874
23420	Fresno, CA Fresno County, CA	1.1196
23460	Gadsden, AL Etowah County, AL	0.8118
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9470
23580	Gainesville, GA Hall County, GA	0.9263
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9407
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8617
24140	Goldsboro, NC Wayne County, NC	0.9298
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8000

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
24300	Grand Junction, CO Mesa County, CO	0.9978
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9340
24500	Great Falls, MT Cascade County, MT	0.8933
24540	Greeley, CO Weld County, CO	0.9848
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9874
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9164
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9608
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0130
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3736
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9182
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9150
25260	Hanford-Corcoran, CA Kings County, CA	1.1054
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9308

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9045
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1257
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	0.9128
25980	Hinesville-Fort Stewart, GA[3] Liberty County, GA Long County, GA	0.9265
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9161
26180	Honolulu, HI Honolulu County, HI	1.2011
26300	Hot Springs, AR Garland County, AR	0.9268
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8000
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	1.0005
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV	0.9411

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Wayne County, WV	
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9236
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9234
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	1.0076
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9644
27060	Ithaca, NY Tompkins County, NY	0.9777
27100	Jackson, MI Jackson County, MI	0.9467
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8204
27180	Jackson, TN Chester County, TN Madison County, TN	0.8668
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9152

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
27340	Jacksonville, NC Onslow County, NC	0.8316
27500	Janesville, WI Rock County, WI	0.9826
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8924
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8106
27780	Johnstown, PA Cambria County, PA	0.8054
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8050
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9566
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0984
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0663
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	0.9773
28420	Kennewick-Pasco-Richland, WA Benton County, WA	1.0079

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8914
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	0.9534
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8015
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9508
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9924
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9377
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8516
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8000
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0565
29420	Lake Havasu City - Kingman, AZ Mohave County, AZ	0.9963
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8675

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
29540	Lancaster, PA Lancaster County, PA	0.9522
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0099
29700	Laredo, TX Webb County, TX	0.8508
29740	Las Cruces, NM Dona Ana County, NM	0.9080
29820	Las Vegas-Paradise, NV Clark County, NV	1.2174
29940	Lawrence, KS Douglas County, KS	0.8485
30020	Lawton, OK Comanche County, OK	0.8350
30140	Lebanon, PA Lebanon County, PA	0.9106
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9626
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9356
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9265
30620	Lima, OH Allen County, OH	0.9587
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9925
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	0.8819
30860	Logan, UT-ID Franklin County, ID	0.8914

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Cache County, UT	
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8512
31020	Longview, WA Cowlitz County, WA	1.1397
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2415
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9406
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8879
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8923
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9732
31460	Madera, CA Madera County, CA	0.8074
31540	Madison, WI Columbia County, WI Dane County, WI	1.1153

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	Iowa County, WI	
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0535
31900	Mansfield, OH Richland County, OH	0.9488
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.4531
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9162
32780	Medford, OR Jackson County, OR	1.0418
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9389
32900	Merced, CA Merced County, CA	1.2451
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9997
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9314
33260	Midland, TX Midland County, TX	0.9994
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0251

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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	1.1339
33540	Missoula, MT Missoula County, MT	0.9125
33660	Mobile, AL Mobile County, AL	0.8042
33700	Modesto, CA Stanislaus County, CA	1.2401
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8034
33780	Monroe, MI Monroe County, MI	0.9093
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8423
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8673
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.8000
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0467
34620	Muncie, IN Delaware County, IN	0.8633
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0226
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.8799

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	Horry County, SC	
34900	Napa, CA Napa County, CA	1.4766
34940	Naples-Marco Island, FL Collier County, FL	0.9836
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	0.9665
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2664
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1930
35300	New Haven-Milford, CT New Haven County, CT	1.1941
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	0.9257

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
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	1.3104
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9220
35980	Norwich-New London, CT New London County, CT	1.1591
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6365
36100	Ocala, FL Marion County, FL	0.8656
36140	Ocean City, NJ Cape May County, NJ	1.1691
36220	Odessa, TX Ector County, TX	0.9636
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9308
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	0.8872
36500	Olympia, WA Thurston County, WA	1.1733

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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	0.9601
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9266
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9635
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8832
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2154
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9490
37380	Palm Coast, FL Flagler County, FL	0.9115
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8502
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	0.8239
37764	Peabody, MA Essex County, MA	1.0929
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8382

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37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9191
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1165
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0555
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8060
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8825
38340	Pittsfield, MA Berkshire County, MA	1.0622
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9501
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4932
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0111
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR	1.1650

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	Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0037
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1105
39140	Prescott, AZ Yavapai County, AZ	1.0394
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	1.0877
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9540
39380	Pueblo, CO Pueblo County, CO	0.8861
39460	Punta Gorda, FL Charlotte County, FL	0.9128
39540	Racine, WI Racine County, WI	0.9208
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9984
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9761
39740	Reading, PA Berks County, PA	0.9399
39820	Redding, CA Shasta County, CA	1.3964
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0492

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9522
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1663
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8807
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1404
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8960
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0002

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
40484	Rockingham County, NH Strafford County, NH	1.0094
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9184
40660	Rome, GA Floyd County, GA	0.9289
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3802
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8850
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1162
41100	St. George, UT Washington County, UT	0.9174
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0556
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	0.9159
41420	Salem, OR Marion County, OR	1.1069

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Polk County, OR	
41500	Salinas, CA Monterey County, CA	1.5241
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9403
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9313
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8567
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9006
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1734
41780	Sandusky, OH Erie County, OH	0.9020
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5792
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5469
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6415

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.5052
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2652

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2196
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2111
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6708
42140	Santa Fe, NM Santa Fe County, NM	1.0790
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5791
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9307
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8474
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1954
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9373
43100	Sheboygan, WI Sheboygan County, WI	0.9071
43300	Sherman-Denison, TX Grayson County, TX	0.9177
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8585
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9066
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9513
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9927

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
43900	Spartanburg, SC Spartanburg County, SC	0.9178
44060	Spokane, WA Spokane County, WA	1.0738
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9256
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0581
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8567
44220	Springfield, OH Clark County, OH	0.9027
44300	State College, PA Centre County, PA	0.9089
44700	Stockton, CA San Joaquin County, CA	1.2219
44940	Sumter, SC Sumter County, SC	0.8397
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9953
45104	Tacoma, WA Pierce County, WA	1.1432
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	0.9002

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9239
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8282
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9567
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8905
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0784
46060	Tucson, AZ Pima County, AZ	0.9386
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8588
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8640
46340	Tyler, TX Smith County, TX	0.8953
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8547
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA	0.8163

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA Solano County, CA	1.4603
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8262
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0542
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	0.9035
47300	Visalia-Porterville, CA Tulare County, CA	1.0316
47380	Waco, TX McLennan County, TX	0.8742
47580	Warner Robins, GA Houston County, GA	0.9141
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0072

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
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	1.1011
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8634
48140	Wausau, WI Marathon County, WI	0.9778
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8216
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9706
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9922
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7998
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS	0.9223

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Sumner County, KS	
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8982
48700	Williamsport, PA Lycoming County, PA	0.8233
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0877
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9243
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9967
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9169
49340	Worcester, MA Worcester County, MA	1.1020
49420	Yakima, WA Yakima County, WA	1.0117
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3947
49620	York-Hanover, PA York County, PA	0.9679
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9066
49700	Yuba City, CA Sutter County, CA	1.1326

CBSA Code	Urban Area (Constituent Counties)[1]	Wage Index[2]
	Yuba County, CA	
49740	Yuma, AZ Yuma County, AZ	0.9438

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

[2]Wage index values are based on FY 2005 hospital cost report data before reclassification. These data form the basis for the pre-floor, pre-reclassified hospital wage index. The budget neutrality adjustment factor (BNAF) or the hospice floor is then applied to the pre-floor, pre-reclassified hospital wage index to derive the hospice wage index. Wage index values greater than or equal to 0.8 are subject to a BNAF. The hospice floor calculation is as follows: Wage index values below 0.8 are adjusted to be the greater of a) the 75 percent reduced BNAF OR b) the minimum of the pre-floor, pre-reclassified hospital wage index value x 1.15, or 0.8000.
For the FY 2010 hospice wage index, the BNAF was reduced by 75 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. Proposed Hospice Wage Index for Rural Areas by CBSA- FY 2010

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.8000
2	Alaska	1.2100
3	Arizona	0.8596
4	Arkansas	0.8000
5	California	1.2483
6	Colorado	0.9732
7	Connecticut	1.1203
8	Delaware	1.0131
10	Florida	0.8648
11	Georgia	0.8000
12	Hawaii	1.1186
13	Idaho	0.8000
14	Illinois	0.8528
15	Indiana	0.8617
16	Iowa	0.8953
17	Kansas	0.8189
18	Kentucky	0.8000
19	Louisiana	0.8000
20	Maine	0.8791
21	Maryland	0.9034
22	Massachusetts[1]	1.1868
23	Michigan	0.9038
24	Minnesota	0.9213
25	Mississippi	0.8000
26	Missouri	0.8117
27	Montana	0.8805
28	Nebraska	0.8878
29	Nevada	0.9541
30	New Hampshire	1.0392
31	New Jersey[2]	------
32	New Mexico	0.8961
33	New York	0.8283

CBSA Code	Nonurban Area	Wage Index
34	North Carolina	0.8721
35	North Dakota	0.8000
36	Ohio	0.8734
37	Oklahoma	0.8000
38	Oregon	1.0391
39	Pennsylvania	0.8507
40	Puerto Rico[3]	0.4654
41	Rhode Island[2]	------
42	South Carolina	0.8683
43	South Dakota	0.8749
44	Tennessee	0.8000
45	Texas	0.8028
46	Utah	0.8407
47	Vermont	1.0250
48	Virgin Islands	0.8000
49	Virginia	0.8000
50	Washington	1.0354
51	West Virginia	0.8000
52	Wisconsin	0.9532
53	Wyoming	0.9473
65	Guam	0.9774

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

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