utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revised collection; *Title of Information Collection:* Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program; *Use:* The Centers for Medicare & Medicaid Services (CMS) will conduct competitive bidding programs in which certain suppliers will be awarded contracts to provide competitively bid DMEPOS items to Medicare beneficiaries in a competitive bidding area (CBA). CMS conducted its first round of bidding in 2007 which was implemented on July 1, 2008. The first round of bidding was subsequently delayed by section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

As required by MIPPA, CMS conducted the competition for the Round 1 Rebid in 2009. The Round 1 Rebid contract and prices became effective on January 1, 2011. The Medicare Modernization Act (MMA) requires the Secretary to recompete contracts not less often than once every 3 years; therefore, CMS is preparing to recompete competitive bidding contracts in the Round 1 Rebid areas.

The 60-day **Federal Register** notice published on May 7, 2012, (77 FR 26763). Subsequently, the Application for Suppliers/Networks collection instrument has been revised by clarifying, removing and renumbering a few questions. The burden estimate has not changed. *Form Number:* CMS–10169 (OCN: 0938–1016); *Frequency:* Reporting—Occasionally; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 16,003; *Total Annual Responses:* 20,047; *Total Annual Hours:* 34,795. (For policy questions regarding this collection contact James Cowher at 410–786–1948. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on August 27, 2012.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: July 24, 2012.

Martique Jones,

Director, Regulations Development Group, Division B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2012–18346 Filed 7–26–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1434–N]

RIN 0938–AR17

Medicare Program; Hospice Wage Index for Fiscal Year 2013

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

ACTION: Notice.

SUMMARY: This notice sets forth the hospice wage index for fiscal year (FY) 2013 and will continue the phase-out of the wage index budget neutrality adjustment factor (BNAF), with an additional 15 percent BNAF reduction, for a total BNAF reduction through FY 2013 of 55 percent. The BNAF phase-out will continue with successive 15 percent reductions from FY 2014 through FY 2016. This notice clarifies that providers should report additional diagnoses on hospice claims. This notice also updates the public on the status of hospice payment reform and the quality reporting program.

DATES: This notice is effective on October 1, 2012.

FOR FURTHER INFORMATION CONTACT:

Anjana Patel, (410) 786–2120 for questions regarding hospice wage index.

Katie Lucas, (410) 786–7723 for questions regarding diagnosis reporting on claims.

Zinnia Harrison, (410) 786–4587 for questions regarding payment reform.

Robin Dowell, (410) 786–0060 for questions regarding quality reporting for hospices.

Hillary Loeffler, (410) 786–0456 for questions regarding this notice.

SUPPLEMENTARY INFORMATION:

Addenda Are Only Available Through the Internet on the CMS Web Site

In the past, the Addenda referred to throughout the preamble of our proposed and final rules or notices were available in the **Federal Register**. However, the Addenda of the annual proposed and final rules, or annual notices, will no longer be available in the **Federal Register**. Instead, these Addenda to the annual proposed and final rules or annual notices will be available only through the Internet on the CMS Web site. The Addenda to the FY 2013 Hospice Wage Index Notice are available at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.* Readers who experience any problems accessing any of the Addenda to the proposed and final rules or notices related to the hospice wage index that are posted on the CMS Web site identified above should contact Anjana Patel at 410–786–2120.

Table of Contents

I. Background

A. General

1. Hospice Care

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

Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Section 1814(i) of the Act provides payment for Medicare participating hospices.

2. Medicare Payment for Hospice Care

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

B. Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels. Our regulations at § 418.306(c) require each hospice's labor market to be established using the most current hospital wage data available, including any changes by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions. OMB revised the MSA definitions beginning in 2003 with new designations called the Core Based Statistical Areas (CBSAs). For the purposes of the hospice benefit, the term ''MSA-based'' refers to wage index values and designations based on the previous MSA designations before 2003. Conversely, the term ''CBSA-based'' refers to wage index values and designations based on the OMB revised MSA designations in 2003, which now include CBSAs. In the August 11, 2004 Inpatient Prospective Payment System (IPPS) final rule (69 FR 48916, 49026), labor market area definitions were revised and 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 Fiscal Year (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 fiscal years 2007 and beyond, we have used CBSAs exclusively to calculate wage index values.

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

In the August 8, 1997 **Federal Register** (62 FR 42860), we published a final rule implementing a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking committee. The Committee's statement was included in the appendix of that final rule (62 FR 42883).

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

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

The BNAF is calculated by computing estimated payments using the most recent, completed year of hospice claims data. The units (days or hours) from those claims are multiplied by the updated hospice payment rates to calculate estimated payments. For the FY 2012 Hospice Wage Index final rule, that meant estimating payments for FY 2012 using units (days or hours) from the FY 2010 hospice claims data, and applying the FY 2012 hospice payment rates. The FY 2012 hospice wage index values are then applied to the labor portion of the payments only. The procedure is repeated using the same units from the claims data and the same payment rates, but using the 1983 Bureau of Labor Statistics (BLS)-based wage index instead of the updated raw pre-floor, pre-reclassified hospital wage index (note that both wage indices include their respective floor adjustments). The total payments are then compared, and the adjustment required to make total payments equal is computed; that adjustment factor is the BNAF.

The FY 2010 Hospice Wage Index final rule (74 FR 39384) finalized a provision for a 7-year phase-out of the BNAF, which is applied to the wage index values. The BNAF was reduced by 10 percent in FY 2010, an additional 15 percent in FY 2011 and by an additional 15 percent again in FY 2012, for a total reduction of 40 percent to date, and will be reduced by an additional 15 percent in each of the next 4 years, for complete phase out in 2016.

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

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

Pre-floor, pre-reclassified hospital wage index values of 0.8 or greater are currently adjusted by a reduced BNAF; however, adjusting a wage index value by a reduced BNAF still results in an increase in the wage index value. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by either: (1) The hospice BNAF, reduced by a total of 40 percent for FY 2012; or (2) the hospice floor (which is a 15 percent increase) subject to a maximum wage index value of 0.8; whichever results in the greater value. Once the BNAF is completely phased out, the hospice floor adjustment will simply consist of increasing any wage index value less than 0.8 by 15 percent, subject to a maximum wage index value of 0.8.

For example, if in FY 2012, County A had a pre-floor, pre-reclassified hospital wage index (raw wage index) value of 0.3994, we would perform the following calculations using the budget-neutrality factor (which for this example is an unreduced BNAF of 0.058593, less 40 percent, or 0.035156) 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 40 percent reduced BNAF: ($0.3994 \times 1.035156 = 0.4134$)

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

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

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

2. Definition of Rural and Urban Areas

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

When the raw pre-floor, pre-reclassified hospital wage index was adopted for use in deriving the hospice wage index, it was decided not to take into account Inpatient Prospective Payment System (IPPS) geographic reclassifications. This policy of following OMB designations of rural or urban, rather than considering some Counties to be ''deemed'' urban, is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the hospice wage index.

3. Areas Without Hospital Wage Data

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data on which to base the calculation of the hospice wage index. Beginning in FY 2006, we adopted a policy to use the FY 2005 pre-floor, pre-reclassified hospital wage index value for rural areas when no hospital wage data were available. We also adopted the policy that for urban labor markets without a hospital from which a hospital wage index data could be derived, all of the CBSAs within the State would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. Consequently, in subsequent fiscal years, we applied the average pre-floor, pre-reclassified hospital wage index data from all urban areas in that State, to urban areas without a hospital. In FY 2012, the only CBSA was 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2008 final rule (72 FR 50214, 50217), we considered alternatives to our methodology to update the pre-floor, pre-reclassified hospital wage index for rural areas without hospital wage data. We indicated that we believed that the best imputed proxy for rural areas, would: (1) Use pre-floor, pre-reclassified hospital data; (2) use the most local data available to impute a rural pre-floor, pre-reclassified hospital wage index; (3) be easy to evaluate; and, 4) be easy to update from year to year.

Therefore, in FY 2008 through FY 2012, in cases where there was a rural area without rural hospital wage data, we used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. This approach does not use rural data; however, the approach, which uses pre-floor, pre-reclassified hospital wage data, is easy to evaluate, is easy to update from year to year, and uses the most local data available. In the FY 2008 rule (72 FR at 50217), we noted that in determining an imputed rural pre-floor, pre-reclassified hospital wage index, we interpret the term ''contiguous'' to mean sharing a border. For example, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket counties. We determined that the borders of Dukes and Nantucket counties are contiguous with Barnstable and Bristol counties. Under the adopted methodology, the pre-floor, pre-reclassified hospital wage index values for the counties of Barnstable (CBSA 12700, Barnstable Town, MA) and Bristol (CBSA 39300, Providence-New Bedford-Fall River, RI-MA) would be averaged resulting in an imputed pre-floor, pre-reclassified rural hospital wage index for FY 2008. We noted in the FY 2008 final hospice wage index rule that while we believe that this policy could be readily applied to other rural areas that lack hospital wage data (possibly due to hospitals converting to a different provider type, such as a Critical Access Hospital, that does not submit the appropriate wage data), if a similar situation arose in the future, we would re-examine this policy.

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

on the pre-floor, pre-reclassified hospital wage index (or indices) of CBSAs contiguous to the rural area in question does not recognize the unique circumstances of Puerto Rico. While we have not yet identified an alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico, we will continue to evaluate the feasibility of using existing hospital wage data and, possibly, wage data from other sources. For FY 2008 through FY 2012, we have used the most recent pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047.

4. CBSA Nomenclature Changes

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

5. 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 more information regarding this section, please refer to 76 FR 47305 (''Hospice Wage Index for FY 2012'', August 4, 2011).

For FY 2012, the data collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2007 were used to compute the 2011 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 2011 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 2007) were the most recent complete cost data.

Beginning in FY 2008, the IPPS apportioned the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses were located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). We are continuing to use the raw pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the use of raw pre-floor, pre-reclassified hospital (IPPS) wage data used to derive the FY 2012 hospice wage index values reflects the application of our policy to use those data to establish the hospice wage index. The FY 2013 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, in FY 2009 and subsequent fiscal years, hospice wage index values for the following CBSAs have been affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI–MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974), and Lake County-Kenosha County, IL–WI (CBSA 29404).

6. Hospice Payment Rates

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the market basket index, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent fiscal years will be the market basket percentage for the fiscal year. It has been longstanding practice to use the inpatient hospital market basket as a proxy for a hospice market basket.

Historically, the rate update has been published through a separate administrative instruction issued annually in the summer to provide adequate time to implement system change requirements. Hospices determine their payments by applying the hospice wage index set forth in this Notice to the labor portion of the published hospice rates. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity, as set out at section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act). Congress also required in section 1814(i)(5)(A) through (C) of the Act that hospices begin submitting quality data, based on measures to be specified by the Secretary, for FY 2014 and subsequent fiscal years. Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by 2 percentage points.

II. Provisions of Notice

A. FY 2013 Hospice Wage Index

1. Background

As previously noted, the hospice final rule published in the **Federal Register** on December 16, 1983 (48 FR 56008) provided for adjustment to hospice payment rates to reflect differences in area wage levels. We apply the appropriate hospice wage index value to the labor portion of the hospice payment rates based on the geographic area where hospice care was furnished. Each hospice's labor market area is based on definitions of MSAs issued by the OMB. In this notice, we are using the pre-floor, pre-reclassified hospital wage index, based solely on the CBSA designations, as the basis for determining wage index values for the FY 2013 hospice wage index. The updated hospice wage index was previously published in the **Federal Register**; for FY 2013 and subsequent years, the updated hospice wage index is posted to the CMS Web site shortly after the associated rule or notice is published. The hospice wage index is based on the most currently available hospital wage data.

As noted above, our hospice payment rules utilize the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. In this notice, we are again using the pre-floor and pre-reclassified hospital wage index

data as the basis to determine the hospice wage index, which is then used to adjust the labor portion of the hospice payment rates based on the geographic area where the beneficiary receives hospice care. We believe the use of the pre-floor, pre-reclassified hospital wage index data, as a basis for the hospice wage index, results in the appropriate adjustment to the labor portion of the costs. For the FY 2013 update to the hospice wage index, we are continuing to use the most recent pre-floor, pre-reclassified hospital wage index available at the time of publication.

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 notice. Currently, the only CBSA that is affected by this policy is CBSA 25980, Hinesville-Fort Stewart, Georgia. We continue to apply this policy for FY 2013 notice.

Currently, the only rural areas where there are no hospitals from which to calculate a pre-floor, pre-reclassified hospital wage index are in Puerto Rico. In previous years, Massachusetts had a rural area where there were no hospitals from which to calculate a pre-floor, pre-reclassified hospital wage index. This area of Massachusetts now has an IPPS hospital with wage data for computing the FY 2012 rural Massachusetts hospital wage index. The hospital was formerly a Critical Access Hospital, but converted to an IPPS hospital in FY 2008, the base year for the FY 2012 hospital wage index.

As described in section I.B.4 of this notice, for FY 2013, we 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 is then adjusted upward by the hospice 15 percent floor adjustment in the computing of the FY 2013 hospice wage index.

3. FY 2013 Wage Index With an Additional 15 Percent Reduced Budget Neutrality Adjustment Factor (BNAF)

The hospice wage index set forth in this notice will be effective October 1, 2012 through September 30, 2013. We are not finalizing any modifications to the hospice wage index methodology. For this notice, the FY 2012 hospital wage index was the most current hospital wage data available for calculating the FY 2013 hospice wage index values. We used the FY 2012 pre-floor, pre-reclassified hospital wage index data for this calculation.

As noted above, for this FY 2013 wage index notice, the hospice wage index values are based solely on the adoption of the CBSA-based labor market definitions and the hospital wage index. We continue to use the most recent pre-floor and pre-reclassified hospital wage index data available (based on FY 2008 hospital cost report wage data). A detailed description of the methodology used to compute the hospice wage index is contained in the September 4, 1996 hospice wage index proposed rule (61 FR 46579), the August 8, 1997 hospice wage index final rule (62 FR 42860), and the August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384).

The August 6, 2009 FY 2010 Hospice Wage Index final rule finalized a provision to phase out the BNAF over seven years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in each of the next six years, with complete phase out in FY 2016. Therefore, in accordance with the August 6, 2009 FY 2010 Hospice Wage Index final rule, the BNAF for FY 2013 was reduced by an additional 15 percent for a total BNAF reduction of 55 percent (10 percent from FY 2010, an additional 15 percent from FY 2011, an additional 15 percent for FY 2012, and an additional 15 percent in FY 2013).

The unreduced BNAF for FY 2013 is 0.060438 (or 6.0438 percent). A 55 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 0.027197 (or 2.7197 percent). Pre-floor, pre-reclassified hospital wage index values which are less than 0.8 are subject to the hospice floor calculation; that calculation is described in section I.B.1. The BNAF is updated based on availability of more complete data.

The addenda with the wage index values for rural and urban areas will not be published in the **Federal Register**. The wage index values for rural areas and urban areas are available via the Internet at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.*

The final hospice wage index for FY 2013 includes the BNAF reduction.

4. Effects of Phasing Out the BNAF

The full (unreduced) BNAF calculated for the FY 2013 notice is 6.0438 percent. As implemented in the August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384), for FY 2013, we are reducing the BNAF by an additional 15 percent, for a total BNAF reduction of 55 percent (a 10 percent reduction in FY 2010, plus a 15 percent reduction in FY 2011, plus a 15 percent reduction in FY 2012, plus a 15 percent reduction in FY 2013), with additional reductions of 15 percent per year in each of the next 3 years until the BNAF is phased out in FY 2016.

For FY 2013, this is mathematically equivalent to taking 45 percent of the full BNAF value, or multiplying 0.060438 by 0.45, which equals 0.027197 (2.7197 percent). The BNAF of 2.7197 percent reflects a 55 percent reduction in the BNAF. The 55 percent reduced BNAF (2.7197 percent) was applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater in the final FY 2013 hospice wage index.

The hospice floor calculation still applies to any pre-floor, pre-reclassified hospital wage index values less than 0.8. The hospice floor calculation is described in section I.B.1 of this notice. We examined the effects of an additional 15 percent reduction in the BNAF, for a total BNAF reduction of 55 percent, on the final FY 2013 hospice wage index compared to the total 40 percent reduced BNAF which was used for the FY 2012 hospice wage index. The additional 15 percent BNAF reduction applied to the final FY 2013 wage index resulted in a (rounded) 0.9 percent reduction in wage index values in 92.8 percent of CBSAs, and no reduction in wage index values in 7.2 percent of CBSAs. We note that these are reductions in wage index values, not in payments. See Table 1 in section V of this notice for the effects on payments. The wage index values are located at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html,* and they already reflect the additional 15 percent BNAF reduction.

Those CBSAs whose pre-floor, pre-reclassified hospital wage index values had the hospice 15 percent floor adjustment applied before the BNAF reduction will not be affected by this ongoing phase out of the BNAF. These CBSAs, which typically include rural areas, are protected by the hospice 15 percent floor adjustment. We estimate that 32 CBSAs are already protected by the hospice 15 percent floor adjustment, and are therefore completely unaffected by the BNAF reduction. There are 332 hospices in these 32 CBSAs.

Additionally, for some CBSAs with pre-floor, pre-reclassified wage index values less than 0.8, it will now be more advantageous to apply the hospice 15 percent floor adjustment rather than the BNAF adjustment, as a result of the additional 15 percent reduction in the

BNAF applied in FY 2013. Areas where the hospice floor calculation would have yielded a wage index value greater than 0.8 if the 40 percent reduction in BNAF were maintained, but which will have a final wage index value less than 0.8 after the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 55 percent) is applied, will now be eligible for the hospice floor adjustment. These CBSAs may see a smaller reduction in their hospice wage index values if the hospice 15 percent floor adjustment is applied. We estimate that 4 CBSAs will have their pre-floor, pre-reclassified hospital wage index value become newly protected by the hospice 15 percent floor adjustment due to the additional 15 percent reduction in the BNAF applied in the final FY 2013 hospice wage index. Because of the protection given by the hospice 15 percent floor adjustment, these CBSAs will usually 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 57 hospices located in these 4 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 notice. Therefore, the projected reduction in payments due solely to the additional 15 percent reduction of the BNAF applied in FY 2013 is estimated to be 0.60 percent, as calculated from the difference in column 3 and column 4 of Table 1 in section V of this notice. In addition, the estimated effects of the phase-out of the BNAF will be mitigated by any inpatient hospital market basket updates in payments. The final market basket update applicable to hospice payments for FY 2013 is 1.6 percent. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act). This final 1.6 percent market basket update for FY 2013 is based on a 2.6 percent inpatient hospital market basket percentage increase (based on IHS Global Insight, Inc's second quarter 2012 forecast with historical data through the first quarter of 2012), less a 0.7 percentage point productivity adjustment and a 0.3 percentage point reduction. The final FY 2013 hospice market basket update is communicated through an administrative instruction.

The combined estimated effects of the updated wage data, an additional 15 percent reduction of the BNAF, and the market basket update are shown in Table 1 in section V of this notice. The updated wage data are estimated to decrease payments by 0.1 percent (column 3 of Table 1). The additional 15 percent reduction in the BNAF, which has already been applied to the wage index values in this notice, is estimated to reduce payments by 0.6 percent. Therefore, the changes in the wage data and the additional 15 percent BNAF reduction reduce estimated hospice payments by 0.7 percent, when compared to FY 2012 payments (column 4 of Table 1). However, so that hospices can fully understand the total estimated effects on their revenue, we have also accounted for the 1.6 percent market basket update for FY 2013. The net effect of that 1.6 percent increase and the 0.7 percent reduction due to the updated wage data and the additional 15 percent BNAF reduction, is an estimated increase in payments to hospices in FY 2013 of 0.9 percent (column 5 of Table 1).

B. Clarification Regarding Diagnosis Reporting on Hospice Claims

Recent analyses by Abt Associates, our hospice contractor, showed that 77.2 percent of hospice claims from 2010 only report a principal diagnosis. However, by definition, hospice patients are at the end-of-life; most are elderly and likely have multiple co-morbidities. Therefore, we believe that hospice claims which only report a principal diagnosis are not providing an accurate description of the patients' conditions. Providers should code and report coexisting or additional diagnoses to more fully describe the Medicare patients they are treating.

The *ICD–9–CM Official Guidelines for Coding and Reporting* (*ICD–9–CM Coding Guidelines*) require reporting of all additional or co-existing diagnoses. These *ICD–9–CM Coding Guidelines* are provided by CMS and the Centers for Disease Control's (CDC's) National Center for Health Statistics (NCHS) to health care providers. The current *ICD–9–CM Coding Guidelines* use the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) and are available through the CMS Web site at: *http://www.cms.gov/ICD9ProviderDiagnosticCodes/or* on the CDC's Web site at *http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf.* As noted in the *ICD–9–CM Coding Guidelines,* ''These coding and reporting guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD–9–CM itself. * * * Adherence to these guidelines when assigning ICD–9–CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).''

In addition, at 45 CFR 162.1002, the Secretary adopted the ICD–9–CM code set, including *The Official ICD–9–CM Guidelines for Coding and Reporting* and CMS' Hospice Claims Processing manual requires that hospice claims include other diagnoses ''as required by ICD–9–CM Coding Guidelines'' (IOM 100–04, chapter 11, section 30.1, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf*). As such, HIPAA, federal regulations, and the Medicare hospice claims processing manual all require that these *ICD–9–CM Coding Guidelines* be applied to the coding and reporting of diagnoses on hospice claims.

Finally, CMS is in the early stages of hospice payment reform; as noted in the Payment Reform Update in section II.C of this notice, we are considering multiple approaches to reform, including case-mix adjustment. To adequately account for any clinical complexities a given patient might have as a result of related co-morbidities, those co-morbidities must be included on the Medicare hospice claim. While some hospice providers are reporting additional or co-existing diagnoses on claims, a majority are not. As such, the current claims data do not allow us to appropriately analyze whether a case-mix adjustment would or would not be a reasonable approach to, or part of, payment reform.

ICD–9–CM Coding Clinic is the official publication for the *ICD–9–CM Coding Guidelines.* The Coding Clinic recognizes there can be discrepancies between the *ICD–9–CM Coding Guidelines* or Coding Clinic advice, and payer coding policies. The Coding Clinic's goal is to provide advice according to the most accurate and correct coding consistent with ICD–9–CM principles. However, payers have additional goals, including those related to responsible fiscal management. The Coding Clinic noted that it is not

possible to write coding guidelines that are consistent with all payer guidelines. The Coding Clinics wrote that ''there are a variety of payment policies that may impact on coding. Many of those payment policies * * * may be inconsistent with ICD–9–CM rules/ conventions.'' (''*Coding Clinic for ICD–9–CM'',* Volume 17, Number 3, Third Quarter 2000, pp 13–14). In the Medicare hospice benefit, coexisting or additional diagnoses could be related or unrelated to the hospice patient's terminal illness. The Medicare hospice benefit only covers and pays for hospices to provide palliation and management of the patient's terminal illness and related conditions. Therefore, to meet payment policy goals, we are clarifying for hospices that they should report on hospice claims all coexisting or additional diagnoses that are related to the terminal illness; they should not report coexisting or additional diagnoses that are unrelated to the terminal illness. Hospice patients receive care in both outpatient and non-outpatient settings.

The *ICD–9–CM Coding Guidelines* use different terminology to refer to coexisting or additional diagnoses, depending on whether a patient is in an outpatient or non-outpatient setting. In a non-outpatient setting, these co-morbidities are referred to as other or additional diagnoses. In an outpatient setting, they are referred to as coexisting diagnoses. These terms are explained more fully in sections III and IV of the *ICD–9–CM Coding Guidelines.*

Section III of the *ICD–9–CM Coding Guidelines* addresses non-outpatient settings, and states that ''For reporting purposes the definition for ''other diagnoses'' is interpreted as additional conditions that affect patient care in terms of requiring: Clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.'' Using the Uniform Hospital Discharge Data Set (UHDDS) definitions, ''Other Diagnoses'' are defined as ''all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.'' While UHDDS definitions initially applied to hospitals, the *ICD–9–CM Coding Guidelines* note that their application has been extended to all non-outpatient settings, which includes hospice inpatient units and nursing facilities.

Section IV.K of the *ICD–9–CM Coding Guidelines* addresses outpatient settings, and instructs providers to ''Code all documented conditions that coexist at the time of the encounter/ visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist.''

We do not believe that requiring reporting of coexisting or additional diagnoses that are related to the terminal illness would create a burden for hospices; some providers already report these diagnoses on their claims. Information about related and unrelated diagnoses should already be included as part of the plan of care, and determined by the hospice interdisciplinary group (IDG). The hospice conditions of participation (CoPs) at § 418.54(c)(2) require that the comprehensive assessment include ''complications and risk factors that affect care planning''. The CoPs at § 418.56(e)(4) require that the hospice IDG ''provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.'' The existing standard practice for hospices is to include the related and unrelated diagnoses on the patient's plan of care in order to assure coordinated, holistic patient care and to monitor the effectiveness of the care that is delivered.

We are clarifying that all of a patient's coexisting or additional diagnoses s should be reported on the hospice claim. We note that doing so will bring hospices into compliance with existing, longstanding policy, and will provide data needed for hospice payment reform. Hospices should not report diagnoses which are unrelated to the terminal illness on their claims. Hospice claims currently include a field for the patient's principal diagnosis, but allow for up to 17 additional diagnoses to be included on a paper UB–04 claim, or up to 24 additional diagnoses on the 837I 5010 electronic claim.

C. Update on Hospice Payment Reform

Section 1814(i)(6) of the Act was amended by section 3132(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively known as the Affordable Care Act). The amendment authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and for other purposes. The types of data and information described in the Act would capture resource utilization, which can be collected on claims, cost reports, and possibly other mechanisms as we determine to be appropriate. The data collected may be used to revise the methodology for determining the payment rates for routine home care and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, we are required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

According to the MedPAC March 2012 ''Report to Congress: Medicare Payment Policy'' (available at *http://medpac.gov/chapters/Mar12_Ch11.pdf*), Medicare expenditures for hospice services exceeded $13 billion in 2010, and the aggregate Medicare margin in 2009 was 7.1 percent. In addition, MedPAC found 53 percent growth in the number of hospices from 2000 to 2010, of which a majority were for-profit hospices. MedPAC also noted a change in patient case-mix from predominantly cancer diagnoses to non-cancer diagnoses. The growth in Medicare expenditures, margins, number of new hospices, and the change in patient case-mix has brought attention to changes in the hospice industry.

Over the past several years, MedPAC, the Government Accountability Office, and the HHS Office of Inspector General (OIG) all recommended that we collect more comprehensive data in order to better understand the utilization of the Medicare hospice benefit. MedPAC has also suggested an alternative payment model that it believes will address the vulnerabilities in the current payment system. As part of our research, we will investigate the MedPAC, OIG, and GAO recommendations as well as other payment options.

We are moving forward with the hospice payment reform research. Our contractor, Abt Associates, completed an environmental scan; a draft analytic plan; and convened technical advisory panel meetings under the initial contract. They will continue, under a contract awarded in September 2011, to review the most current peer-reviewed literature; to convene additional stakeholder meetings; to conduct further research and analyses based on the analytic plan; to identify potential data collection needs; and to research and develop hospice payment model options. In order to determine how to best revise the hospice payment methodology, we will consult with hospice programs and MedPAC. We will continue to collaborate with the HHS Office of the Assistant Secretary of Planning and Evaluation (ASPE) along

with other federal experts regarding hospice payment reform research efforts and update stakeholders on our progress.

D. Update on the Hospice Quality Reporting Program

In last year's Hospice Wage Index final rule (76 FR 47302, 47318, August 4, 2011), we finalized a hospice Quality Reporting Program (QRP) as required by section 3004 of the Affordable Care Act. The quality measures adopted for the hospice program for FY 2014 include a measure related to pain management and a measure that assesses whether a hospice participates in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three indicators related to patient care. Hospices are required to begin collecting quality data in October 2012, and will submit that quality data in 2013. Hospices failing to report quality data in 2013 will have their market basket update reduced by 2 percentage points in FY 2014. We note that these requirements are not changing.

We have proposed quality data reporting requirements for FY 2015 and thereafter. However, we did not publish the proposal in this notice. Please see the Home Health Prospective Payment System Rate Update for Calendar Year 2013 proposed rule for a detailed discussion on our proposal for the hospice quality data reporting requirements affecting payments in FY 2015 and each subsequent year.

Please follow the instructions in the Home Health Prospective Payment System Rate Update for Calendar Year 2013 proposed rule (CMS–1358–P) to comment on the hospice proposals described in that proposed rule. We will respond to those comments in the Home Health Prospective Payment System Rate Update for Calendar Year 2013 final rule.

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and we incorporate a statement of finding and its reasons in the notice. We find it is unnecessary to undertake notice and comment rulemaking for the update in this notice because the update does not make any substantive changes in policy, but merely reflects the application of previously established methodologies which permit no discretion on the part of the Secretary. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

IV. Collection of Information Requirements

This document does not impose information collection requirements as defined by the Paperwork Reduction Act of 1995.

V. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This notice has been designated an ''economically'' significant notice, under section 3(f)(1) of EO 12866. We have prepared a regulatory impact analysis that to the best of our ability presents the costs and benefits of this notice.

2. Statement of Need

This notice follows 42 CFR 418.306(c) which requires annual issuance, in the **Federal Register**, of the hospice wage index based on the most currently available CMS hospital wage data, including any changes to the definitions of MSAs or CBSAs. In addition, this notice clarifies for hospice providers that they must include all related diagnoses on hospice claims. Finally, this notice updates the public on the status of hospice payment reform and the hospice quality reporting program.

3. Overall Impacts

The overall impact of this notice is an estimated net decrease in Federal payments to hospices of $100 million for FY 2013. We estimated the impact on hospices, as a result of the changes to the FY 2013 hospice wage index and of reducing the BNAF by an additional 15 percent, for a total BNAF reduction of 55 percent (10 percent in FY 2010, 15 percent in FY 2011, 15 percent in FY 2012, and 15 percent in FY 2013). The BNAF reduction is part of a 7-year BNAF phase-out that was finalized in previous rulemaking (74 FR 39384 (August 6, 2009)), and is not a policy change.

As discussed previously, the methodology for computing the hospice wage index was determined through a negotiated rulemaking committee and promulgated in the August 8, 1997 hospice wage index final rule (62 FR 42860). The BNAF, which was promulgated in the August 8, 1997 rule, is being phased out. This notice updates the hospice wage index in accordance with the 2010 Hospice Wage Index final rule, which finalized a 10 percent reduced BNAF for FY 2010 as the first year of a 7-year phase-out of the BNAF, to be followed by an additional 15 percent per year reduction in the BNAF in each of the next 6 years. The total phase-out will be complete by FY 2016.

4. Detailed Economic Analysis

Column 4 of Table 1 shows the combined effects of the updated wage data (the 2012 pre-floor, pre-reclassified hospital wage index) and of the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 55 percent), comparing estimated payments for FY 2012 to estimated payments for FY 2013. The FY 2012 payments used for comparison have a 40 percent reduced BNAF applied. We estimate that the total hospice payments for FY 2013 will decrease by $100 million as a result of the application of the updated wage data ($ − 10 million) and the additional 15 percent reduction in the BNAF ($ − 90 million). This estimate does not take into account the market basket update communicated separately through an administrative instruction, which after adjustments is 1.6 percent for FY 2013. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as mandated by the Affordable Care Act and set out at section

1886(b)(3)(B)(xi)(II) of the Act. In addition, in FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point as mandated by the Affordable Care Act (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act). This 1.6 percent market basket update is based on a 2.6 percent inpatient hospital market basket percentage increase for FY 2013 reduced by 0.7 percentage point for the productivity adjustment and by 0.3 percentage point as mandated by the Affordable Care Act. The final FY 2013 hospice update and associated payment rates are communicated through an administrative instruction in the summer. The estimated effect of the 1.6 percent market basket update on payments to hospices is approximately $240 million. Taking into account the 1.6 percent market basket update (+$240 million), in addition to the updated wage data ($− 10 million), and the additional 15 percent reduction in the BNAF ($− 90 million), it is estimated that hospice payments would increase by $140 million in FY 2013 ($240 million − $10 million − $90 million = $140 million). The percent change in estimated payments to hospices due to the combined effects of the updated wage data, the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 55 percent), and the market basket update of 1.6 percent is reflected in column 5 of the impact table (Table 1).

a. Effects on Hospices

This section discusses the impact of the projected effects of the hospice wage index, including the effects of a 1.6 percent market basket update for FY 2013 that is communicated separately through an administrative instruction. This notice continues to use the CBSA-based pre-floor, pre-reclassified hospital wage index as a basis for the hospice wage index and continues to use the same policies for treatment of areas (rural and urban) without hospital wage data. The final FY 2013 hospice wage index is based upon the 2012 pre-floor, pre-reclassified hospital wage index and the most complete claims data available (FY 2011) with an additional 15 percent reduction in the BNAF (combined with the 10 percent reduction in the BNAF taken in FY 2010, an additional 15 percent taken in 2011, an additional 15 percent in 2012, and an additional 15 percent taken in 2013 for a total BNAF reduction of 55 percent in FY 2013). The BNAF reduction is part of a 7-year BNAF phase-out that was finalized in previous rulemaking, and is not a policy change.

For the purposes of our impacts, our baseline is estimated FY 2012 payments with a 40 percent BNAF reduction, using the 2010 pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3 of Table 1) compares our baseline to estimated FY 2013 payments (holding payment rates constant) using the updated wage data (2012 pre-floor, pre-reclassified hospital wage index). Consequently, the estimated effects illustrated in column 3 of Table 1 show the distributional effects of the updated wage data only. The effects of using the updated wage data combined with the additional 15 percent reduction in the BNAF are illustrated in column 4 of Table 1.

We have included a comparison of the combined effects of the additional 15 percent BNAF reduction, the updated wage data, and a 1.6 percent market basket update for FY 2013 (Table 1, column 5). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue based on changes to the hospice wage index and the BNAF phase-out as discussed in this Notice, and the FY 2013 market basket update which will be communicated separately through an administrative instruction. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BUDGET NEUTRALITY ADJUSTMENT FACTOR (BNAF) BY AN ADDITIONAL 15 PERCENT (FOR A TOTAL BNAF REDUCTION OF 55 PERCENT) AND APPLYING A 1.6 PERCENT† MARKET BASKET UPDATE TO THE FY 2013 HOSPICE WAGE INDEX, COMPARED TO THE FY 2012 HOSPICE WAGE INDEX WITH A 40 PERCENT BNAF REDUCTION

	Number of hospices	Number of routine home care days in thousands	Percent change in hospice payments due to FY2013 wage index change	Percent change in hospice payments due to wage index change, additional 15% reduction in budget neutrality adjustment	Percent change in hospice payments due to wage index change, additional 15% reduction in budget neutrality adjustment and market basket update
	(1)	(2)	(3)	(4)	(5)
ALL HOSPICES	3,659	83,400	(0.1)	(0.7)	0.9
URBAN HOSPICES	2,598	72,885	(0.1)	(0.7)	0.9
RURAL HOSPICES	1,061	10,515	(0.0)	(0.4)	1.2
BY REGION—URBAN:					
NEW ENGLAND	138	2,750	0.2	(0.4)	1.2
MIDDLE ATLANTIC	256	7,872	0.2	(0.4)	1.2
SOUTH ATLANTIC	378	16,417	(0.4)	(1.0)	0.6
EAST NORTH CENTRAL	346	10,946	(0.5)	(1.1)	0.5
EAST SOUTH CENTRAL	178	4,614	(0.5)	(1.0)	0.5
WEST NORTH CENTRAL	192	4,592	0.3	(0.3)	1.3

TABLE 1—ANTICIPATED IMPACT ON MEDICARE HOSPICE PAYMENTS OF UPDATING THE PRE-FLOOR, PRE-RECLASSIFIED HOSPITAL WAGE INDEX DATA, REDUCING THE BUDGET NEUTRALITY ADJUSTMENT FACTOR (BNAF) BY AN ADDITIONAL 15 PERCENT (FOR A TOTAL BNAF REDUCTION OF 55 PERCENT) AND APPLYING A 1.6 PERCENT† MARKET BASKET UPDATE TO THE FY 2013 HOSPICE WAGE INDEX, COMPARED TO THE FY 2012 HOSPICE WAGE INDEX WITH A 40 PERCENT BNAF REDUCTION—Continued

	Number of hospices	Number of routine home care days in thousands	Percent change in hospice payments due to FY2013 wage index change	Percent change in hospice payments due to wage index change, additional 15% reduction in budget neutrality adjustment	Percent change in hospice payments due to wage index change, additional 15% reduction in budget neutrality adjustment and market basket update
	(1)	(2)	(3)	(4)	(5)
WEST SOUTH CENTRAL	506	9,530	0.4	(0.2)	1.4
MOUNTAIN	251	6,081	(0.1)	(0.7)	0.9
PACIFIC	316	8,667	0.2	(0.4)	1.2
OUTLYING	37	1,415	0.2	0.2	1.8
BY REGION—RURAL:					
NEW ENGLAND	27	219	0.8	0.2	1.8
MIDDLE ATLANTIC	45	534	(0.2)	(0.7)	0.8
SOUTH ATLANTIC	140	2,327	(0.2)	(0.6)	1.0
EAST NORTH CENTRAL	147	1,732	(0.6)	(1.2)	0.4
EAST SOUTH CENTRAL	154	1,812	(0.1)	(0.2)	1.4
WEST NORTH CENTRAL	196	1,131	0.3	(0.1)	1.5
WEST SOUTH CENTRAL	190	1,576	0.4	(0.1)	1.5
MOUNTAIN	109	681	0.1	(0.4)	1.2
PACIFIC	52	490	1.4	0.7	2.3
OUTLYING	1	14	0.0	0.0	1.6
BY SIZE/DAYS:					
0–3499 DAYS (small)	681	1,185	0.1	(0.4)	1.2
3500–19,999 DAYS (medium)	1784	18,086	0.1	(0.5)	1.1
20,000+ DAYS (large)	1194	64,129	(0.1)	(0.7)	0.9
TYPE OF OWNERSHIP:					
VOLUNTARY	1141	31,433	(0.1)	(0.7)	0.9
PROPRIETARY	1999	43,637	(0.1)	(0.6)	1.0
GOVERNMENT	519	8,330	(0.0)	(0.6)	1.0
HOSPICE BASE:					
FREESTANDING	2586	67,320	(0.1)	(0.7)	0.9
HOME HEALTH AGENCY	557	9,935	(0.1)	(0.7)	0.9
HOSPITAL	498	5,970	0.0	(0.5)	1.0
SKILLED NURSING FACILITY	18	176	(0.2)	(0.9)	0.7

BNAF = Budget Neutrality Adjustment Factor.

Comparison is to FY 2012 data with a 40 percent BNAF reduction.

* Provider data as of December 31, 2011 for hospices with claims filed in FY 2011.

† The 1.6 percent final market basket update for FY 2013 is based on a 2.6 percent inpatient hospital market basket percentage increase, reduced by a 0.7 percentage point productivity adjustment and by 0.3 percentage point. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act).

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

Table 1 shows the results of our analysis. In column 1, we indicate the number of hospices included in our analysis as of December 31, 2011 which had also filed claims in FY 2011. In column 2, we indicate the number of routine home care days that were included in our analysis, although the analysis was performed on all types of hospice care. Columns 3, 4, and 5 compare FY 2012 estimated payments with those estimated for FY 2013. The estimated FY 2012 payments incorporate a BNAF which has been reduced by 40 percent. Column 3 shows the percentage change in estimated Medicare payments for FY 2013 due to the effects of the updated wage data only, compared with estimated FY 2012 payments. The effect of the updated wage data can vary from region to region depending on the fluctuations in the wage index values of the pre-floor, pre-reclassified hospital wage index.

Column 4 shows the percentage change in estimated hospice payments from FY 2012 to FY 2013 due to the combined effects of using the updated wage data and reducing the BNAF by an additional 15 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2012 to FY 2013 due to the combined effects of using updated wage data, an additional 15 percent BNAF reduction, and the final 1.6 percent 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 2,598 hospices located in urban areas and 1,061 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 2011. 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 3,659 hospices. Approximately 45.4 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 84 percent of hospice patients in 2010 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 index as well as the most complete claims data available (FY 2011) in developing the impact analysis. The FY 2013 payment rates will be adjusted to reflect the inpatient hospital market basket percentage increase, less a productivity adjustment of 0.7 percentage point and a reduction of 0.3 percentage point, both mandated by the Affordable Care Act. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity in accordance with section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act). As previously noted, we publish these rates through administrative instructions rather than in a notice. The final FY 2013 market basket update is 1.6 percent which is based on an inpatient hospital market basket percentage increase of 2.6 percent less the FY 2013 productivity adjustment of 0.7 percentage point and less 0.3 percentage point. Since the inclusion of the effect of a market basket update provides a more complete picture of projected total hospice payments for FY 2013, the last column of Table 1 shows the combined impacts of the updated wage data, the additional 15 percent BNAF reduction, and the 1.6 percent market basket update. As discussed in the FY 2006 hospice wage index final rule (70 FR 45130, 45133, August 5, 2005), hospice agencies may use multiple hospice wage index values to compute their payments based on potentially different geographic locations.

Before January 1, 2008, the location of the beneficiary was used to determine the CBSA for routine and continuous home care, and the location of the hospice agency was used to determine the CBSA for respite and general inpatient care. Beginning January 1, 2008, the hospice wage index CBSA utilized is based on the location of the site of service. As the location of the beneficiary's home and the location of the hospice may vary, there will still be variability in geographic location for an individual hospice. We anticipate that the CBSA of the various sites of service will usually correspond with the CBSA of the geographic location of the hospice, and thus we will continue to use the location of the hospice for our analyses of the impact of the changes to the hospice wage index in this Notice. 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. When considering hospice ownership, a majority are proprietary (for-profit), with 1,660 designated as non-profit or government hospices and 1,999 as proprietary. The vast majority of hospices are freestanding.

b. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care. The majority of the days provided by a hospice are routine home care (RHC) days, representing about 97 percent of the services provided by a hospice. Therefore, the number of RHC days can be used as a proxy for the size of the hospice, that is, the more days of care provided, the larger the hospice. As discussed in the August 4, 2005 final rule, we currently use three size designations to present the impact analyses. The three categories are—(1) small agencies having 0 to 3,499 RHC days; (2) medium agencies having 3,500 to 19,999 RHC days; and (3) large agencies having 20,000 or more RHC days. The FY 2013 updated wage data without any BNAF reduction are anticipated to decrease payments to large hospices by 0.1 percent and increase payments to small and medium hospices by 0.1 percent (column 3). The updated wage data and the additional 15 percent BNAF reduction (for a total BNAF reduction of 55 percent) are anticipated to decrease estimated payments to small hospices by 0.4 percent, to medium hospices by 0.5 percent, and to large hospices by 0.7 percent (column 4). Finally, the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 55 percent), and the final 1.6 percent market basket update are projected to increase estimated payments by 1.2 percent for small hospices, by 1.1 percent for medium hospices, and by 0.9 percent for large hospices (column 5).

c. Geographic Location

Column 3 of Table 1 shows updated wage data without the BNAF reduction. Urban hospices are anticipated to experience a decrease of 0.1 percent but there is no effect on rural hospices. Urban hospices can anticipate an increase in payments in New England, Middle Atlantic, Pacific and Outlying regions by 0.2 percent; in the West North Central region by 0.3 percent; and in the West South Central region by 0.4 percent. Urban hospices can anticipate a decrease in payments ranging from 0.5 percent in the East North Central and

East South Central regions, to 0.1 percent in the Mountain region.

Column 3 shows estimated percentages for rural hospices. Rural hospices are estimated to see a decrease in payments in four regions, ranging from 0.6 percent in the East North Central region to 0.1 percent in the East South Central region. Rural hospices can anticipate an increase in payments in five regions ranging from 0.1 percent in the Mountain region to 1.4 percent in the Pacific region. There is no anticipated change in payments for Outlying regions due to the FY 2013 Wage Index update.

Column 4 shows the combined effect of the updated wage data and the additional 15 percent BNAF reduction on estimated payments, as compared to the FY 2012 estimated payments using a BNAF with a 40 percent reduction. Overall, hospices are anticipated to experience a 0.7 percent decrease in payments, with urban hospices experiencing an estimated decrease of 0.7 percent and rural hospices experiencing an estimated decrease of 0.4 percent.

All urban areas other than Outlying regions are estimated to see decreases in payments, ranging from 1.1 percent in the East North Central region to 0.2 percent in the West South Central region. In the Outlying regions, payments are anticipated to increase by 0.2 percent.

Rural hospices are estimated to experience a decrease in payments in all regions except Pacific (0.7 percent) and New England (0.2 percent) regions. The decrease in payments ranges from 1.2 percent in East North Central region to 0.1 percent in the West North Central and West South Central regions. Payments in the Outlying region are anticipated to stay relatively stable.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and the 1.6 percent market basket update on estimated FY 2013 payments as compared to the estimated FY 2012 payments. We note that the FY 2012 payments had a 40 percent BNAF reduction applied to them. Overall, hospices are anticipated to experience a 0.9 percent increase in payments, with urban hospices anticipated to experience a 0.9 percent increase in payments, and rural hospices anticipated to experience a 1.2 percent increase in payments.

Urban hospices are anticipated to experience an increase in estimated payments in every region, ranging from 0.5 percent in the East North Central and East South Central regions to 1.8 percent in Outlying regions. Rural hospices in every region are estimated to see an increase in payments ranging from 0.4 percent in the East North Central region to 2.3 percent in the Pacific region.

d. Type of Ownership

Column 3 demonstrates the effect of the updated wage data on FY 2013 estimated payments, versus FY 2012 estimated payments. We anticipate that using the updated wage data would decrease estimated payments to voluntary (non-profit) hospices and to proprietary (for-profit) hospices by 0.1 percent. Government hospices are expected to have no change in payments.

Column 4 demonstrates the combined effects of the updated wage data and of the additional 15 percent BNAF reduction. Estimated payments to voluntary (non-profit), proprietary (for-profit) and government hospices are anticipated to decrease by 0.7 percent, 0.6 percent, and 0.6 percent, respectively.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 55 percent), and a 1.6 percent market basket update on estimated payments, comparing FY 2013 to FY 2012 (using a BNAF with a 40 percent reduction). Estimated FY 2013 payments are anticipated to increase by 0.9 percent for voluntary (non-profit) hospices, and by 1.0 percent for government hospices and proprietary (for-profit) hospices.

e. Hospice Base

Column 3 demonstrates the effect of using the updated wage data, comparing estimated payments for FY 2013 to FY 2012. Estimated payments are anticipated to decrease for freestanding, home health agency and skilled nursing facility based hospices by 0.1 percent, 0.1 percent and 0.2 percent, respectively. There is no anticipated change in payments for hospital based facilities.

Column 4 shows the combined effects of the updated wage data and reducing the BNAF by an additional 15 percent, comparing estimated payments for FY 2013 to FY 2012. All hospice facilities are anticipated to experience decrease in payments ranging from 0.9 percent for skilled nursing facility based hospices to 0.5 percent for hospital based hospices.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and a 1.6 percent market basket update on estimated payments, comparing FY 2013 to FY 2012. Estimated payments are anticipated to increase for all hospices, ranging from 0.7 percent for skilled nursing facility based hospices to 1.0 percent for hospital based hospices.

f. Effects on Other Providers

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

g. Effects on the Medicare and Medicaid Programs

This notice only affects Medicare hospices, and therefore has no effect on Medicaid programs. As described previously, estimated Medicare payments to hospices in FY 2013 are anticipated to decrease by $10 million due to the update in the wage index data, and to decrease by $90 million due to the additional 15 percent reduction in the BNAF (for a of total 55 percent reduction in the BNAF). However, the final market basket update of 1.6 percent is anticipated to increase Medicare payments by $240 million. Therefore, the total effect on Medicare hospice payments is estimated to be a $140 million increase. We note that the final market basket update and associated FY 2013 payment rates are officially communicated in the summer through an administrative instruction.

h. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 2 below, we have prepared an accounting statement showing the classification of the expenditures associated with this notice. Table 2 provides our best estimate of the decrease in Medicare payments under the hospice benefit as a result of the changes presented in this notice using data for 3,659 hospices in our database.

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2012 TO FY 2013

[In $millions]

Category	Transfers
Annualized Monetized Transfers.	$ – 100.*

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2012 TO FY 2013—Continued

[In $millions]

Category	Transfers
From Whom to Whom	Federal Government to Hospices.

*The $100 million estimated reduction in transfers includes the additional 15 percent reduction in the BNAF and the updated wage data. It does not include the market basket update, which is 1.6 percent for FY 2013. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act). This 1.6 percent is based on an inpatient hospital market basket percentage increase of 2.6 percent reduced by a 0.7 percentage point productivity adjustment and by 0.3 percentage point.

i. Conclusion

In conclusion, the overall effect of this notice is estimated to be the $100 million reduction in Federal payments due to the wage index changes (including the additional 15 percent reduction in the BNAF). Furthermore, the Secretary has determined that this will not have a significant impact on a substantial number of small entities, or have a significant effect relative to section 1102(b) of the Act.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that almost all hospices are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $7.0 million to $34.5 million in any 1 year), or being nonprofit organizations that are not dominant in their markets. While the SBA does not define a size threshold in terms of annual revenues for hospices, it does define one for home health agencies ($13.5 million; see *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf*). For the purposes of this notice, 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 notice has a significant impact on a substantial number of small entities (for example, hospices). Using CY 2010 Medicare hospice data from the Health Care Information System (HCIS), we estimate that 95 percent of hospices have Medicare revenues below $13.5 million or are nonprofit organizations and therefore are considered small entities.

The effects of this notice on hospices are shown in Table 1. Overall, Medicare payments to all hospices would decrease by an estimated 0.7 percent over last year's payments in response to the wage index we are setting forth in this notice, reflecting the combined effects of the updated wage data and the additional 15 percent reduction in the BNAF. The combined effects of the updated wage data and additional 15 percent reduction in the BNAF on small and large sized hospices (as defined by routine home care days rather than by the SBA definition), is an estimated reduction of 0.4 percent and 0.7 percent, respectively. Medium sized hospices are anticipated to experience an estimated reduction in payments of 0.5 percent as a result of the updated wage data and the additional 15 percent reduction in the BNAF. Furthermore, when examining the distributional effects of the updated wage data combined with the additional 15 percent BNAF reduction, the highest estimated reductions in payments are experienced by the urban East North Central and East South Central regions, and by the rural East North Central region.

HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of only the updated wage data and the additional 15 percent reduced BNAF (for a total BNAF reduction of 55 percent) for all hospices is an estimated reduction of 0.7 percent. Furthermore, since HHS's practice in determining ''significant economic impact'' considers either total revenue or total costs, it is necessary for total hospice revenues to include the effect of the market basket update of 1.6 percent. As a result, we consider the combined effect of the updated wage data, the additional 15 percent BNAF reduction, and the 1.6 percent FY 2013 market basket update inclusive of the overall impact, thereby reflecting an aggregate increase in estimated hospice payments of 0.9 percent for FY 2013. For small and medium hospices (as defined by routine home care days), the estimated effects on revenue when accounting for the updated wage data, the additional 15 percent BNAF reduction, and the market basket update reflect increases in payments of 1.2 percent and 1.1 percent, respectively. Overall average hospice revenue effects will be slightly less than these estimates since according to the National Hospice and Palliative Care Organization, about 16 percent of hospice patients are non-Medicare. Therefore, the Secretary has determined that this notice will not create a significant economic impact on a substantial number of small entities.

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

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 million. This notice is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of $139 million or more.

VI. Federalism Analysis

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

VII. Files Available to the Public via the Internet

This section lists the Addenda referred to in the preamble of this notice. Beginning in CY 2012, the Addenda for the annual hospice wage index proposed and final rulemakings or notices will no longer appear in the **Federal Register**. Instead, the Addenda will be available only through the Internet. We will continue to post the Addenda through the Internet.

The following addenda are posted to the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html:*

Addendum A: The FY 2013 Hospice Wage Index for Urban Areas

Addendum B: The FY 2013 Hospice Wage Index for Rural Areas

Readers who experience any problems accessing the Addenda that are posted on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html* should contact Anjana Patel at (410) 786–2120.

(Catalog of Federal Domestic Assistance Program No. 93.778, No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 5, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 16, 2012.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3259–FN]

Medicare Program; Application by the American Association of Diabetes Educators (AADE) for Continued Recognition as a National Accreditation Organization for Accrediting Entities To Furnish Outpatient Diabetes Self-Management Training

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

ACTION: Final Notice.

SUMMARY: This final notice announces the approval of an application from the American Association of Diabetes Educators for continued recognition as a national accreditation program for accrediting entities that wish to furnish outpatient diabetes self-management training to Medicare beneficiaries.

DATES: *Effective Date:* This notice is effective on August 27, 2012.

FOR FURTHER INFORMATION CONTACT: Jacqueline Leach, (410) 786–4282.

Kristin Shifflett, (410) 786–4133.

Maria Hammel, (410) 786–1775.

SUPPLEMENTARY INFORMATION

I. Background

Under the Medicare program, eligible beneficiaries may receive outpatient diabetes self-management training (DSMT) when ordered by the physician (or qualified non-physician practitioner) treating the beneficiary's diabetes, provided certain requirements are met by the provider. Pursuant to our regulations at 42 CFR 410.141(e)(3), we use national accrediting organizations (NAOs) to assess whether provider entities meet Medicare requirements when providing DSMT services for which Medicare payment is made. If a provider entity is accredited by an approved accrediting organization, it is ''deemed'' to meet applicable Medicare requirements.

Under section 1865(a)(1)(B) of the Social Security Act (the Act), a NAO must have an agreement in effect with the Secretary, and meet the standards and requirements specified by the Secretary in part 410, subpart H, to qualify for deeming authority. The regulations pertaining to application procedures for NAOs for DSMT are specified at § 410.142 (CMS process for approving national accreditation organizations).

A NAO applying for deeming authority must provide us with reasonable assurance that the accrediting organization requires accredited entities to meet requirements that are at least as stringent as our requirements.

We may approve and recognize a nonprofit organization with demonstrated experience in representing the interests of individuals with diabetes to accredit entities to furnish DSMT. The accreditation organization, after being approved and recognized by CMS, may accredit an entity to meet one of the sets of quality standards in § 410.144 (Quality standards for deemed entities).

Section 1865(a)(2) of the Act further requires that we review the applying accreditation organization's requirements for accreditation, as follows:

- Survey procedures.
- Ability to provide adequate resources for conducting required surveys.
- Ability to supply information for use in enforcement activities.
- Monitoring procedures for providers found out of compliance with the conditions or requirements.
- Ability to provide CMS with necessary data for validation.

We then examine the NAO's accreditation requirements to determine if they meet or exceed the Medicare conditions as we would have applied them. Section 1865(a)(3)(A) of the Act requires that we publish a notice identifying the national accreditation body making the request within 30 days of receipt of a completed application. The notice must describe the nature of the request and provide at least a 30-day public comment period. We have 210 days from receipt of the request to publish a finding of approval or denial of the application. If we recognize an accreditation organization in this manner, any entity accredited by the national accreditation body's CMS-approved program for that service will be ''deemed'' to meet the Medicare conditions for coverage.

II. Provisions of the Proposed Notice

On February 24, 2012, we published a proposed notice in the **Federal Register** (77 FR 11130) entitled, ''Application by the American Association of Diabetes Educators (AADE) for Continued Recognition as a National Accreditation Organization for Accrediting Entities to Furnish Outpatient Diabetes Self-Management Training,'' to notify the public of the AADE's request for continued approval of its accreditation to deem entities furnishing DSMT services.

III. Analysis of and Responses to Public Comments on the Proposed Notice

We received 1 public comment in response to the February 24, 2012 proposed notice. A summary of the comment and our response is set forth below.

Comment: A commenter supported the approval of the AADE to deem DSMT programs. The commenter stated that the AADE provides guidance for its members and represents the values of the profession. The commenter further stated that qualified diabetes educators can lead the way toward a healthier population by guiding those with chronic conditions toward healthier lifestyles and stronger self-advocacy.

Response: We thank the commenter for his or her comment. The goal of the DSMT program is to provide