Commander, Coast Guard Sector Baltimore.

(2) *Official Patrol* means any vessel assigned or approved by Commander, Coast Guard Sector Baltimore with a commissioned, warrant, or petty officer on board and displaying a Coast Guard ensign.

(3) *Participant* includes all vessels participating in the 2007 Cambridge Offshore Challenge under the auspices of the Marine Event Permit issued to the event sponsor and approved by Commander, Coast Guard Sector Baltimore.

(b) *Regulated area* includes all waters of the Choptank River, from shoreline to shoreline, bounded to the west by the Route 50 Bridge and bounded to the east by a line drawn along longitude 076° W, between Goose Point, MD and Oystershell Point, MD. All coordinates reference Datum: NAD 1983.

(c) *Special local regulations:* (1) Except for event participants and persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the regulated area.

(2) The operator of any vessel in the regulated area must:

(i) Stop the vessel immediately when directed to do so by any Official Patrol.

(ii) Proceed as directed by any Official Patrol.

(iii) When authorized to transit the regulated area, all vessels shall proceed at the minimum speed necessary to maintain a safe course that minimizes wake near the race course.

(d) *Enforcement period.* This section will be enforced from 10:30 a.m. on September 22, 2007 to 5:30 p.m. on September 23, 2007.

Dated: August 23, 2007.

Fred M. Rosa, Jr.,

Rear Admiral, U.S. Coast Guard Commander, Fifth Coast Guard District.

[FR Doc. E7–17337 Filed 8–30–07; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. COTP San Francisco Bay 07–038]

Special Local Regulations for Marine Events; San Francisco Bay Navy Fleet Week Parade of Ships and Blue Angels Demonstration, San Francisco Bay, CA

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce the special local regulations in the navigable waters of San Francisco Bay for the annual U.S. Navy and City of San Francisco sponsored Fleet Week Parade of Navy Ships and Blue Angels Flight Demonstration to be held on October 4, 2007, through October 7, 2007. This action is necessary to ensure the safety of event participants and spectators. During the enforcement period, no persons or vessels may enter the regulated area without permission of the Captain of the Port (COTP) or his designated representative.

DATES: The regulations in 33 CFR 100.1105(b)(1), regulated area ''Alpha'' for Navy Parade of Ships, will be enforced from 11:30 a.m. to 1 p.m. on October 6, 2007. The regulations in 33 CFR 100.1105(b)(2), regulated area ''Bravo'' for the U.S. Navy Blue Angels Activities, will be enforced from 11:30 a.m. to 5 p.m. on October 4, 2007, and 12:30 p.m. to 5 p.m. on October 5, 2007, through October 7, 2007. If the U.S. Navy Blue Angels Activities are delayed by inclement weather, the regulation will also be enforced on October 8, 2007, from 12:30 p.m. to 5 p.m.

FOR FURTHER INFORMATION CONTACT: Lieutenant Eric Ramos, Waterways Safety Branch, U.S. Coast Guard Sector San Francisco, at (415) 556–2950 extension 143, or the Sector San Francisco Command Center, at (415) 399–3547.

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulation for the annual San Francisco Bay Navy Fleet Week Parade of Ships and Blue Angels Demonstration in 33 CFR 100.1105; the Navy Parade of Ships will be enforced from 11:30 a.m. to 1 p.m. on October 6, 2007; and the U.S. Navy Blue Angels Activities will be enforced from 11:30 a.m. to 5 p.m. on October 4, 2007, and 12:30 p.m. to 5 p.m. on October 5, 2007, through October 7, 2007. If the U.S. Navy Blue Angels Activities are delayed by inclement weather, the regulation will also be enforced on October 8, 2007, from 12:30 p.m. to 5 p.m. These regulations can also be found in the October 1, 1993, issue of the **Federal Register** 58 FR 51242. Under the provisions of 33 CFR 100.1105 a vessel may not enter the regulated area, unless it receives permission from the COTP. Additionally, no person or vessel may enter or remain within 500 yards ahead of the lead Navy parade vessel, within 200 yards astern of the last parade vessel, and within 200 yards on either side of all parade vessels. No person or vessel shall anchor, block, loiter in, or impede the transit of ship parade participants or official patrol vessels. When hailed by U.S. Coast Guard patrol personnel by siren, radio, flashing light, or other means, a person or vessel shall come to an immediate stop. Persons or vessels shall comply with all directions given.

The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in enforcing this regulation.

This notice is issued under authority of 33 CFR 100.1105 and 5 U.S.C 552(a). In addition to this notice in the **Federal Register**, the Coast Guard will provide the maritime community with extensive advance notification of this enforcement period via the Local Notice to Mariners, and Broadcast Notice to Mariners.

Dated: 20 August 2007.

W.J. Uberti,

Captain, U.S. Coast Guard, Captain of the Port, San Francisco.

[FR Doc. E7–17340 Filed 8–30–07; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1539–F]

RIN 0938–AO72

Medicare Program; Hospice Wage Index for Fiscal Year 2008

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

ACTION: Final rule.

SUMMARY: This final rule sets forth the hospice wage index for fiscal year 2008. This final rule also revises the methodology for updating the wage index for rural areas without hospital wage data and provides clarification of selected existing Medicare hospice regulations and policies.

EFFECTIVE DATES: These regulations are effective on October 1, 2007.

FOR FURTHER INFORMATION CONTACT: Terri Deutsch, (410) 786–9462.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

1. Hospice Care

Hospice care is an approach to treatment that recognizes that the

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

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

2. Medicare Payment for Hospice Care

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

B. Hospice Wage Index

Our regulations at § 418.306(c) require each hospice's labor market to be established using the most current hospital wage data available, including any changes to the Metropolitan Statistical Areas (MSAs) definitions, which have been superseded by Core-Based Statistical Areas (CBSAs).

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

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

The hospice wage index is updated annually. Our most recent annual update notice, published in the September 1, 2006 **Federal Register** (71 FR 52080), set forth updates to the hospice wage index for FY 2007. On October 3, 2006, we published a correction notice in the **Federal Register** (71 FR 58415) and we published a subsequent correction notice on January 26, 2007 (72 FR 3856), to correct technical errors that appeared in the September 1, 2006 notice.

1. Changes to Core-Based Statistical Areas

The annual update to the hospice wage index is published in the **Federal Register** and is based on the most current available hospital wage data, as well as any changes by the Office of Management and Budget (OMB) to the definitions of MSAs. The August 4, 2005 final rule (70 FR 45130) adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Micropolitan Statistical Areas and the creation of MSAs and Combined Statistical Areas. In adopting the OMB Core-Based Statistical Area (CBSA) geographic designations, we provided for a 1-year transition with a blended wage index for all providers for FY 2006. For FY 2006, the hospice wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index. As discussed in the August 4, 2005 final rule and in the September 1, 2006 notice, for FY 2007 and subsequent years we will use the full CBSA-based wage index values, as presented in Tables A and B of this final rule for FY 2008.

2. Raw Wage Index Values

Raw wage index values (that is, inpatient hospital pre-floor and pre-reclassified wage index values) as described in the August 8, 1997 hospice wage index final rule (62 FR 42860), are subject to either a budget neutrality adjustment or application of the wage index floor. Raw wage index values of 0.8 or greater are adjusted by the budget neutrality adjustment factor. Budget neutrality means that, in a given year, estimated aggregate payments for Medicare hospice services using the updated wage index values will equal estimated payments that would have been made for these services if the 1983 wage index values had remained in effect. To achieve this budget neutrality, the raw wage index is multiplied by a budget neutrality adjustment factor. The budget neutrality adjustment factor is calculated by comparing what we would have paid using current rates and the 1983 wage index to what would be paid using current rates and the new wage index. The budget neutrality adjustment factor is computed and applied annually. For the FY 2008 hospice wage index in the final rule, FY 2007 hospice payment rates were used in the budget neutrality adjustment factor calculation.

Raw wage index values below 0.8 are adjusted by the greater of: (1) The hospice budget neutrality adjustment factor; or (2) the hospice wage index floor (a 15 percent increase) subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index (raw wage index value) of 0.4000, we would perform the following calculations using the budget neutrality factor (which for this example is 1.060988) and the hospice wage index floor to determine County A's hospice wage index:

Raw wage index value below 0.8 multiplied by the budget neutrality adjustment factor:

$(0.4000 \times 1.060988 = 0.4244)$.

Raw wage index value below 0.8 multiplied by the hospice wage index floor:

$(0.4000 \times 1.15 = 0.4600)$.

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

3. Hospice Payment Rates

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended section 1814(i)(1)(C)(ii) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the market basket index, minus 1 percentage point. Payment rates for FY

2008 will be updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs will be the market basket percentage for the fiscal year. Accordingly, the FY 2008 update to the payment rates for each of the four levels of care (routine home care, continuous home care, general inpatient care and inpatient respite care) will be the full market basket percentage increase for FY 2008. The rate update for FY 2008 is implemented through a separate administrative instruction and is not part of this rule. Historically, the rate update has been published through a separate administrative instruction issued annually in July to provide adequate time to implement necessary system changes and allow for provider notification. Providers determine their payment rates by applying the wage index in this rule to the labor portion of the published hospice rates.

4. Proxy for the Hospital Market Basket

As discussed above, the hospice payment rates for fiscal years after 2002 are adjusted each year based upon the full hospital market basket percentage increase. In the FY 2007 update notice (72 FR 52082) published on September 1, 2006, we indicated that beginning in April 2006, with the publication of March 2006 data, the Bureau of Labor Statistic's (BLS's) Employment Cost Index (ECI) began using a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Classification System (SIC), which no longer exists. The ECIs had been used as the data source for wages and salaries and other price proxies in the hospital market basket. In the FY 2007 update notice we noted that no changes would be made to the usage of the NAICS-based ECI; however, input was solicited on this issue. We received no comments. As a result, in the proposed rule we did not propose any changes.

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

On May 1, 2007, we published a proposed rule in the **Federal Register** (72 FR 24116) that set forth the proposed hospice wage index for FY 2008. The following is a summary of each of the proposed provisions followed by our response to public comments. We received 19 timely items of correspondence, one from a physician, 6 from hospice providers, and 12 from associations.

A. Annual Update to the Hospice Wage Index

We did not propose any modifications to the hospice wage index methodology as described in the 1997 final rule (62 FR 42860). In accordance with our regulations and the agreement signed with other members of the Hospice Wage Index Negotiated Rulemaking Committee, we use the most current hospital data available to adjust for area wage differences. As noted above, payment rates for each of the four levels of care (routine home care, continuous home care, general inpatient care and inpatient respite care) are adjusted annually based upon the hospital market basket for that year and are promulgated through administrative instructions issued annually in July in order to allow for sufficient time for system changes and provider notification.

We use the previous fiscal year's hospital wage index data to calculate the hospice wage index values. For the FY 2008 proposed and final hospice wage index values, we used the FY 2007 hospital pre-floor and pre-reclassified hospital wage data. This means that the hospital wage data used for the hospice wage index is not adjusted to take into account any geographic reclassification of hospitals including those in accordance with sections 1886(d)(B) or 1886(d)(10) of the Act. We also do not take into account reclassifications in accordance with section 508 of the MMA or the out-migration adjustment for hospitals (section 505 of the MMA).

All hospice wage index values for FY 2008 are adjusted by either the FY 2008 budget neutrality adjustment factor or the wage index floor adjustment. For wage index values 0.8 or greater, the value is multiplied by the budget neutrality adjustment factor. Wage index values that are below 0.8, receive the greater of a 15 percent increase or the budget neutrality adjustment factor subject to a maximum wage index value of 0.8. In other words, the floor adjustment is the greater of the raw wage index value multiplied by the proposed budget neutrality adjustment factor or the raw wage index value for that area is multiplied by 15 percent subject to a maximum value of 0.8. Budget neutrality means that, in a given year, estimated aggregate payments for Medicare hospice services using the updated wage index will equal estimated payments that would have been made for the same services if the wage index adopted for hospices in 1983 had remained in effect. For a detailed discussion of the methodology used to compute the hospice wage index see the September 4, 1996 proposed rule (61 FR 46579) and the August 8, 1997 final rule (62 FR 42860).

As indicated in the proposed rule, we did not propose any changes in the methodology used in calculating the hospice wage index values and we did not solicit comments. However, we received eight items of correspondence pertaining to future changes, the methodology for computing the wage index for Puerto Rico, the publication of the market basket update through administrative issuance, and the inadequacy of rural payment rates.

Comment: We received two comments stating that any future changes proposed for hospice payments should follow the negotiated rulemaking process rather than notice and comment. The same commenters also expressed support for a more reasonable and consistent approach to constructing wage index adjustments for hospitals and post acute providers. The commenters also indicated that any changes in the wage index approach should require an extended transition period to prevent disruptive swings.

Response: We thank the commenters for their suggestions and we will keep them under advisement as we analyze the need for future refinements.

Comment: One commenter suggested that the hospice payment rates be published with the hospice wage index regulations as is done in other prospective payment systems.

Response: As we discussed in the proposed rule, historically the payment rate updates have been promulgated through a separate administrative instruction or administrative issuance in July of each year to provide adequate time to implement necessary system changes. As the hospice wage index regulation is scheduled for publication at the end of August, inclusion of the hospice payment updates in this regulation would not allow sufficient time for system changes to be made to accommodate the October 1 implementation date of the payment updates.

Comment: Several commenters noted that there are challenges in furnishing hospice care in rural areas, citing underdevelopment, long distances for staff to travel, staff recruitment challenges and the need for rural hospices to be competitive in the wages and benefits that they provide. One commenter stated that rural areas adjacent to urban areas are at a greater disadvantage as they are competing for staff in urban areas with higher wages. Another commenter stated that rural home based salary adjustment based on the hospital wage index is inadequate

and should be reimbursed at a higher rate. The commenter also stated that there are extra costs for mileage expenses for rural staff and suggested that an ''expansive geography index'' be applied to the hospice wage index formula for rural counties. Another commenter indicated willingness to discuss this issue further to investigate ways to encourage hospice care in rural areas.

Response: We thank the commenters for their comments and suggestions. We recognize that there are challenges in providing health care in urban as well as in rural areas. Recruitment challenges, competitiveness in wages and benefits and commuting difficulties are factors that are facing all health care providers. We believe that the hospital wage data reflects these factors and as a result, the hospice wage index values are also reflective of these challenges. In addition, the application of the hospice floor for raw values below 0.8 provides a higher wage index value to many rural areas. However, we will consider these comments and suggestions as we analyze the need for future refinements to the hospice payment methodology.

Comment: One hospice provider from Puerto Rico provided us with a study that it had undertaken. It requested that this report be used by CMS to make the ''right'' decision about the correct wage index for Puerto Rico. This study concluded that 34 hospices in Puerto Rico will see a decrease in their hospice payments by 2.6 percent in FY 2008. Several of the conclusions presented in this study compare a hospice in Arecebo, Puerto Rico to hospitals in New England and Albuquerque, New Mexico, list the economic challenges in Puerto Rico, and suggested the payment rate that it believes should be used for Puerto Rico.

Response: We thank the commenter for sending its study to us. However, as the study concludes that payment rates and wage index values should be determined utilizing the same methodology used for the hospital wage index values, we believe the study is based on an erroneous and incorrect understanding of the content of the hospice wage index proposed rule as well as the methodology that had been developed and agreed upon through the negotiated rulemaking committee.

As noted above, the methodology for the hospice wage index was developed, and an agreement on the methodology was signed, by members of the Hospice Wage Index Negotiated Rulemaking Committee. We note that Puerto Rico was represented by the hospice associations' participants on the committee. Hospices in Puerto Rico had notice of the committee deliberations and they had an opportunity to apply to be on the committee, and were encouraged to attend and make a statement to the committee. A detailed description of the methodology is contained in both the September 4, 1996 proposed rule (61 FR 46579) and the August 8, 1997 final rule (62 FR 42860).

The commenter is incorrect in stating that the payment rates for Puerto Rico will decrease 2.6 percent in FY 2008. We indicated in the proposed rule that the impact analysis demonstrates the impact of the FY 2008 wage index values and is not a projection of the anticipated expenditures of hospice payments for FY 2008. The impact analysis compares hospice payments using the FY 2007 hospice wage index to the estimated payments using the FY 2008 wage index. For urban Puerto Rico, the proposed rule indicated that, using the FY 2007 payment rates and the FY 2008 wage index values, payments are anticipated to decrease 2.6 percent, which represents only the affects of the wage index and does not reflect the payment increase for FY 2008. As noted above, the FY 2008 hospice payment rates will reflect the market basket update.

We do not understand the study's comparison between Puerto Rico and Albuquerque, New Mexico or New England regions and as a result cannot respond. However, it is important to note that wage index values fluctuate from year to year for counties as well as regions and we do not believe that comparisons to other regions provide any substantive information. It is also important to note that the FY 2007 hospital pre-floor, pre-reclassified hospital wage data reflects data from the FY 2003 hospital cost reports and the data provided in the Puerto Rico study reflect data from later years. We will share the information provided in this study with the organizational component within CMS that develops the inpatient hospital wage data, as it appears that the study relates to the development of the hospital wage index.

B. Rural Areas Without Hospital Wage Data

When adopting OMB's new labor market designations, 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 (70 FR 45135, August 4, 2005). For FY 2006 and FY 2007, we adopted a policy to use the FY 2005 pre-floor, pre-reclassified hospital wage index value for rural areas where no rural hospital wage data were available. We also adopted the policy that for urban labor markets without an urban 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 wage index data to use as a reasonable proxy for these areas. In the August 2005 final rule and in the September 2006 update notice, we applied the average wage index data from all urban areas lacking hospital wage data in that state. Currently, the only CBSA that is affected by this policy is CBSA 25980, Hinesville-Fort Stewart, Georgia. We proposed to continue this approach for urban areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculations for the FY 2008 and subsequent hospice wage indexes.

In the proposed rule we noted that under the CBSA labor market areas, there are no rural hospitals in rural locations in Massachusetts and Puerto Rico. In the August 2005 final rule (70 FR 45135) and in the September 2006 update notice (71 FR 52081), we applied the FY 2005 pre-floor, pre-reclassified hospital wage data in both FY 2006 and FY 2007 for rural Massachusetts and rural Puerto Rico. In the proposed rule, we considered alternatives in our methodology to update the wage index for rural areas without hospital wage index data consistent with other prospective payment systems. We noted that we believe 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 wage index; (3) be easy to evaluate and; (4) be easy to update from year to year. Although our current methodology meets the first three criteria, it could not be easily updated from year to year because the FY 2005 pre-floor, pre-reclassified hospital wage data would continue to be used. Therefore, in cases where there is a rural area without rural hospital wage data, we proposed using the average pre-floor, pre-reclassified wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. This approach meets all of the stated criteria (72 FR 24118).

We noted in the proposed rule that we interpret the term ''contiguous'' to mean ''sharing a border''. We cited the example of Massachusetts, where 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. Therefore, the pre-floor, pre-reclassified 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 wage index for rural Massachusetts.

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 (CAH), that do not submit the appropriate wage data), should a similar situation arise in the future, we may re-examine this policy.

In the proposed rule we noted that we do not believe that this policy would be appropriate for Puerto Rico. 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 that we believe necessitate a separate and distinct policy for Puerto Rico. Consequently, any alternative methodology for imputing a wage index for rural Puerto Rico would need to take into account those differences. Our policy of imputing a rural wage index based on the wage index(es) of CBSAs contiguous to the rural area in question does not recognize the unique circumstances of Puerto Rico. We also noted that while we have not yet identified an alternative methodology for imputing a 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. Accordingly, we propose to continue using the most recent pre-floor, pre-reclassified wage index previously available for Puerto Rico, which is 0.4047 (72 FR 24118–19).

Comment: We received four items of correspondence in response to our proposal for rural areas without hospital wage data. Two commenters supported the proposal. Two commenters stated that the proposed methodology, while not ideal, comes closest to what the commenters believe is an equitable solution in resolving a perceived flaw in using hospital data to adjust payment to non-hospital providers. The commenters also assumed that a better alternative would emerge over the next few years in the course of revising the hospital wage index. One commenter agreed with the methodology but asked that we do not use this formula for other situations without review and reexamination of the policy. The same commenter commended us for demonstrating flexibility and good judgment in creating a different system for Massachusetts and Puerto Rico.

We note that we received no comments on the methodology employed for urban areas without a hospital from which to derive hospital wage data.

Response: We thank the commenters for their support. We continue to believe that our proposed methodology results in the most appropriate imputed proxy for rural areas in meeting the criteria we identified as follows: (1) Use pre-floor, pre-re-classified hospital data, (2) use the most local data available to impute a rural wage index, (3) be easy to evaluate; and (4) be easy to update from year to year. We will consider the suggestion for evaluating the policy if needed in other situations.

C. Nomenclature Changes

We proposed to clarify that all hospice rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index data used to determine the current hospice wage index (72 FR 24119). We received no comments on this proposal.

D. Payment for Hospice Care Based on the Location Where Care Is Furnished

Under the Medicare hospice program, hospice providers receive payment for four levels of care based upon the individual's needs. The payment rates are adjusted to reflect the variation in geographic locations. Section 4442 of the BBA amended section 1814(i)(2) of the Act, effective for services furnished on or after October 1, 1997, required the application of the local wage index value of the geographic location at which the service is furnished for hospice care provided in the home. Prior to this provision, local wage index values were applied based on the geographic location of the hospice provider, regardless of where the hospice care was furnished. In the proposed rule, we noted that we believe that for the majority of hospice providers the office and the site for the provision of home and inpatient care occur in the same geographic area. However, with the substantial growth of hospice providers in multiple states and with multiple sites within a State, hospice providers have been able to inappropriately maximize reimbursement by locating their offices in high-wage areas and delivering services in a lower-wage area. We also believe that hospice providers are able to inappropriately maximize reimbursement by locating their inpatient services either directly or under contractual arrangements in lower wage areas than their offices.

Section 4442 of the BBA applies the wage index value of a home's geographic location for services provided there, but is silent as to what wage index value should be used for hospice services provided in an inpatient setting. We believe that the application of the wage index values should reflect the location of the services provided rather than the location of an office. We believe such application results in a reimbursement rate that is a more accurate reflection of the wages paid by the hospice for the staff used to furnish care. We proposed that effective January 1, 2008, all payment rates (routine home care, continuous home care, inpatient respite and general inpatient care) be adjusted by the geographic wage index value of the area where hospice services are provided. This would require hospice providers to include the geographic location of the inpatient facility for general inpatient and inpatient respite levels of care on claims submitted for payment. We proposed to modify § 418.302 accordingly.

In the proposed rule we also indicated that as hospice claims do not contain information identifying the location of the facility where general inpatient and respite care are provided, we are unable to predict the savings or costs associated with the changes associated with this proposed provision. However, we believe most hospice providers provide hospice care in the same geographic location as their offices. Therefore, we believe the impact of implementing this proposal will be negligible.

Comment: We received eight items of correspondence, of which six supported the provision to base payment rates on the geographic wage index value of the area where inpatient hospice services are provided.

Response: We thank the commenters for their support of this provision.

Comment: One commenter suggested that we suspend the implementation of this provision until we have additional data from providers on the impact.

Response: In the proposed rule we indicated that, as hospice claims do not contain information identifying the location of the facility where inpatient care is provided, we are unable to predict the savings or costs associated with changes in this provision. Effective January 1, 2007, hospice providers were required to indicate the type of location where care was provided (for example, nursing home, assisted living facility, hospital unit), but not the geographic location (which would be used to adjust payments). As we have indicated, we believe that for most providers, the location of the inpatient facility and the hospice provider are the same. We do not believe that postponing the

implementation of this provision would enable us to collect any additional information.

Comment: One commenter indicated that this change will significantly increase the complexity of filing hospice claims and will increase hospice costs due to the need to include the CBSA for the geographic location, as well as the code of where the patient is receiving hospice services.

Response: We appreciate the concern regarding the complexity of filing claims and the perceived increased costs to hospices. We are in the process of developing operational instructions that we believe will help simplify the billing process. Hospice providers currently are required to identify the geographic location of their patients for the routine home care and continuous home care levels of care, and the location of the hospice office for general inpatient care and inpatient respite care. We are now also requiring hospice providers to identify the geographic location where inpatient care is provided. We believe that for the majority of hospice providers, the location of the facility for the provision of both the general inpatient and inpatient respite levels of care will be the same as the location of the hospice office. For those majority of cases, this change will require the hospice provider to indicate the same CBSA location of the office on the claims as the location of the facility where inpatient levels of care are provided. As a result, we believe that the impact on hospices for implementing this provision should be negligible as most hospices currently provide this information on the claims.

Comment: Several commenters concurred with the provision but objected to the statement that hospice providers are able to inappropriately maximize reimbursement by having their offices located in a higher wage area. One commenter indicated that the statement was misleading and unnecessarily harsh. Another commenter suggested removing the statement. One commenter interpreted this statement as being demeaning and inflammatory. The same commenter stated that most hospices would not benefit from manipulating the location of an inpatient facility. Several commenters indicated that there is nothing prohibiting a hospice from having their inpatient facilities in a higher wage area, though the commenters stated it was doubtful that a hospice would do this or arrange contracts in order to manipulate reimbursement. Some commenters stated that urban areas have higher rates and that hospices generally have contracts with all hospitals in an area. Some commenters indicated patients have choices about where to receive care and would complain if they were forced to receive inpatient care out of their area.

Response: While we appreciate the commenters objection to the statement that we made about hospice providers being able to inappropriately maximize reimbursement by locating their offices in a higher age area, we concur with the commenter that nothing prohibits a hospice from locating its inpatient services, either directly or under contractual arrangements, in a higher wage area, as well. In fact, we have received anecdotal information that leads us to believe that there are hospice offices that have been intentionally located in higher wage areas than those of their patients in order to maximize their reimbursement. We supported our proposal by noting the potential for maximizing reimbursement based on the location of the main office, which was the same rationale used by the congressional committee when the BBA 1997 provision requiring the application of the local wage index of the geographic location where the service is furnished for hospice care provided in the home was enacted. We believe that the same rationale applies to the inpatient facility locations as well. Our intent for this provision is to have all levels of payment adjusted by the wage index that applies to the site where the service is being provided.

Comment: One commenter interpreted the proposed provision as reducing reimbursement to a lesser amount based on distance from the main office. The same commenter stated that staff were paid at the home office area rate and suggested that payment be based on the costs at the main office.

Response: We believe that the suggestion that using distance from the main office determines payment rates is a misinterpretation of the intent of this provision as well as the statement concerning maximizing reimbursement based upon the location of the hospice main office. As we have discussed in the proposed rule, we were not proposing to modify the methodology used for computing the hospice wage index values. The intent of the proposal is to employ the same methodology for applying the wage index value for geographic variations regardless of where hospice care is provided.

E. Educational Requirements for Nurse Practitioners

On December 8, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). Section 408 of the MMA, Recognition of Attending Nurse Practitioners as Attending Physicians to Serve Hospice Patients, amended sections 1861(dd)(3)(B) and 1814(a)(7) of the Act to add nurse practitioners (NPs) to the definition of an attending physician for beneficiaries who have elected the hospice benefit. Section 408 of the MMA was implemented through an administrative issuance (Change Request (CR) 3226, Transmittals 22 and 304, September 24, 2004). In the August 4, 2005 FY 2006 final rule (70 FR 45139), we revised § 418.3 to reflect that an attending physician can be a nurse practitioner who meets the training, education and experience requirements as the Secretary may prescribe.

We indicated in the proposed rule that we believe that the definition of attending physician, which includes nurse practitioners under the Medicare hospice benefit, should be consistent with the provisions of section 410.75 that provide for Medicare Part B coverage of nurse practitioner services. Therefore, to ensure consistency, we proposed to revise the definition of ''attending physician'' at § 418.3(1)(ii) to cross reference the training, education, and experience requirements as described in § 410.75(b).

Comment: We received six items of correspondence regarding our proposal to conform the educational requirements for nurse practitioners serving as the attending physician to the requirements described in § 410.75. All commenters supported this provision. One commenter requested that the hospice physician definition be revised to include nurse practitioners, although the commenter recognized that any such revision could not allow nurse practitioners to certify the terminal illness of a patient. Another commenter suggested that the definition of attending physician be clarified by using the term ''attending nurse practitioner'' instead of referring to nurse practitioners as ''attending physicians.'' One commenter requested that the nurse practitioner qualifications provisions at § 410.75 be amended to reflect current and evolving educational requirements for advanced practice registered nurses. The commenter requested that the term ''master's degree'' in § 410.75(b)(ii)(4) be replaced with ''graduate degree'' to reflect nurse practitioners with doctoral degrees.

Response: We thank the commenters for their support of this provision. As noted in the proposed rule and earlier in this rule, the implementation of section 408 of the MMA, which amended sections 1861(dd)(3)(B) and

1814(a)(7) of the Act to add nurse practitioners to the definition of an attending physician, was discussed in the August 4, 2005 final rule (70 FR 45130). Section 418.304(e)(2)(iv) specifies that nurse practitioners may bill and receive payment for services provided as the attending physician, only if the services are not related to the certification of the terminal illness in § 418.22(c)(1)(ii). Section 418.22(c) specifies that certification of the terminal illness is obtained from ''the medical director of the hospice or the physician member of the hospice interdisciplinary group''. Therefore, we believe it would be inconsistent with statute and regulations to allow nurse practitioners to bill and receive payment for certifying an individual's terminal illness. As the role of the nurse practitioner is explicit in statute, nurse practitioners are not included as a hospice physician and may not serve in that role.

We concur with the commenter that the definition of attending physician should use the term ''attending nurse practitioner''. However, as the statute at sections 1861(dd)(3)(B) and § 1814(a)(7) explicitly uses the term ''attending physician'' for a nurse practitioner serving as the attending physician, we do not accept this recommendation.

We did not propose to replace the term master's degree in 410.75(b)(ii)(4) with ''graduate degree''. Therefore, we will not make the change in this final rule. However, we will provide your suggestion to the area within CMS responsible for advanced practitioner educational requirements.

F. Caregiver Breakdown and General Inpatient Care

In the proposed rule, we discussed a concern that some hospice providers are requesting payment for the general inpatient level of care for circumstances that do not qualify under the statute at section 1861(dd)(1)(G) of the Act, our regulations at § 418.202(e), or Medicare hospice policy in Chapter 9 of the Medicare Benefit Policy Manual. We provided clarification of existing statute, regulation and policy in the proposed rule and did not propose any changes (72 FR 24120).

As discussed in the proposed rule, the Medicare hospice benefit places emphasis on the provision of items and services to enable an individual to remain at home in the company of family and friends. Section 1861(dd)(1)(G) of the Act provides for short-term inpatient hospice care to be available when an individual's pain and symptoms must be closely monitored or the intensity of interventions that are required cannot be provided in any other settings. Inpatient respite care is available for family members, who serve as the primary caregivers, to obtain rest for a period of no more than 5 days at a time. Hospice providers should submit claims for inpatient respite care in situations where there is an unexpected loss of the individual's support structure that results in an inability to maintain the individual in his or her home, but the individual does not require an inpatient level of care.

Medicare policy states that skilled nursing care may be required by a patient whose home support has broken down, if this breakdown makes it no longer feasible to furnish needed care in the home setting. If the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual's home, and if the individual's pain and symptom management can no longer be provided at home, then the individual may be eligible for a short term general inpatient level of care. To receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries *must* require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. It is the level of care provided to meet the individual's needs and not the location of where the individual resides, or caregiver breakdown, that determine payment rates for Medicare services.

Caregiver breakdown is the loss of the individual's support structure and should not be confused with the coverage requirements for medically reasonable and necessary care for pain and symptom management that cannot be managed in any other setting. Therefore, caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met. As discussed above, for the general inpatient level of care, the intensity of interventions required for pain and symptom management is such that it cannot be provided in any setting other than an inpatient setting.

As explained in the proposed rule, this is a clarification of current Medicare policy and as such does not create new limitations on access to hospice care. As noted in the proposed rule, we intend to monitor the usage of general inpatient care. Additionally, the circumstances addressed by this policy, and the clarification discussed above, should not be construed as similar to situations where an individual does not have family, friends or other individuals who are able to take on the role of a caregiver when a hospice election is made. In the proposed rule, we indicated that inpatient respite care could be used in situations where there is caregiver breakdown. However, in situations where there is a lack of a caregiver at the time of the election, the inpatient respite level of care does not apply. Inpatient respite care is unavailable when there is no caregiver to whom relief must be provided. The established policy that the level of care required to provide pain and symptom management determines payment and not the location of where the individual resides or receives hospice services, also applies in situations where there is not an appropriate caregiver. We recognize the difficulties surrounding the provision of hospice care to an individual who is terminally ill and who does not have caregivers at home. This may be particularly challenging in rural areas. Section 409 of the MMA (Pub. L. 108–173) established the Rural Hospice Demonstration which hopes to test alternative mechanisms for providing hospice services for beneficiaries who lack an appropriate caregiver and who reside in rural areas. In this demonstration, a hospice organization may provide all services in an inpatient facility which serves as a beneficiary's home; however, payment for inpatient care must meet the usual level of care requirements. In this demonstration, inpatient respite care is not possible since there is no caregiver. For specific information on this demonstration, refer to: *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.aspitemID=CMS1183983*.

Comment: We received nine items of correspondence regarding the clarification of the general inpatient level of care and its use when there is a breakdown in caregiver support. Several commenters supported the clarification, however the majority did not, as we describe below. Several commenters stated that they shared our concern that the general inpatient level of care not become a source of abuse and the need to focus on hospice providers who use the general inpatient level of care inappropriately. Two commenters stated that they supported steps to eliminate any potential collusion or inducements in this area.

Response: We appreciate the comments and thank those who were in support of this provision. The intent of this clarification was to ensure that the general inpatient level of care be utilized appropriately and in accordance with statute, regulations and policy. Our focus was not on fraudulent or abusive use of the general inpatient level of care, but rather on ensuring that

the general inpatient level of care is properly utilized in accordance with established criteria.

Comment: Some commenters believed that the clarification was overly prescriptive while others believed that this was not a clarification of existing policy, but was a new interpretation. Some commenters expressed that the intent of the general inpatient level of care, at the inception of the benefit, was to address the need for pain control and symptom management as well as care for patients whose caregiver or home support has broken down, making it no longer feasible to furnish care in the home. One commenter indicated that use of the general inpatient level of care in the event of caregiver breakdown met the requirements in 418.302 as a condition of participation. The same commenter added that the proposed interpretation shifts the focus from caring for patients in the appropriate setting to a billing and reimbursement issue. Some commenters stated that this provision was designed to reduce expenditures without regard to patient safety and hospice expenses.

Other commenters also strongly disagreed with the clarification. They indicated that Medicare policy has been interpreted for more than twenty years to mean that general inpatient level of care can be used for caregiver breakdown and the practice of billing at the higher level of care in those circumstances is consistent with written CMS and fiscal intermediary guidance.

Some commenters stated that the definition of general inpatient care in the hospice regulations supported the use of general inpatient level of care for caregiver breakdown. One commenter stated that it was inappropriate to punish patients by removing a long established benefit for the hospice program because of the perception that some hospices are using the general inpatient level of care inappropriately.

Response: We disagree with the commenter who believes that this clarification is a new interpretation. Rather, we seek to clarify here our established policy by providing what we believe is a helpful explanation of how our policies should be interpreted and applied. We are not making any policy changes with this clarification. We believe that this clarification is needed because, as some commenters recognize, the general inpatient level of care has been used for situations where caregiver breakdown has occurred.

The level of care needed to manage pain and symptoms is the basis for the general inpatient level of care in the statute, regulations and policy, none of which recognizes caregiver breakdown as an indication for the general inpatient level of care. The Medicare Benefit Policy Manual, Chapter 9—Coverage of Hospice Services, section 40.1.5—Short-Term Inpatient Care, indicates that skilled nursing care may be needed by a patient whose home support has broken down. In the proposed rule we acknowledged this and indicated that if the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual's home, and if the individual's pain and symptom management can no longer be provided at home, then the individual may be eligible for a short term general inpatient level of care. Section 1861(dd)(1) of the Act defines hospice care as the items and services to be provided to a terminally ill individual by a hospice directly or under arrangement. The statute goes on to specify the items and services, but does not include caregiver services. This means that Medicare does not pay for caregiver services under the hospice benefit. In further support, § 418.98 sets forth the hospice conditions of participation requiring hospices to make available ''inpatient care* * * for pain control, symptom management and respite purposes * * *.'' Section 418.202 lists the covered hospice services and includes short-term inpatient care at § 418.202(e), stating ''inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home.'' Further, § 418.302(b)(4) provides that ''a general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.''

We believe that there is no support for the comments that suggest that the intent of the general inpatient level of care was to include care for patients whose home support has broken down. We also disagree with the comment that this clarification shifts the focus from caring for patients to a purely billing and reimbursement issue and that there needs to be a humane and practical alternative. Our discussions in the proposed rule and in this final rule have focused on the provision of care and the level of care needed by the patient. However, certain billing requirements and payment amounts are associated with each level of care. In cases where a particular level of care is provided because of circumstances that are inappropriate to warrant that particular level of care (here, general inpatient provided because of caregiver breakdown), it is inappropriate for the hospice to bill and receive payment for the general inpatient level of care.

Comment: Several commenters indicated that the general inpatient level of care was appropriate in rare circumstances where the patient's care network breakdown is not recoverable after a short period of inpatient respite care. Other commenters expressed the need to provide inpatient care immediately for caregiver breakdown. The same commenters believe that the immediate need would prohibit the use of inpatient respite care, which they indicated was a planned admission. One commenter strongly objected to the statement in the proposed rule that specified the requirement for the provision of an intensity of care to support the general inpatient level of care. However, some commenters stated that more frequent use of general inpatient level of care is appropriate as hospices are experiencing difficulty finding adequate caregivers.

Some commenters stated that general inpatient level of care provided the only option other than discharging patients from the hospice benefit to long term care facilities. Others stated that the proposed clarification implied that hospice care must be terminated when there is a situation of caregiver breakdown, as there was no Medicare hospice benefit category to care for patients without caregiver support. Some commenters stated that we did not address how caregiver breakdown situations should be addressed while others implied that unless hospices could bill for general inpatient level of care for caregiver breakdown, patients' symptoms could be uncontrolled necessitating the general inpatient level of care.

Response: We disagree with the comment that we did not indicate how caregiver breakdown situations should be addressed. We indicated in the proposed rule that there is nothing prohibiting a Medicare approved facility from serving as the individual's home. However, Medicare daily per-diem payments are based on medically reasonable and necessary levels of care as described in the Medicare regulations at § 418.302: A routine home care day is a day on which an individual is at home and is not receiving continuous care; a continuous home care day is a day on which an individual is not in an inpatient facility and receives hospice

care consisting predominantly of nursing care on a continuous basis at home during brief periods of crisis as described in § 418.204(a), to maintain the terminally ill patient at home; an inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis for respite; and a general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other setting. Medicare payment is made based on the medically reasonable and necessary level of care provided, and not simply where that care is provided. As discussed above, it is not appropriate to bill Medicare for the general inpatient care day for situations where the individual's caregiver support has broken down unless the coverage requirements for the general inpatient level of care are otherwise met.

We disagree with the comments that patients will need to be discharged from the hospice benefit to long term care facilities because discharge for caregiver breakdown does not meet the discharge requirements in the regulations at § 418.26. The requirements for discharge at § 418.26 state that a hospice may discharge a patient if the patient moves out of the hospice service area or transfers to another hospice; the hospice determines that the patient is no longer terminally ill; or the hospice discharges the patient for cause. We also disagree with the comment that patients will be forced to revoke the hospice benefit if there is caregiver breakdown. Revocation of the hospice benefit as described in § 418.28 is an action initiated by the individual (patient) and not by the hospice provider. Finally, we disagree with the comment that denying the use of the general inpatient level of care for caregiver breakdown will result in limitation of access. We have discussed various ways of providing care in this situation, such as the use of inpatient respite or use of alternative sources of payment for room and board, that we believe are appropriate alternatives to meeting the needs of the individual.

Comment: One commenter stated that hospices have seen an erosion of the use of the inpatient benefit and many offer very little inpatient care. This commenter concluded that the clarification represents a reduction in the benefit and will create a new limitation on access to hospice care and patients will seek inpatient hospital admissions instead of receiving hospice services at the general inpatient level of care. Several commenters stated that fiscal intermediaries have allowed the use of general inpatient care for caregiver breakdown.

Response: We disagree that our clarification on the use of the general inpatient level of care represents a reduction in the Medicare hospice benefit and that it will result in a limitation on access to hospice care. As we noted above, we are not making any policy changes concerning general inpatient care, rather, we are clarifying our established policy. We also disagree that there has been an erosion of the use of general inpatient level of care. Our data, which is available on the hospice Web site at *http://www.cms.hhs.gov/center/hospice.asp* demonstrates that use and payment for the general inpatient level of care has been increasing each year. We also do not agree that better compliance with statute, regulations and policy will limit access to hospice care nor do we see our clarification as an inducement to increase hospital admissions.

Comment: One commenter questioned why this clarification was being made when we were unable to quantify the extent of the use of general inpatient in the event of caregiver breakdown and suggested that further analysis be done. The same commenter indicated that the cost savings were inaccurate as our assumption of potential savings is based on current reimbursement rates for inpatient respite services. The same commenter believes that the inpatient respite care payment rate is inadequate. Several other commenters indicated that the reimbursement rate for inpatient respite care was inadequate.

Several commenters suggested the following: Extending the current 5-day limitation on inpatient respite care; revising policy to allow for the use of the general inpatient level of care when documentation indicates that a sufficient caregiver network cannot be restored in a few days; or establishing an alternative payment mechanism in the hospice benefit for situations where there is caregiver breakdown.

One commenter suggested that Medicare work with hospice providers to increase the average length of stay to that which was originally intended in legislation and in regulation. The same commenter stated that studies show that hospice care saves Medicare dollars. Several offered to work with CMS to find an alternative policy to meet patient needs while protecting the Medicare trust fund.

Response: We appreciate these suggestions and will keep them in mind as we continue to evaluate Medicare hospice payment policy. We noted in the proposed rule that we are unable to quantify the use of the general inpatient level of care for caregiver breakdown. In the proposed rule we provided an example of the potential impact, as we did not have empirical data to suggest the actual usage. This example demonstrated the cost savings to Medicare by using as an example, what we believe could be a cost saving if we assumed that 5 percent of the days and expenditures for general inpatient level of care were attributable to caregiver breakdown. However, the unavailability of exact utilization rates does not preclude us from ensuring that the general inpatient level of care is being billed as we intended. Based upon the comments we received, we believe that the use of the general inpatient level of care for caregiver breakdown may be more pervasive than we had envisioned at the time of the proposed rule.

We disagree with the commenter who suggested that the original legislation and regulation intended for the average length of stay to be at a specified level. While the statute defines the terminal diagnosis as having a prognosis of six months or less if the disease runs its normal course, this does not imply that there is, or ever was, a targeted length of stay that is required. The regulations require that an individualized plan of care be developed and updated to identify patient and family needs and the medically reasonable and necessary items and services that are required to meet these needs. In addition, as individuals vary in their responses to illness and care, we expect to see some variability in lengths of stay. We do not believe that it is feasible or prudent to specify or predetermine what lengths of stay should or must be achieved to measure or evaluate the effectiveness of care provided.

Regarding the comment that the reimbursement rate for inpatient respite care is inadequate, in the proposed rule, we did not propose to make any adjustments on the payment rates and merely indicated that the hospice payment rates are adjusted annually based upon the full market basket percentage increase. We are aware of studies which suggest that the inpatient respite care payment rate may not reflect the costs for providing this level of care. We will consider the comments made concerning the inpatient respite care rate as we continue to examine Medicare hospice payment policy.

G. Certification of the Terminal Illness

Section 1814(a)(7)(A)(i) of the Act stipulates that the individual's attending physician and the hospice medical director initially certify the individual's terminal diagnosis with a prognosis of

six months or less if the disease runs its normal course. Our regulations at § 418.22 discuss the requirements of the certification, including documentation requirements. As discussed in the proposed rule, we are aware that some providers permit the hospice admission nurse to determine eligibility for hospice services and to certify the individual's terminal diagnosis. In the proposed rule, we explained that the statute is explicit in the requirement that the attending physician and the hospice medical director determine the terminal diagnosis, and his or her signature on the certification attests to that fact.

Comment: We received three items of correspondence regarding this clarification. One commenter supported the clarification of the responsibility of the hospice medical director and the attending physician to certify the terminal illness. One commenter asked if a hospice medical director visit is required at the time of admission to a hospice and what is the time frame for the visit. Another commenter stated that concurrence of the hospice medical director and the attending physician may be tacit and no communication is required between them.

Response: As discussed above, section 1814(a)(7)(A)(i) of the Act stipulates that the individual's attending physician and the hospice medical director each initially certify that the individual is terminally ill with a medical life expectancy of six months or less if the disease runs its normal course. Our regulations at § 418.25(a) of hospice regulations indicate, that the hospice admits a patient only on the recommendation of the medical director in consultation with, or with input, from the patient's attending physician (if any). As noted in the proposed rule, the requirements of the physician certification, including supportive documentation, were discussed in the Medicare Program; Hospice Care Amendments proposed rule (67 CFR 70363) and final rule (70 CFR 70548). Current regulations do not address a time frame for a physician or hospice medical director visit.

III. Provisions of the Final Regulations

In this final rule, we are adopting the following provisions, as set forth in the proposed rule, without change. We are also publishing the FY 2008 urban and rural wage index values for hospices in the addendum as well as the table that reflects the impact of the FY 2008 wage index values.

A. Annual Update to the Hospice Wage Index

The FY 2008 hospice wage index values have been computed utilizing OMB's geographic location definitions (CBSA). The budget neutrality adjustment factor was computed utilizing data from the FY 2006 claims processed through June 2007. The FY 2008 budget neutrality adjustment factor of 1.066671 was applied to hospital wage data above 0.8. The budget neutrality adjustment factor or the hospice floor was applied to the hospital wage data below 0.8, not to exceed 0.8. The wage index values are reflected in Table A and Table B of the Addendum. Specifically, Table A reflects the FY 2008 wage index values for urban areas under the CBSA designations. Table B reflects the FY 2008 wage index values for rural areas under the CBSA designations.

B. Rural Areas Without Hospital Wage Data

For FY 2008 and subsequent hospice wage index values, for urban labor markets without an urban hospital from which hospital wage index data could be derived, all of the CBSAs within the State will be used to calculate a statewide urban average wage index to use as a reasonable proxy for these areas. Currently, the only CBSA that is affected by this is CBSA 25980, Hinesville-Fort Stewart, Georgia.

For FY 2008 and subsequent hospice wage index values, in cases where there is a rural area without rural hospital wage data, we will use the average pre-floor, pre-reclassified wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. This approach meets the criteria that we believe would be the best imputed proxy for rural areas, which (1) uses pre-floor, pre-reclassified hospital data; (2) uses the most local data available to impute a rural wage index; (3) is easy to evaluate; and (4) is easy to update from year-to-year. Currently there are no hospitals in rural locations in Massachusetts and Puerto Rico.

We interpret the term ''contiguous'' to mean sharing a border. For example, we have determined that the borders of Dukes and Nantucket counties are contiguous with Barnstable and Bristol Counties. Therefore, the pre-floor, pre-reclassified 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 wage index for rural Massachusetts. Should a similar situation arise in the future, we may re-examine this policy.

As discussed in the proposed rule, as there are sufficient economic differences between hospitals in the United States and those in Puerto Rico, we do not believe that this policy would be appropriate for Puerto Rico. We also noted that as we have not yet identified an alternative methodology for imputing a wage index for rural Puerto Rico, we will continue to evaluate the use of other sources. Accordingly, we will continue to use the most recent pre-floor, pre-reclassified wage index previously available for Puerto Rico.

C. Nomenclature Changes

This final rule and all subsequent hospice rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current hospice wage index. The tables in this final rule reflect changes made by these bulletins. The OMB bulletins may be accessed at *http://www.whitehouse.gov/omb/bulletins/index.html.*

D. Payment for Hospice Care Based on the Location Where Care Is Furnished

Effective January 1, 2008, all payment rates (routine home care, continuous home care, inpatient respite and general inpatient care) will be adjusted by the geographic wage index value of the area where hospice services are provided. In other words, the wage component of each payment rate is multiplied by the wage index value applicable to the location in which the hospice services are provided. Section 418.302 is amended to reflect this change. Hospice providers will be required to indicate on hospice claims, the CBSA for the location where hospice care is provided.

E. Educational Requirements for Nurse Practitioners

In order to align the hospice qualifications for nurse practitioners under § 418.3 and Part B nurse practitioners under § 410.75, the definition of ''attending physician'' at § 418.3 is revised to cross reference the training, education and experience requirements described in § 410.75(b).

F. Caregiver Breakdown and General Inpatient Care

We are not implementing any changes regarding the general inpatient level of care and caregiver breakdown, but are providing clarification of existing policy, statute, and hospice regulations. The Medicare hospice benefit provides for care that is medically reasonable and necessary for the palliation and

management of terminal and related conditions, and is structured in such a way to enable the individual with a terminal condition to remain at home, in the company of family and friends. The statute, our regulations at § 418.202(e), and Medicare hospice policy require that in order to receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. It is the level of care provided to meet the individual's needs that determines payment rates for Medicare services. In other words, caregiver breakdown should not be billed as general inpatient care regardless where the services are provided, unless the intensity-of-care requirement is met. If an individual no longer is able to remain at home or if the individual's caregiver is no longer able to provide care, and the required care does not meet the requirements for general inpatient care, the hospice may not bill this care at the general inpatient level of care. This situation is considered to be caregiver breakdown. This does not imply or suggest that the individual must be discharged from the hospice if caregiver breakdown occurs. It does mean that the hospice must find alternative means for the provision of caregiver services, which may include payment for room and board, as Medicare does not pay for caregiver services, nor does it pay for room and board.

G. Certification of Terminal Illness

We are not making any changes to the certification of terminal illness requirements. We are clarifying that the statute requires that the attending physician and the hospice medical director, not the admission nurse, initially certify the terminal diagnosis with a prognosis of six months or less if the disease runs its normal course. The regulations require that there be documentation in the medical record to support the initial as well as any subsequent certifications. The admission nurse may obtain information supporting the terminal illness in order to allow the attending physician and the medical director to have the necessary information to make the terminal illness determination. But, the determination of the terminal illness cannot be delegated to an admission nurse or any other employee.

IV. Collection of Information Requirements

This document does not impose any information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. We estimated the impact on hospices, as a result of the changes to the FY 2008 hospice wage index. As discussed previously, the methodology for computing the wage index was determined through a negotiated rulemaking committee and implemented in the August 8, 1997 final rule (62 FR 42860). This final rule updates the hospice wage index in accordance with our regulation and that methodology, incorporating the CBSA designations used in the FY 2007 hospital wage index data.

- Table 1 categorizes the impact of the FY 2008 wage index values on hospices by various geographic and provider characteristics. We estimate that the total hospice payments will increase $2,860,000 as a result of the application of the FY 2008 wage index values. As discussed in the proposed rule as well as in this final rule, the impact analysis only reflects the FY 2008 wage index values. The FY 2008 hospice payment rates are promulgated through administrative issuance and are not included in the impact analysis.
- Table A reflects the FY 2008 wage index values for urban areas designations.
- Table B reflects the FY 2008 wage index values for rural areas designations.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). We have determined that this final rule is not an economically significant rule under this Executive Order.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospices and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any one year (for details, see the Small Business Administration's regulation at 65 FR 69432, that sets forth size standards for health care industries). For purposes of the RFA, most hospices are small entities. As indicated in Table 1 below, there are 2,956 hospices. Approximately 53 percent of Medicare certified hospices are identified as voluntary, government, or other agencies and, therefore, are considered small entities. Because the National Hospice and Palliative Care Organization estimates that approximately 79 percent of hospice patients are Medicare beneficiaries, we have not considered other sources of revenue in this analysis. Furthermore, the wage index methodology was previously determined by consensus, through a negotiated rulemaking committee that included representatives of national hospice associations, rural, urban, large and small hospices, multi-site hospices, and consumer groups. Based on all of the options considered, the committee agreed on the methodology described in the committee statement, and it was adopted into regulation in the August 8, 1997 final rule. In developing the process for updating the wage index in the 1997 final rule, we considered the impact of this methodology on small entities and attempted to mitigate any potential negative effects.

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

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any one year by State, local, and tribal governments, in the aggregate, or by the private sector, of $120 million or more. This final rule is not anticipated to have an effect on State, local, or tribal governments or on the private sector of $120 million or more.

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

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

B. Anticipated Effects

As discussed in the proposed rule, we are unable to quantify the extent of the usage of the general inpatient level of care in the event of caregiver breakdown. Therefore, we are unable to definitively anticipate the impact of our clarification of the general inpatient level of care policy in the event of caregiver breakdown. For this reason, we solicited comment on what the impact of our clarification might be. We did not receive any substantive comments on the impact. Based on anecdotal evidence as well as substantial increases in the number of claims submitted for general inpatient care, however, we believe a small proportion of patient days attributed to general inpatient care would be appropriately allocated to inpatient respite care with this clarification. Significant savings could be realized even if only a small proportion of patient days attributed to general inpatient care were allocated to inpatient respite care.

In the proposed rule we cited an example to determine the impact. In that example, we allocated 5.0 percent of general inpatient care days to inpatient respite care, using the FY 2005 patient days, expenditures and number of beneficiaries electing the hospice benefit to estimate the impact of the clarification of existing policy in this final rule. The number of inpatient days was adjusted from 1,250,678 to 1,188,144. The number of inpatient respite days was adjusted from 96,646 to 159,180. While inpatient respite expenditures increased from $14,000,000 to $23,058,570, general inpatient care expenditures decreased from $737,300,000 to $700,435,000. In total, if 5.0 percent of patient days that were attributed to general inpatient care in FY 2005 were allocated to the inpatient respite level of care, it would have resulted in net savings of $27,806,430.

The impact analysis of this final rule represents the projected effects of the changes in the hospice wage index from FY 2007 to FY 2008. We estimate the effects by estimating payments for FY 2008 using the FY 2007 wage index values while holding all other payment variables constant.

We note that certain events may combine to limit the scope or accuracy of our impact analysis because such an analysis is future oriented and, thus, 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.

For the purposes of this final rule, we compared estimated payments using the FY 1983 hospice wage index to estimated payments using the FY 2008 wage index and determined the hospice wage index to be budget neutral. Budget neutrality means that, in a given year, estimated aggregate payments for Medicare hospice services using the FY 2008 wage index would equal estimated aggregate payments that would have been made for the same services if the 1983 wage index had remained in effect. Budget neutrality to 1983 does not imply that estimated payments would not increase since the budget neutrality applies only to the wage index portion and not the total payment rate, which accommodates inflation.

As discussed above, we use the latest claims file available to us to develop the impact table when we issue the annual yearly wage index update. For the purposes of this final rule, data were obtained from the National Claims History file using FY 2006 claims processed through June 2007, which was the most recent available data. We deleted bills from hospice providers that have since closed. For the purposes of this final rule, this file is adequate to demonstrate the impact of the FY 2008 wage index values and is not intended to project the anticipated expenditures for FY 2008. This impact analysis compares hospice payments using the FY 2007 hospice wage index to the estimated payments using the FY 2008 wage index. We note that estimated payments for FY 2008 are determined by using the wage index for FY 2008 and payment rates for FY 2007. We also note that the results in the impact analysis table (Table 1) in this final rule differ from the proposed rule, because we have incorporated the most recent data to determine the budget neutrality adjustment factor. As noted in previous sections, payment rates for FY 2008 are published through administrative issuance.

Table 1 demonstrates the results of our analysis. In column 1 we indicate the number of hospices included in our analysis. 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. Column 3 estimates payments using the FY 2007 wage index values and the FY 2007 payment rates. Column 4 estimates payments using FY 2008 wage index values as well as the FY 2007 payment rates. Column 5 compares columns 3 and 4 and shows the percentage change in estimated hospice payments based on the hospice category.

Table 1 also categorizes hospices by various geographic and provider characteristics. The first row 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 1,974 hospices located in urban areas and 982 hospices located in rural areas. The next two groupings in the table indicate the number of hospices by census region, also broken down by urban and rural hospices. The sixth 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 2006. 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 below, there are 2,956 hospices. Approximately 53 percent of Medicare-certified hospices are identified as voluntary, government, or other agencies and, therefore, are considered small entities. Because the National Hospice and Palliative Care Organization estimates that

approximately 79 percent of hospice patients are Medicare beneficiaries, we have not considered other sources of revenue in this analysis. Furthermore, the wage index methodology was previously determined by consensus, through a negotiated rulemaking committee that included representatives of national hospice associations; rural, urban, large, and small hospices; multi-site hospices; and consumer groups. Based on all of the options considered, the committee agreed on the methodology described in the committee statement, and it was adopted into regulation in the August 8, 1997 final rule. In developing the process for updating the wage index in the 1997 final rule, we considered the impact of this methodology on small entities and attempted to mitigate any potential negative effects.

As stated previously, the following discussions are limited to demonstrating trends rather than projected dollars. We used the CBSA designations and wage indices as well as the data from FY 2006 claims processed through June 2007 in developing the impact analysis. For FY 2008, the wage index is the variable that differs between the FY 2007 payments and the FY 2008 estimated payments. FY 2007, payment rates are used for both FY 2007 actual payments and the FY 2008 estimated payments. The FY 2008 payment rates will be adjusted to reflect the full FY 2008 hospital market basket, as required by section 1814(i)(1)(C)(ii)(VII) of the Act. As previously noted, we publish these rates through administrative issuances.

As discussed in the FY 2006 final rule (70 FR 45129), hospice agencies may use multiple wage indices to compute their payments based on potentially different geographic locations. For the purposes of this final rule, the location of the beneficiary is used for routine and continuous home care or the CBSA for the location of the hospice agency for respite and general inpatient care. As noted above, beginning January 1, 2008, the wage index utilized will be based on the location of the site of service. As the location of the beneficiary's home and the location of the facility may vary, there will still be variability in geographic location. We anticipate that the location of the various sites will correspond with the geographic location of the hospice and thus we will continue to use the location of the hospice for our analyses. For this analysis, we use payments to the hospice in the aggregate based on the location of the hospice. The impact of hospice wage index changes has been analyzed according to the type of hospice, geographic location, type of ownership, hospice base, and size.

Our analysis shows that most hospices are in urban areas and provide the vast majority of routine home care days. Most hospices are medium-sized followed by large hospices. Hospices are almost equal in numbers by ownership with 1,578 designated as non-profit and 1,378 as proprietary. The vast majority of hospices are freestanding.

1. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care days. The majority of the days provided by a hospice are routine home care (RHC) days representing over 70 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: small agencies having 0 to 3,499 RHC days; medium agencies having 3,500 to 19,999 RHC days; and large agencies having 20,000 or more RHC days. Using RHC days as a proxy for size, our analysis indicates that the proposed FY 2008 wage index values are anticipated to have virtually no impact on hospice providers, with a slight increase of 0.1 percent anticipated for medium hospices while no change is anticipated for small or large hospices.

2. Geographic Location

Our analysis demonstrates that the proposed FY 2008 wage index values will result in little change in estimated payments with urban hospices anticipated to experience no change while rural hospices are anticipated to experience a slight increase of 0.3 percent. For urban hospices, the greatest increase of 0.9 percent is anticipated to be experienced by the Mountain regions, followed by an increase for East North Central of 0.7 percent and Pacific regions of 0.6 percent. The remaining urban regions are anticipated to experience a decrease ranging from 0.1 percent in the West North Central and Middle Atlantic regions to 0.6 percent in the East South Central region. The greatest decrease of 2.4 percent is anticipated for Puerto Rico.

For rural hospices, Puerto Rico is anticipated to experience no change. Two regions are anticipated to experience a decrease of 1.1 percent for New England and 0.3 percent for the mountain regions. The remaining regions are anticipated to experience an increase ranging from 0.1 percent for the South Atlantic region to 0.6 percent for the Middle Atlantic, East South Central and West North Central regions.

3. Type of Ownership

By type of ownership, non-profit hospices are anticipated to experience a slight increase of 0.1 percent in payment while government hospices are anticipated to experience a slight increase of 0.2 percent. No change is anticipated for proprietary hospices. Not specified hospices in the ''other'' category are anticipated to experience a slight decrease of 0.2 percent.

4. Hospice Base

No change in payment is anticipated for freestanding facilities. Home health, hospital, and skilled nursing facilities are anticipated to experience an increase of 0.1, 0.3, and 0.7 percent, respectively.

TABLE 1.—IMPACT OF HOSPICE WAGE INDEX CHANGE

	Number of Hospices	Number of Routine Home Care Days in Thousands	Payments using FY 2007 Wage Index in Thousands	Estimated Payments using FY 2008 CBSA Wage Index in Thousands	Percent Change in Hospice Payments
	(1)	(2)	(3)	(4)	(5)
ALL HOSPICES:	2956	61,125	9,148,694	9,151,554	0.0
URBAN HOSPICES	1974	52,426	8,048,410	8,048,224	0.0
RURAL HOSPICES	982	8,699	1,100,284	1,103,330	0.3
BY REGION—URBAN:					
NEW ENGLAND	112	1,772	313,059	311,816	−0.4

TABLE 1.—IMPACT OF HOSPICE WAGE INDEX CHANGE—Continued

	Number of Hospices	Number of Routine Home Care Days in Thousands	Payments using FY 2007 Wage Index in Thousands	Estimated Payments using FY 2008 CBSA Wage Index in Thousands	Percent Change in Hospice Payments
	(1)	(2)	(3)	(4)	(5)
MIDDLE ATLANTIC	198	5,211	843,068	842,000	−0.1
SOUTH ATLANTIC	285	11,385	1,839,567	1,831,476	−0.4
EAST NORTH CENTRAL	294	7,568	1,158,628	1,166,376	0.7
EAST SOUTH CENTRAL	157	4,333	586,642	583,333	−0.6
WEST NORTH CENTRAL	151	3,413	471,129	470,666	−0.1
WEST SOUTH CENTRAL	336	7,113	1,007,361	1,002,636	−0.5
MOUNTAIN	182	4,531	702,881	709,230	0.9
PACIFIC	225	6,302	1,054,910	1,061,223	0.6
PUERTO RICO	34	797	71,165	69,468	−2.4
BY REGION—RURAL:					
NEW ENGLAND	26	144	21,134	20,910	−1.1
MIDDLE ATLANTIC	43	408	52,441	52,765	0.6
SOUTH ATLANTIC	124	1,840	238,972	239,136	0.1
EAST NORTH CENTRAL	140	1,125	146,434	146,747	0.2
EAST SOUTH CENTRAL	142	1,982	240,058	241,528	0.6
WEST NORTH CENTRAL	188	944	120,343	121,061	0.6
WEST SOUTH CENTRAL	163	1,307	153,527	153,934	0.3
MOUNTAIN	103	576	74,972	74,718	−0.3
PACIFIC	52	365	51,809	51,936	0.2
PUERTO RICO	1	7	595	595	0.0
ROUTINE HOME CARE DAYS:					
0–3499 DAYS (small)	617	1,060	142,491	142,458	0.0
3500–19,999 DAYS (medium)	1429	14,208	1,994,694	1,996,162	0.1
20,000+ DAYS (large)	910	45,856	7,011,509	7,012,935	0.0
TYPE OF OWNERSHIP:					
VOLUNTARY	1220	27,555	4,270,787	4,274,723	0.1
PROPRIETARY	1378	30,166	4,380,444	4,379,751	0.0
GOVERNMENT	193	986	133,503	133,745	0.2
OTHER	165	2,417	363,960	363,335	−0.2
HOSPICE BASE:					
FREESTANDING	1767	45,209	6,752,227	6,750,239	0.0
HOME HEALTH AGENCY	620	9,105	1,369,110	1,370,605	0.1
HOSPITAL	555	6,606	994,451	997,560	0.3
SKILLED NURSING FACILITY	14	205	32,906	33,149	0.7

Note: FY 2007 payment rates were used for estimated payments for FY 2008. FY 2008 payment rates will be adjusted to reflect the full hospital market basket and will be promulgated through administrative issuance.

C. Conclusion

Our impact analysis compared the FY 2007 wage index to the estimated payments using the FY 2008 wage index. Through the analysis, we estimate that total hospice payments, based on the FY 2008 wage index values, will effectively be budget neutral with an estimated increase from FY 2007 of $2,860,000. As discussed, the budget neutrality adjustment factor is determined by using the pre-floor, pre-reclassified hospital wage data. The impact analysis compares the wage index values, which have had either the budget neutrality adjustment factor or the hospice floor applied. Additionally, we compared estimated payments using the FY 1983 hospice wage index to estimated payments using the FY 2008 wage index and determined the current hospice wage index to be budget neutral, as required by the negotiated rulemaking committee. As noted above, the payment rates used reflect the FY 2007 rates. The FY 2008 payment rates will be adjusted to reflect the full FY 2008 hospital market basket, as required by section 1814(i)(1)(C)(ii)(VII) of the Act. We publish these rates through administrative issuances.

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

List of Subjects for 42 CFR Part 418

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

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

PART 418—HOSPICE CARE

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

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

Subpart A—General Provision and Definitions

■ 2. Section 418.3 is amended by revising paragraph (1)(ii) in the definition of ''attending physician'' to read as follows:

§ 418.3 Definitions.

* * * * *

(1) * * *

(ii) Nurse practitioner who meets the training, education, and experience requirements as described in § 410.75 (b) of this chapter.

* * * * *

Subpart G—Payment for Hospice Care

■ 3. Section 418.302 is amended by revising paragraph (g) to read as follows:

§ 418.302 Payment procedures for hospice care.

* * * * *

(g) Payment for routine home care, continuous home care, general inpatient care and inpatient respite care is made on the basis of the geographic location where the services are provided.

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

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: July 19, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: August 17, 2007.

Michael O. Leavitt,

Secretary.

BILLING CODE 4120–01–P

Note: The following Addendum will not appear in the Code of Federal Regulations.

ADDENDUM

TABLE A--HOSPICE WAGE INDEX FOR URBAN AREAS BY CBSA

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
10180	Abilene, TX Callahan, TX Jones, TX Taylor, TX	0.8533
10380	Aguadilla-Isabela-San Sebastián, PR Aguada, PR Aguadilla, PR Moca, PR Isabela, PR Lares, PR Rincón, PR San Sebastián, PR Anasco, PR	0.4502
10420	Akron, OH Portage, OH Summit, OH	0.9231
10500	Albany, GA Dougherty, GA Lee, GA Baker, GA Terrell, GA Worth, GA	0.9590
10580	Albany-Schenectady-Troy, NY Albany, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.9301
10740	Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM Torrance, NM	1.0089
10780	Alexandria, LA Rapides, LA Grant, LA	0.8540

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
10900	Allentown-Bethlehem-Easton, PA-NJ Carbon, PA Lehigh, PA Northampton, PA Warren, NJ	1.0610
11020	Altoona, PA Blair, PA	0.9400
11100	Amarillo, TX Potter, TX Randall, TX Armstrong, TX Carson, TX	0.9780
11180	Ames, IA Story, IA	1.0411
11260	Anchorage, AK Anchorage, AK Matanuska-Susitna, AK	1.2825
11300	Anderson, IN Madison, IN	0.9260
11340	Anderson, SC Anderson, SC	0.9618
11460	Ann Arbor, MI Washtenaw, MI	1.1548
11500	Anniston-Oxford, AL Calhoun, AL	0.8288
11540	Appleton, WI Calumet, WI Outagamie, WI	1.0085
11700	Asheville, NC Buncombe, NC Madison, NC Haywood, NC Henderson, NC	0.9830
12020	Athens-Clarke County, GA Clarke, GA Madison, GA Oconee, GA Oglethorpe, GA	1.0513

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index [1]
12060	Atlanta-Sandy Springs-Marietta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA De Kalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA Butts, GA Dawson, GA Haralson, GA Heard, GA Jasper, GA Lamar, GA Meriwether, GA Pike, GA	1.0413
12100	Atlantic City, NJ Atlantic, NJ	1.2620
12220	Auburn-Opelika, AL Lee, AL	0.8636
12260	Augusta-Richmond County, GA-SC Aiken, SC Columbia, GA Edgefield, SC McDuffie, GA Richmond, GA Burke, GA	1.0312

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index [1]
12420	Austin-Round Rock, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9967
12540	Bakersfield, CA Kern, CA	1.1440
12580	Baltimore-Towson, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD	1.0761
12620	Bangor, ME Penobscot, ME	1.0358
12700	Barnstable Town, MA Barnstable, MA	1.3375
12940	Baton Rouge, LA Ascension, LA East Baton Rouge Parish, LA Livingston, LA West Baton Rouge Parish, LA East Feliciana, LA Iberville, LA Pointe Coupee, LA St. Helena, LA West Feliciana, LA	0.8623
12980	Battle Creek, MI Calhoun, MI	1.0413
13020	Bay City, MI Bay, MI	0.9868
13140	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.9168
13380	Bellingham, WA Whatcom, WA	1.1844
13460	Bend, OR Deschutes, OR	1.1459

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
13644	Bethesda-Gaithersburg-Frederick, MD Frederick, MD Montgomery, MD	1.1630
13740	Billings, MT Carbon, MT Yellowstone, MT	0.9293
13780	Binghamton, NY Broome, NY Tioga, NY	0.9372
13820	Birmingham-Hoover, AL Blount, AL Jefferson, AL Shelby, AL St. Clair, AL Bibb, AL Chilton, AL Walker, AL	0.9487
13900	Bismarck, ND Burleigh, ND Morton, ND	0.8000
13980	Blacksburg-Christiansburg-Radford, VA Giles, VA Montgomery, VA Pulaski, VA Radford City, VA	0.8761
14020	Bloomington, IN Greene, IN Owen, IN Monroe, IN	0.9102
14060	Bloomington-Normal, IL McLean, IL	0.9540
14260	Boise City-Nampa, ID Ada, ID Canyon, ID Boise, ID Gem, ID Owyhee, ID	1.0028
14484	Boston-Quincy, MA Norfolk, MA Plymouth, MA Suffolk, MA	1.2458
14500	Boulder, CO Boulder, CO	1.1040

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
14540	Bowling Green, KY Edmonson, KY Warren, KY	0.8691
14740	Bremerton-Silverdale, WA Kitsap, WA	1.1641
14860	Bridgeport-Stamford-Norwalk, CT Fairfield, CT	1.3503
15180	Brownsville-Harlingen, TX Cameron, TX	1.0059
15260	Brunswick, GA Brantley, GA Glynn, GA McIntosh, GA	1.0842
15380	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	1.0052
15500	Burlington, NC Alamance, NC	0.9252
15540	Burlington-South Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0106
15764	Cambridge-Newton-Framingham, MA Middlesex, MA	1.1701
15804	Camden, NJ Burlington, NJ Camden, NJ Gloucester, NJ	1.1085
15940	Canton-Massillon, OH Carroll, OH Stark, OH	0.9633
15980	Cape Coral-Fort Myers, FL Lee, FL	0.9965
16180	Carson City, NV Carson City, NV	1.0693
16220	Casper, WY Natrona, WY	0.9755
16300	Cedar Rapids, IA Linn, IA Benton, IA Jones, IA	0.9481

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
16580	Champaign-Urbana, IL	1.0287
	Champaign, IL	
	Ford, IL	
	Piatt, IL	
16620	Charleston, WV	0.9112
	Kanawha, WV	
	Putnam, WV	
	Boone, WV	
	Clay, WV	
	Lincoln, WV	
16700	Charleston-North Charleston, SC	0.9755
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	1.0191
	Cabarrus, NC	
	Gaston, NC	
	Mecklenburg, NC	
	Union, NC	
	York, SC	
	Anson, NC	
16820	Charlottesville, VA	1.0800
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
	Nelson, VA	
16860	Chattanooga, TN-GA	0.9545
	Catoosa, GA	
	Dade, GA	
	Hamilton, TN	
	Marion, TN	
	Walker, GA	
	Sequatchie, TN	
16940	Cheyenne, WY	0.9664
	Laramie, WY	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
16974	Chicago-Naperville-Joliet, IL	1.1468
	Cook, IL	
	De Kalb, IL	
	Du Page, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	McHenry, IL	
	Will, IL	
17020	Chico, CA	1.1790
	Butte, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0241
	Boone, KY	
	Brown, OH	
	Campbell, KY	
	Clermont, OH	
	Dearborn, IN	
	Gallatin, KY	
	Grant, KY	
	Hamilton, OH	
	Kenton, KY	
	Ohio, IN	
	Pendleton, KY	
	Warren, OH	
	Franklin, IN	
	Bracken, KY	
	Butler, OH	
17300	Clarksville, TN-KY	0.8998
	Christian, KY	
	Montgomery, TN	
	Stewart, TN	
	Trigg, KY	
17420	Cleveland, TN	0.8650
	Bradley, TN	
	Polk, TN	
17460	Cleveland-Elyria-Mentor, OH	1.0027
	Cuyahoga, OH	
	Geauga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
17660	Coeur d'Alene, ID	0.9967
	Kootenai, ID	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
17780	College Station-Bryan, TX Brazos, TX Burleson, TX Robertson, TX	0.9648
17820	Colorado Springs, CO El Paso, CO Teller, CO	1.0348
17860	Columbia, MO Boone, MO Howard, MO	0.9112
17900	Columbia, SC Lexington, SC Richland, SC Calhoun, SC Fairfield, SC Kershaw, SC Saluda, SC	0.9529
17980	Columbus, GA-AL Chattahoochee, GA Harris, GA Muscogee, GA Russell, AL Marion, GA	0.8788
18020	Columbus, IN Bartholomew, IN	0.9939
18140	Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH Morrow, OH Union, OH	1.0781
18580	Corpus Christi, TX Nueces, TX San Patricio, TX Aransas, TX	0.9135
18700	Corvallis, OR Benton, OR	1.2316
19060	Cumberland, MD-WV Allegany, MD Mineral, WV	0.9009

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
19124	Dallas-Plano-Irving, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Hunt, TX Kaufman, TX Rockwall, TX Delta, TX	1.0747
19140	Dalton, GA Murray, GA Whitfield, GA	0.9699
19180	Danville, IL Vermilion, IL	0.9884
19260	Danville, VA Danville City, VA Pittsylvania, VA	0.9014
19340	Davenport-Moline-Rock Island, IA-IL Henry, IL Rock Island, IL Scott, IA Mercer, IL	0.9436
19380	Dayton, OH Greene, OH Miami, OH Montgomery, OH Preble, OH	0.9640
19460	Decatur, AL Lawrence, AL Morgan, AL	0.8703
19500	Decatur, IL Macon, IL	0.8717
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia, FL	0.9881

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index [1]
19740	Denver-Aurora, CO Adams, CO Arapahoe, CO Broomfield, CO Denver, CO Douglas, CO Jefferson, CO Clear Creek, CO Elbert, CO Gilpin, CO Park, CO	1.1659
19780	Des Moines-West Des Moines, IA Dallas, IA Polk, IA Warren, IA Guthrie, IA Madison, IA	0.9828
19804	Detroit-Livonia-Dearborn, MI Wayne, MI	1.0966
20020	Dothan, AL Geneva, AL Henry, AL Houston, AL	0.8000
20100	Dover, DE Kent, DE	1.0504
20220	Dubuque, IA Dubuque, IA	0.9742
20260	Duluth, MN-WI Douglas, WI St. Louis, MN Carlton, MN	1.0712
20500	Durham, NC Chatham, NC Durham, NC Orange, NC Person, NC	1.0481
20740	Eau Claire, WI Chippewa, WI Eau Claire, WI	1.0272
20764	Edison, NJ Middlesex, NJ Somerset, NJ Monmouth, NJ Ocean, NJ	1.1936

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index [1]
20940	El Centro, CA Imperial, CA	0.9681
21060	Elizabethtown, KY Hardin, KY Larue, KY	0.9277
21140	Elkhart-Goshen, IN Elkhart, IN	1.0054
21300	Elmira, NY Chemung, NY	0.8789
21340	El Paso, TX El Paso, TX	0.9657
21500	Erie, PA Erie, PA	0.9416
21604	Essex County, MA Essex, MA	1.1113
21660	Eugene-Springfield, OR Lane, OR	1.1601
21780	Evansville, IN-KY Gibson, IN Henderson, KY Posey, IN Vanderburgh, IN Warrick, IN Webster, KY	0.9676
21820	Fairbanks, AK Fairbanks North Star, AK	1.1796
21940	Fajardo, PR Ceiba, PR Fajardo, PR Luquillo, PR	0.4641
22020	Fargo, ND-MN Cass, ND Clay, MN	0.8800
22140	Farmington, NM San Juan, NM	0.9162
22180	Fayetteville, NC Cumberland, NC Hoke, NC	0.9541
22220	Fayetteville-Springdale-Rogers, AR-MO Benton, AR Washington, AR Madison, AR McDonald, MO	0.9456

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
22380	Flagstaff, AZ Coconino, AZ	1.2374
22420	Flint, MI Genesee, MI	1.1700
22500	Florence, SC Darlington, SC Florence, SC	0.8947
22520	Florence-Muscle Shoals, AL Colbert, AL Lauderdale, AL	0.8366
22540	Fond Du Lac, WI Fond Du Lac, WI	1.0734
22660	Fort Collins-Loveland, CO Larimer, CO	1.0180
22744	Ft Lauderdale-Pompano Beach-Deerfield Beach, FL Broward, FL	1.0809
22900	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK Franklin, AR Le Flore, OK	0.8246
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa, FL	0.9219
23060	Fort Wayne, IN Allen, IN Wells, IN Whitley, IN	1.0152
23104	Fort Worth-Arlington, TX Johnson, TX Parker, TX Tarrant, TX Wise, TX	1.0207
23420	Fresno, CA Fresno, CA	1.1673
23460	Gadsden, AL Etowah, AL	0.8604
23540	Gainesville, FL Alachua, FL Gilchrist, FL	0.9896
23580	Gainesville, GA Hall, GA	0.9555

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
23844	Gary, IN Lake, IN Porter, IN Jasper, IN Newton, IN	0.9956
24020	Glens Falls, NY Warren, NY Washington, NY	0.8879
24140	Goldsboro, NC Wayne, NC	0.9782
24220	Grand Forks, ND-MN Grand Forks, ND Polk, MN	0.8479
24300	Grand Junction, CO Mesa, CO	1.0313
24340	Grand Rapids-Wyoming, MI Kent, MI Barry, MI Ionia, MI Newaygo, MI	1.0085
24500	Great Falls, MT Cascade, MT	0.9171
24540	Greeley, CO Weld, CO	1.0242
24580	Green Bay, WI Brown, WI Kewaunee, WI Oconto, WI	1.0440
24660	Greensboro-High Point, NC Guilford, NC Randolph, NC Rockingham, NC	0.9457
24780	Greenville, NC Pitt, NC Greene, NC	1.0061
24860	Greenville, SC Greenville, SC Pickens, SC Laurens, SC	1.0458
25020	Guayama, PR Arroyo, PR Guayama, PR Patillas, PR	0.3720

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
25060	Gulfport-Biloxi, MS Hancock, MS Harrison, MS Stone, MS	0.9509
25180	Hagerstown-Martinsburg, MD-WV Washington, MD Morgan, WV Berkeley, WV	0.9641
25260	Hanford-Corcoran, CA Kings, CA	1.0968
25420	Harrisburg-Carlisle, PA Cumberland, PA Dauphin, PA Perry, PA	1.0029
25500	Harrisonburg, VA Harrisonburg City, VA Rockingham, VA	0.9678
25540	Hartford-West Hartford-East Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1620
25620	Hattiesburg, MS Forrest, MS Lamar, MS Perry, MS	0.8000
25860	Hickory-Lenoir-Morganton, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9611
25980	Hinesville-Fort Stewart, GA Liberty, GA Long, GA	0.9790
26100	Holland-Grand Haven, MI Ottawa, MI	0.9774
26180	Honolulu, HI Honolulu, HI	1.1836
26300	Hot Springs, AR Garland, AR	0.9368
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche, LA Terrebonne, LA	0.8621

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
26420	Houston-Sugar Land-Baytown, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX Austin, TX San Jacinto, TX Brazoria, TX Galveston, TX	1.0675
26580	Huntington-Ashland, WV-KY-OH Boyd, KY Cabell, WV Greenup, KY Lawrence, OH Wayne, WV	0.9597
26620	Huntsville, AL Limestone, AL Madison, AL	0.9608
26820	Idaho Falls, ID Bonneville, ID Jefferson, ID	0.9694
26900	Indianapolis-Carmel, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Marion, IN Morgan, IN Shelby, IN Brown, IN Putnam, IN	1.0555
26980	Iowa City, IA Johnson, IA Washington, IA	1.0362
27060	Ithaca, NY Tompkins, NY	1.0590
27100	Jackson, MI Jackson, MI	1.0197

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
27140	Jackson, MS Hinds, MS Madison, MS Rankin, MS Copiah, MS Simpson, MS	0.8822
27180	Jackson, TN Chester, TN Madison, TN	0.9443
27260	Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL Baker, FL	0.9776
27340	Jacksonville, NC Onslow, NC	0.8780
27500	Janesville, WI Rock, WI	1.0299
27620	Jefferson City, MO Callaway, MO Cole, MO Moniteau, MO Osage, MO	0.8888
27740	Johnson City, TN Carter, TN Unicoi, TN Washington, TN	0.8579
27780	Johnstown, PA Cambria, PA	0.9195
27860	Jonesboro, AR Craighead, AR Poinsett, AR	0.8173
27900	Joplin, MO Jasper, MO Newton, MO	0.9179
28020	Kalamazoo-Portage, MI Kalamazoo, MI Van Buren, MI	1.1418
28100	Kankakee-Bradley, IL Kankakee, IL	1.0755

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
28140	Kansas City, MO-KS Cass, MO Clay, MO Clinton, MO Jackson, MO Johnson, KS Lafayette, MO Leavenworth, KS Miami, KS Platte, MO Ray, MO Wyandotte, KS Franklin, KS Linn, KS Bates, MO Caldwell, MO	1.0128
28420	Kennewick-Richland-Pasco, WA Benton, WA Franklin, WA	1.1033
28660	Killeen-Temple-Fort Hood, TX Bell, TX Coryell, TX Lampasas, TX	0.9494
28700	Kingsport-Bristol-Bristol, TN-VA Bristol City, VA Hawkins, TN Scott, VA Sullivan, TN Washington, VA	0.8517
28740	Kingston, NY Ulster, NY	0.9992
28940	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Union, TN	0.8799
29020	Kokomo, IN Howard, IN Tipton, IN	1.0314
29100	La Crosse, WI-MN Houston, MN La Crosse, WI	1.0054

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
29140	Lafayette, IN Benton, IN Carroll, IN Tippecanoe, IN	0.9526
29180	Lafayette, LA Lafayette, LA St. Martin, LA	0.8842
29340	Lake Charles, LA Calcasieu, LA Cameron, LA	0.8442
29404	Lake County-Kenosha County, IL-WI Lake, IL Kenosha, WI	1.1275
29460	Lakeland, FL Polk, FL	0.9471
29540	Lancaster, PA Lancaster, PA	1.0228
29620	Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	1.0761
29700	Laredo, TX Webb, TX	0.8332
29740	Las Cruces, NM Dona Ana, NM	0.9891
29820	Las Vegas-Paradise, NV Clark, NV	1.2192
29940	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Lawrence, KS Douglas, KS	0.8923
30020	Lawton, OK Comanche, OK	0.8603
30140	Lebanon, PA Lebanon, PA	0.9258
30300	Lewiston, ID-WA Nez Perce, ID Asotin, WA	1.0510
30340	Lewiston-Auburn, ME Androscoggin, ME	0.9734

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
30460	Lexington-Fayette, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Scott, KY Woodford, KY	0.9793
30620	Lima, OH Allen, OH	0.9645
30700	Lincoln, NE Lancaster, NE Seward, NE	1.0765
30780	Little Rock-North Little Rock, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR Grant, AR Perry, AR	0.9483
30860	Logan, UT-ID Cache, UT Franklin, ID	0.9624
30980	Longview, TX Gregg, TX Upshur, TX Rusk, TX	0.9374
31020	Longview, WA Cowlitz, WA	1.0678
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles, CA	1.2544
31140	Louisville, KY-IN Bullitt, KY Clark, IN Floyd, IN Harrison, IN Jefferson, KY Oldham, KY Washington, IN Henry, KY Meade, KY Nelson, KY Shelby, KY Spencer, KY Trimble, KY	0.9726

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
31180	Lubbock, TX	0.9187
	Lubbock, TX	
	Crosby, TX	
31340	Lynchburg, VA	0.9274
	Amherst, VA	
	Bedford, VA	
	Bedford City, VA	
	Campbell, VA	
	Lynchburg City, VA	
	Appomattox, VA	
31420	Macon, GA	1.0154
	Bibb, GA	
	Jones, GA	
	Twiggs, GA	
	Crawford, GA	
	Monroe, GA	
31460	Madera, CA	0.8698
	Madera, CA	
31540	Madison, WI	1.1563
	Dane, WI	
	Columbia, WI	
	Iowa, WI	
31700	Manchester-Nashua, NH	1.0926
	Hillsborough, NH	
	Merrimack, NH	
31900	Mansfield, OH	0.9889
	Richland, OH	
32420	Mayagüez, PR	0.4425
	Hormigueros, PR	
	Mayagüez, PR	
32580	McAllen-Edinburg-Pharr, TX	0.9358
	Hidalgo, TX	
32780	Medford, OR	1.1539
	Jackson, OR	
32820	Memphis, TN-MS-AR	0.9998
	Crittenden, AR	
	DeSoto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
	Marshall, MS	
	Tate, MS	
	Tunica, MS	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
32900	Merced, CA	1.2236
	Merced, CA	
33124	Miami-Miami Beach-Kendall, FL	1.0466
	Miami-Dade, FL	
33140	Michigan City-La Porte, IN	0.9726
	La Porte, IN	
33260	Midland, TX	1.0438
	Midland, TX	
33340	Milwaukee-Waukesha-West Allis, WI	1.0899
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1676
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Pierce, WI	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	St. Croix, WI	
	Washington, MN	
	Wright, MN	
33540	Missoula, MT	0.9523
	Missoula, MT	
33660	Mobile, AL	0.8441
	Mobile, AL	
33700	Modesto, CA	1.2511
	Stanislaus, CA	
33740	Monroe, LA	0.8530
	Ouachita, LA	
	Union, LA	
33780	Monroe, MI	1.0354
	Monroe, MI	
33860	Montgomery, AL	0.8543
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
	Lowndes, AL	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
34060	Morgantown, WV Monongalia, WV Preston, WV	0.8985
34100	Morristown, TN Grainger, TN Hamblen, TN Jefferson, TN	0.8462
34580	Mount Vernon-Anacortes, WA Skagit, WA	1.1218
34620	Muncie, IN Delaware, IN	0.9133
34740	Muskegon-Norton Shores, MI Muskegon, MI	1.0604
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry, SC	0.9397
34900	Napa, CA Napa, CA	1.4266
34940	Naples-Marco Island, FL Collier, FL	1.0604
34980	Nashville-Davidson-Murfreesboro, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN Cannon, TN Hickman, TN Macon, TN Smith, TN Trousdale, TN	1.0504
35004	Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.3506
35084	Newark-Union, NJ-PA Pike, PA Essex, NJ Morris, NJ Sussex, NJ Union, NJ Hunterdon, NJ	1.2685

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
35300	New Haven-Milford, CT New Haven, CT	1.2750
35380	New Orleans-Metairie-Kenner, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. John Baptist, LA St. Tammany, LA	0.9420
35644	New York-White Plains-Wayne, NY-NJ Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY Bergen, NJ Passaic, NJ Hudson, NJ	1.4056
35660	Niles-Benton Harbor, MI Berrien, MI	0.9509
35980	Norwich-New London, CT New London, CT	1.2728
36084	Oakland-Fremont-Hayward, CA Alameda, CA Contra Costa, CA	1.6874
36100	Ocala, FL Marion, FL	0.9458
36140	Ocean City, NJ Cape May, NJ	1.1170
36220	Odessa, TX Ector, TX	1.0745
36260	Ogden-Clearfield, UT Davis, UT Weber, UT Morgan, UT	0.9595

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
36420	Oklahoma City, OK	0.9433
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Grady, OK	
	Lincoln, OK	
36500	Olympia, WA	1.1820
	Thurston, WA	
36540	Omaha-Council Bluffs, NE-IA	1.0080
	Cass, NE	
	Douglas, NE	
	Pottawattamie, IA	
	Sarpy, NE	
	Washington, NE	
	Harrison, IA	
	Mills, IA	
	Saunders, NE	
36740	Orlando, FL	1.0082
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
36780	Oshkosh-Neenah, WI	0.9936
	Winnebago, WI	
36980	Owensboro, KY	0.9331
	Daviess, KY	
	Hancock, KY	
	Mc Lean, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2316
	Ventura, CA	
37340	Palm Bay-Melbourne-Titusville, FL	1.0073
	Brevard, FL	
37460	Panama City-Lynn Haven, FL	0.8562
	Bay, FL	
37620	Parkersburg-Marietta, WV-OH	0.8509
	Pleasants, WV	
	Wirt, WV	
	Washington, OH	
	Wood, WV	
37700	Pascagoula, MS	0.8763
	George, MS	
	Jackson, MS	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
37860	Pensacola-Ferry Pass-Brent, FL	0.8533
	Escambia, FL	
	Santa Rosa, FL	
37900	Peoria, IL	0.9581
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
	Marshall, IL	
	Stark, IL	
37964	Philadelphia, PA	1.1729
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0973
	Maricopa, AZ	
	Pinal, AZ	
38220	Pine Bluff, AR	0.8942
	Jefferson, AR	
	Cleveland, AR	
	Lincoln, AR	
38300	Pittsburgh, PA	0.9252
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
	Armstrong, PA	
38340	Pittsfield, MA	1.0950
	Berkshire, MA	
38540	Pocatello, ID	1.0027
	Bannock, ID	
	Power, ID	
38660	Ponce, PR	0.5568
	Juana Diaz, PR	
	Ponce, PR	
	Villalba, PR	
38860	Portland-South Portland-Biddeford, ME	1.0569
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas, OR Clark, WA Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Skamania, WA	1.2177
38940	Port St. Lucie-Fort Pierce, FL Martin, FL St. Lucie, FL	1.0489
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess, NY Orange, NY	1.1638
39140	Prescott, AZ Yavapai, AZ	1.0492
39300	Providence-New Bedford-Fall River, RI-MA Bristol, MA Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.1502
39340	Provo-Orem, UT Utah, UT Juab, UT	1.0173
39380	Pueblo, CO Pueblo, CO	0.9337
39460	Punta Gorda, FL Charlotte, FL	1.0032
39540	Racine, WI Racine, WI	0.9980
39580	Raleigh-Cary, NC Franklin, NC Johnston, NC Wake, NC	1.0522
39660	Rapid City, SD Pennington, SD Meade, SD	0.9422
39740	Reading, PA Berks, PA	1.0264
39820	Redding, CA Shasta, CA	1.4078

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
39900	Reno-Sparks, NV Washoe, NV Storey, NV	1.2761
40060	Richmond, VA Charles City, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA Amelia, VA Caroline, VA Cumberland, VA King and Queen, VA King William, VA Louisa, VA Sussex, VA	0.9789
40140	Riverside-San Bernardino-Ontario, CA Riverside, CA San Bernardino, CA	1.1631
40220	Roanoke, VA Craig, VA Franklin, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.9224
40340	Rochester, MN Olmsted, MN Dodge, MN Wabasha, MN	1.2169
40380	Rochester, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.9594

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
40420	Rockford, IL Boone, IL Winnebago, IL	1.0655
40484	Rockingham County-Strafford County, NH Rockingham, NH Strafford, NH	1.0836
40580	Rocky Mount, NC Edgecombe, NC Nash, NC	0.9444
40660	Rome, GA Floyd, GA	0.9806
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado, CA Placer, CA Sacramento, CA Yolo, CA	1.4264
40980	Saginaw-Saginaw Township North, MI Saginaw, MI	0.9466
41060	St. Cloud, MN Benton, MN Stearns, MN	1.1053
41100	St. George, UT Washington, UT	0.9883
41140	St. Joseph, MO-KS Andrew, MO Buchanan, MO Doniphan, KS De Kalb, MO	1.0793

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
41180	St. Louis, MO-IL Clinton, IL Franklin, MO Jefferson, MO Jersey, IL Lincoln, MO Madison, IL Monroe, IL St. Charles, MO St. Clair, IL St. Louis, MO St. Louis City, MO Warren, MO Bond, IL Calhoun, IL Macoupin, IL Crawford, MO Washington, MO	0.9605
41420	Salem, OR Marion, OR Polk, OR	1.1134
41500	Salinas, CA Monterey, CA	1.5293
41540	Salisbury, MD Somerset, MD Wicomico, MD	0.9550
41620	Salt Lake City, UT Salt Lake, UT Summit, UT Tooele, UT	1.0029
41660	San Angelo, TX Irion, TX Tom Green, TX	0.8920
41700	San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX Wilson, TX Atascosa, TX Bandera, TX Kendall, TX Medina, TX	0.9434
41740	San Diego-Carlsbad-San Marcos, CA San Diego, CA	1.2111

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
41780	Sandusky, OH Erie, OH	0.9922
41884	San Francisco-San Mateo-Redwood City, CA Marin, CA San Francisco, CA San Mateo, CA	1.6176
41900	San Germán-Cabo Rojo, PR Lajas, PR Cabo Rojo, PR Sabana Grande, PR San Germán, PR	0.5618
41940	San Jose-Sunnyvale-Santa Clara, CA Santa Clara, CA San Benito, CA	1.6579
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas, PR Barceloneta, PR Bayamón, PR Canóvanas, PR Carolina, PR Cataño, PR Comerio, PR Corozal, PR Dorado, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Las Piedras, PR Loiza, PR Naguabo, PR Manatí, PR Morovis, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR. Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR Aibonito, PR Barranquitas, PR Ciales, PR	0.5120

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
	Maunabo, PR Orocovis, PR Quebradillas, PR Arecibo, PR Camuy, PR Hatillo, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo, CA	1.2371
42044	Santa Ana-Anaheim-Irvine, CA Orange, CA	1.2238
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara, CA	1.1830
42100	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.6488
42140	Santa Fe, NM Santa Fe, NM	1.1546
42220	Santa Rosa-Petaluma, CA Sonoma, CA	1.5428
42260	Sarasota-Bradenton-Venice, FL Manatee, FL Sarasota, FL	1.0526
42340	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9974
42540	Scranton--Wilkes-Barre, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8904
42644	Seattle-Bellevue-Everett, WA King, WA Snohomish, WA	1.2196
42680	Sebastian-Vero Beach, FL Indian River County, FL	1.0211
43100	Sheboygan, WI Sheboygan, WI	0.9628
43300	Sherman-Denison, TX Grayson, TX	0.9069

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
43340	Shreveport-Bossier City, LA Bossier, LA Caddo, LA De Soto, LA	0.9456
43580	Sioux City, IA-NE-SD Dixon, NE Dakota, NE Woodbury, IA Union, SD	0.9813
43620	Sioux Falls, SD Lincoln, SD Minnehaha, SD McCook, SD Turner, SD	1.0196
43780	South Bend-Mishawaka, IN-MI St. Joseph, IN Cass, MI	1.0498
43900	Spartanburg, SC Spartanburg, SC	0.9786
44060	Spokane, WA Spokane, WA	1.1144
44100	Springfield, IL Menard, IL Sangamon, IL	0.9483
44140	Springfield, MA Charleston-North Charleston, SC Berkeley, SC Charleston, SC Franklin, MA Hampden, MA Hampshire, MA	1.0751
44180	Springfield, MO Christian, MO Greene, MO Webster, MO Dallas, MO Polk, MO	0.9034
44220	Springfield, OH Clark, OH	0.9166
44300	State College, PA Centre, PA	0.9370
44700	Stockton, CA San Joaquin, CA	1.2205

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
44940	Sumter, SC Sumter, SC	0.8622
45060	Syracuse, NY Madison, NY Onondaga, NY Oswego, NY	1.0337
45104	Tacoma, WA Pierce, WA	1.1508
45220	Tallahassee, FL Gadsden, FL Leon, FL Wakulla, FL Jefferson, FL	0.9538
45300	Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9754
45460	Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN Sullivan, IN	0.9349
45500	Texarkana, TX-Texarkana, AR Bowie, TX Miller, AR	0.8644
45780	Toledo, OH Fulton, OH Lucas, OH Wood, OH Ottawa, OH	1.0225
45820	Topeka, KS Shawnee, KS Jackson, KS Jefferson, KS Osage, KS Wabaunsee, KS	0.9312
45940	Trenton-Ewing, NJ Mercer, NJ	1.1557
46060	Tucson, AZ Pima County, AZ	0.9816

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
46140	Tulsa, OK	0.8643
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
	Okmulgee, OK	
	Pawnee, OK	
46220	Tuscaloosa, AL	0.9112
	Tuscaloosa, AL	
	Greene, AL	
	Hale, AL	
46340	Tyler, TX	0.9398
	Smith, TX	
46540	Utica-Rome, NY	0.8956
	Herkimer, NY	
	Oneida, NY	
46660	Valdosta, GA	0.8927
	Brooks, GA	
	Echols, GA	
	Lanier, GA	
	Lowndes, GA	
46700	Vallejo-Fairfield, CA	1.6146
	Solano, CA	
47020	Victoria, TX	0.9131
	Victoria, TX	
	Calhoun, TX	
	Goliad, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0488
	Cumberland, NJ	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
47260	Virginia Beach-Norfolk-Newport News, VA	0.9376
	Chesapeake City, VA	
	Currituck, NC	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
	Surry, VA	
47300	Visalia-Porterville, CA	1.0633
	Tulare, CA	
47380	Waco, TX	0.9209
	McLennan, TX	
47580	Warner Robins, GA	0.8939
	Houston, GA	
47644	Warren-Farmington Hills-Troy, MI	1.0724
	Lapeer, MI	
	Macomb, MI	
	Oakland, MI	
	St. Clair, MI	
	Livingston, MI	

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV Alexandria City, VA Arlington, VA Calvert, MD Charles, MD Clarke, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA Jefferson, WV Loudoun, VA Manassas City, VA Manassas Park city, VA Prince Georges, MD Prince William, VA Spotsylvania, VA Stafford, VA District of Columbia, DC Warren, VA	1.1791
47940	Waterloo-Cedar Falls, IA Black Hawk, IA Bremer, IA Grundy, IA	0.8969
48140	Wausau, WI Marathon, WI	1.0370
48260	Weirton-Steubenville, WV-OH Brooke, WV Hancock, WV Jefferson, OH	0.8601
48300	Wenatchee, WA Chelan, WA Douglas, WA	1.1036
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach, FL	1.0292
48540	Wheeling, WV-OH Belmont, OH Marshall, WV Ohio, WV	0.8000

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
48620	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS Sumner, KS	0.9667
48660	Wichita Falls, TX Archer, TX Wichita, TX Clay, TX	0.8865
48700	Williamsport, PA Lycoming, PA	0.8682
48864	Wilmington, DE-MD-NJ Cecil, MD New Castle, DE Salem, NJ	1.1396
48900	Wilmington, NC Brunswick, NC New Hanover, NC Pender, NC	1.0491
49020	Winchester, VA-WV Frederick, VA Winchester City, VA Hampshire, WV	1.0764
49180	Winston-Salem, NC Davie, NC Forsyth, NC Stokes, NC Yadkin, NC	0.9894
49340	Worcester, MA Worcester, MA	1.1437
49420	Yakima, WA Yakima, WA	1.0504
49500	Yauco, PR Guánica, PR Guayanilla, PR Peñuelas, PR Yauco, PR	0.4432
49620	York-Hanover, PA York, PA	1.0024
49660	Youngstown-Warren-Boardman, OH-PA Mahoning, OH Trumbull, OH Mercer, PA	0.9389

CBSA Code	Urban Area (Constituent Counties or County Equivalents) [2]	Wage Index[1]
49700	Yuba City, CA Sutter, CA Yuba, CA	1.1445
49740	Yuma, AZ Yuma, AZ	0.9716

[1] Wage index values are based on FY 2003 hospital cost report data before reclassification. This wage index is further adjusted. Wage index values greater than 0.8 are subject to a budget neutrality adjustment. Wage index values below 0.8 are adjusted to be the greater of a 15-percent increase, subject to a maximum wage index value of 0.8, or a budget neutrality adjustment calculated by multiplying the hospital wage index value for a given area by the budget neutrality factor. We have completed all of these adjustments and included them in the wage index values reflected in this table.

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

TABLE B--HOSPICE WAGE INDEX FOR RURAL AREAS

CBSA Code Number	Nonurban Area	Wage Index[3]
1	Alabama	0.8097
2	Alaska	1.1372
3	Arizona	0.9502
4	Arkansas	0.8000
5	California	1.2218
6	Colorado	0.9947
7	Connecticut	1.2490
8	Delaware	1.0352
10	Florida	0.9167
11	Georgia	0.8099
12	Hawaii	1.1145
13	Idaho	0.8661
14	Illinois	0.8875
15	Indiana	0.9107
16	Iowa	0.9260
17	Kansas	0.8531
18	Kentucky	0.8286
19	Louisiana	0.8000
20	Maine	0.9006
21	Maryland	0.9521
22	Massachusetts[5]	1.2438
23	Michigan	0.9666
24	Minnesota	0.9763
25	Mississippi	0.8254
26	Missouri	0.8456
27	Montana	0.9163
28	Nebraska	0.9256
29	Nevada	0.9540
30	New Hampshire	1.1577
31	New Jersey[4]	--------
32	New Mexico	0.8888
33	New York	0.8781
34	North Carolina	0.9161
35	North Dakota	0.8000
36	Ohio	0.9235
37	Oklahoma	0.8138

CBSA Code Number	Nonurban Area	Wage Index[3]
38	Oregon	1.0403
39	Pennsylvania	0.8875
40	Puerto Rico[5]	0.4654
41	Rhode Island[4]	--------
42	South Carolina	0.9137
43	South Dakota	0.9045
44	Tennessee	0.8349
45	Texas	0.8496
46	Utah	0.8683
47	Vermont	1.0394
48	Virgin Islands	0.9032
49	Virginia	0.8469
50	Washington	1.0947
51	West Virginia	0.8114
52	Wisconsin	1.0190
53	Wyoming	0.9915
65	Guam	1.0252

[3] Wage index values are based on FY 2003 hospital cost report data before reclassification. This wage index is further adjusted. Wage index values greater than 0.8 are subject to a budget neutrality adjustment. Wage index values below 0.8 are adjusted to be the greater of a 15-percent increase, subject to a maximum wage index value of 0.8, or a budget neutrality adjustment calculated by multiplying the hospital wage index value for a given area by the budget neutrality factor. We have completed all of these adjustments and included them in the wage index values reflected in this table.

[4] All counties within the State are classified as urban.

[5] Based on CBSA designations Massachusetts and Puerto Rico have areas designated as rural. However, no IPPS hospitals are located in those rural area(s) for FY 2008. Because more recent data is not available for those areas, we are using the methodology described in this final rule.

[FR Doc. 07–4292 Filed 8–30–07; 8:45 am]
BILLING CODE 4120–01–C