Technical Report for the Hospice Wage Index

Contents

1. Executive Summary

The hospice wage index adjusts Medicare fee-for-service (FFS) payments for hospice services to account for differences in wages across geographic areas. The payment for a hospice day consists of a non-labor related portion that is unaffected by the wage index and a labor-related portion that is adjusted by the wage index value for the Core Based Statistical Area (CBSA) or rural area where the service was provided.

The fiscal year (FY) 1998 Hospice Wage Index final rule established that the raw wage index values for the hospice benefit equal the pre-floor and pre-reclassified values of the inpatient prospective payment system (IPPS) wage index for hospitals.[1] For CBSAs or rural areas with a raw wage index value below 0.8000, the hospice floor is applied. The hospice floor increases values below 0.8000 by 15 percent, up to a maximum of 0.8000. The FY 2023 Hospice Wage Index final rule established a 5-percent cap on decreases in a geographic area's wage index value from the prior year.[2]

In response to recent public comments, the Centers for Medicare & Medicaid Services (CMS) is considering changes to the calculation of the hospice wage index. These changes address three primary concerns with the use of the pre-floor, pre-reclassified hospital wage index to adjust hospice payments.

1. Hospital wages included in the IPPS wage index may not accurately reflect the price of labor that hospices face.
2. The labor mix at hospitals that is used to construct the IPPS wage index may not be consistent with the labor mix at hospices.
3. The cost reports used to produce the hospital wage index for a given fiscal year are from four fiscal years earlier (e.g., the FY2026 wage index was based on hospital cost reports from FY2022).

This report examines an alternative approach that would address these three concerns. The alternative wage index is constructed using wage estimates from the Occupational Employment and Wage Statistics (OEWS) surveys from the Bureau of Labor Statistics (BLS). As detailed below, the BLS data is more timely than the data that is used to construct the current wage index. The OEWS provides estimates of average hourly wages for a set of occupations that are most relevant to hospices, across all employers and by geographic area. These all-employer wage estimates reflect the price of labor for specific occupations

[1] A link to the FY1998 final hospice rule.
[2] A link to the FY 2023 final hospice rule.

at not only hospices but also other healthcare providers that hospices compete with when hiring workers. The alternative approach also calculates weights for each of the relevant occupations by estimating the labor mix of a typical hospice using information from hospice claims and the cost reports submitted by freestanding hospices.

We constructed a wage index using the BLS data and found that the resulting wage index was highly correlated with the legacy wage index. The two versions of the wage index were within 0.1 of each other for most areas. However, there were 88 CBSAs and 16 rural areas for which the BLS-based wage index exceeded the legacy wage index by at least 0.1. Generally, the BLS-based wage index was less variable across areas than the legacy wage index. We found that switching from the legacy wage index to the BLS-based wage index would decrease payments by 5.0% or more for 98 hospices and increase payments by 5.0% or more for 885 hospices. In our methodology, we implement the BLS in a budget neutral manner so aggregate payments are no different compared to payments made under the existing hospice wage index.

2. The Current Hospice Wage Index

The Medicare FFS per-diem payment for hospice primarily depends on two factors: the level of care and the location where the service was provided. Exhibit 1 shows the FY2025 national payment rate for each level of care and the labor-related portion of the payment. The labor-related portion is adjusted by the wage index value for the location where the service was provided.

Exhibit 1: FY2026 per-diem payment rates by level of care, and the amount of each payment rate that is adjusted by the wage index

Payment Category	National Rate	Labor-Related Share	Amount Adjusted by the Wage Index
Routine Home Care, days 1-60	$230.83	66.0%	$152.35
Routine Home Care, days 61+	$181.94	66.0%	$120.08
Continuous Home Care, 24 hours	$1,674.29	75.2%	$1,259.07
Inpatient Respite Care	$532.48	61.0%	$324.81
General Inpatient Care	$1,199.86	63.5%	$761.91

As indicated by Exhibit 1, $152.35 of the payment for a Routine Home Care (RHC) hospice day (days 1-60) is adjusted by the wage index value for the CBSA or rural area where the hospice day was provided, while $78.48 of the payment is unaffected by the service location. Exhibit 2 shows how the payment for an RHC day varies across the distribution of

the FY2026 wage index. For example, the payment for an RHC day in the CBSA at the 10th percentile of the wage index distribution is $200.36, while the payment for an RHC day in the CBSA at the 90th percentile is $250.82.

Exhibit 2: FY2026 per-diem payment rates by percentile of the wage index distribution

Percentile	FY2026 Wage Index	CBSA Code	CBSA Name	FY2026 RHC Payment (Days 1 – 60)
Minimum	0.3127	10380	Puerto Rico (Lares and Utuado Municipios)	$126.12
10%	0.8000	N/A	36 CBSAs share this wage index value due to the 0.8000 floor on the hospice wage index	$200.36
25%	0.8448	46140	Tulsa, OK	$207.19
Median	0.9080	48660	Wichita Falls, TX	$216.81
75%	0.9905	17660 44140	Coeur d'Alene, ID Springfield, MA	$229.38
90%	1.1312	99912	Hawaii (Rural)	$250.82
Maximum	1.8317	41940	San Jose-Sunnyvale-Santa Clara, CA	$357.54

Currently, the wage index value for a CBSA or rural area equals the pre-floor, pre-reclassified value of the IPPS hospital wage index for that CBSA or rural area. The IPPS hospital wage index is calculated by dividing the average hourly wage for acute care hospital staff in an area by the national average.[3] For example, a value of 1.1 would indicate that the average hourly wage for hospitals in an area is 10 percent greater than the national average. The average hourly wage in an area is calculated using information on salaries and benefits reported by hospitals on their cost reports. The wage index is also adjusted so that the labor mix in an area (e.g., the proportion of staff hours for registered nurses relative to nursing aides) does not impact the wage index value. Instead, the average hourly wage is calculated based on a national labor mix estimated from a survey of hospitals. Hospitals can request to be reclassified to a nearby area with a higher wage index value if certain

[3] For additional details, see the discussion in "Hospital Wage Index", *Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy, Second Edition.* Committee on Geographic Adjustment Factors in Medicare Payment; Board on Health Care Services; Institute of Medicine; Edmunds M, Sloan FA, editors. Washington (DC): National Academies Press (US); 2011 Jun 1.

criteria are met. There are also floors that increase wage index values for hospitals in some areas.

For some CBSAs or rural areas, the calculation of the hospice wage index value involves adjustments to the pre-floor, pre-reclassified hospital wage index value. The hospice floor increases wage index values for areas with an initial value below 0.8000. The floor increases the wage index value for these areas by 15 percent, up to a maximum of 0.8000. There is also a cap on decreases in the wage index value from year to year, such that the wage index for an area cannot decrease by more than five percent from one year to the next.

Key Issues: CMS has received comments on recent hospice proposed rules that indicate concerns with the current methodology used to calculate the hospice wage index. These comments have noted concerns related to (1) the use of hospital wages which may not reflect the price of labor for hospices, (2) the possibility that the labor mix for hospices differs from the labor mix at hospitals in ways that would have substantive impacts on wage index values, and (3) The cost reports used to produce the hospital wage index for a given fiscal year are from four fiscal years earlier (e.g., the FY2026 wage index was based on hospital cost reports from FY2022).

Discussion Questions:

(1) What aspects of the current hospice wage index are positive and you would like to see remain?
(2) What aspects of the wage index are negative and you would like to see changed?
(3) What regulatory changes should be made to the wage index (e.g., changes to the floor or cap)?

3. An Alternative Approach to Constructing the Hospice Wage Index

In this section, we describe an alternative approach to constructing the hospice wage index that is not based on the hospital wage index. Instead, the wage index is constructed using wage estimates from the Occupational Employment and Wage Statistics (OEWS) surveys from the Bureau of Labor Statistics (BLS) for a set of 10 occupations that are most relevant for hospices. The OEWS data includes wage estimates for metropolitan and non-metropolitan areas, which can be mapped to the CBSAs and rural areas for which wage index values are calculated. The wage estimates are based on data from employers across industries to account for hospices that compete for labor not only with other hospices but with other healthcare providers that hire workers in the same occupations.

This report refers to the alternative wage index as the BLS wage index because it is derived using the wage estimates from the OEWS. In constructing the BLS wage index for hospice, we considered the wage index approach that was finalized in the CY2025 final rule for the End-Stage Renal Disease (ESRD) Prospective Payment System[4] and the approach recommended by MedPAC in its June 2023 report.[5]

3.1 Data Used to Construct the BLS Wage Index

Occupational Employment and Wage Statistics (OEWS) Data

The OEWS data provide estimates of employment and the wage distribution for more than 800 occupations.[6] The estimates are released annually in March or April of each year and are calculated for May of the preceding year. For this report, we used the May 2024 estimates, which were released on April 2, 2025.[7,8] The estimates for each May are based on biannual surveys of non-farm employers over three years. For example, the May 2024 wage estimates (released April 2025) were based on six surveys conducted in November 2021, May and November 2022, May and November 2023, and May 2024.

The estimates are available at three geographic levels: national, state, or metropolitan and non-metropolitan statistical areas.[9] The BLS also provides a crosswalk to map the wage information for metropolitan and non-metropolitan statistical areas into county-level data.[10]

Exhibit 3 below lists the labor categories from the OEWS data that were used to construct a BLS wage index for hospice.

[4] A link to the CY2025 End-Stage Renal Disease final rule.
[5] A link to the June 2023 MedPAC report to Congress.
[6] A link to the list of the occupations in the OEWS.
[7] A link to the technical notes for the May 2023 OEWS estimates.
[8] In the Technical Notes for May 2023 OEWS Estimates, BLS indicates that the, "overall national response rate for the six panels, based on the 50 states and the District of Columbia, is 65.8 percent based on establishments and 64.3 percent based on weighted sampled employment."
[9] In the Technical Notes for May 2024 OEWS Estimates, the BLS states that, "The May 2024 OEWS estimates use the metropolitan area definitions in Office of Management and Budget (OMB) Bulletin 23-01. Nonmetropolitan area definitions are specific to the OEWS program and are set in consultation with the SWAs."
[10] A link to the estimated wages by occupation for all geographic levels for May 2024. The crosswalk that maps metropolitan and non-metropolitan areas to counties for the May 2024 data is available at this second link.

Exhibit 3: BLS labor categories that are used to construct the BLS wage index for the hospice prospective payment system

BLS Occupation Title	Occupation Code
Medical and Health Services Managers*	11-9111
Healthcare Social Workers	21-1022
Occupational Therapists	29-1122
Physical Therapists	29-1123
Speech-Language Pathologists	29-1127
Registered Nurses	29-1141
Nurse Practitioners	29-1171
Physicians, All Other**	29-1229
Licensed Practical and Licensed Vocational Nurses	29-2061
Home Health and Personal Care Aides	31-1120

* The BLS data do not include wage estimates for nursing administrators, so we used wage estimates for medical and health services managers to represent the wages that hospices pay to nursing administrators.

**Physician categories in the BLS data include anesthesiologists, cardiologists, dermatologists, emergency medicine physicians, family medicine physicians, general internal medicine physicians, neurologists, obstetricians and gynecologists, pediatricians, pathologists, psychiatrists, radiologists, and physicians, all other.

BLS Data Timing and Rulemaking

If CMS proposed using the BLS wage index within the FY2027 Hospice Rule (Proposed Rule to be published sometime around March of 2026), the underlying BLS data would come from the April 2025 release. That data contains wage estimates for 2024. For the final rule (to be published sometime around July of 2026), the underlying BLS data would come from the April 2026 release. That data will contain wage estimates for 2025 and would be based on six surveys conducted in November 2022, May and November 2023, May and November 2024, and May 2025.

There are some potential risks with using data from the BLS. These risks, along with mitigation strategies, are described below.

- **Delays in Reporting:** If there was a delay in releasing the BLS data, we would likely need to use the next most recent year of data available. Even if we needed to use an old release of the data (e.g., April 2025 release for the FY2027 Hospice Final Rule), that would still contain more recent data than what is used in the current wage index methodology that relies on hospital cost reports. Further, we could still update other parts of the BLS wage index calculation (that rely on hospice claims and cost reports) with more recent data.
- **Missing Data:** The April 2025 BLS data release does not contain data from Colorado. The Colorado data was updated at the end of July but was not included in

this report. We impute data for Colorado using the 2024 BLS data release and inflate the wage estimates for Colorado to reflect nationwide wage growth for a given occupation between the May 2023 and May 2024 BLS data. It is possible that future BLS data releases may also contain missing data and we would need to use similar approaches to deal with that missing data.

In either case, if the delays, or the missing data, were significant enough, we could potentially freeze all the wage index values and not update the wage index every rulemaking cycle. If there were multi-year delays or ongoing missing data issues, we may also consider reverting to using the hospital wage index to form the hospice wage index.

Discussion Questions:

(1) Given the BLS data is updated annually between the release of the Notice of Proposed Rulemaking (NPRM) and the Final Rule, would it be preferable for the Final Rule to use the updated BLS data?
   a. Alternatively, would it be preferable if both the NPRM and final rule used the same year of BLS data, even if that resulted in a one-year lag in the wage data that would be used?
(2) What do you consider to be the main limitations of the BLS data?
(3) Are the occupations in the BLS data consistent with the occupations that hospices employ?

Hospice Cost Reports

Worksheet A of the freestanding hospice cost reports includes information on the total salaries and other costs that a hospice incurred for each of the following cost centers: nursing administration, physician administrative services, physician services, nurse practitioner, registered nurses, LPN/LVN, physical therapy, occupational therapy, speech/language pathology, medical social services, and hospice aide and homemaker services, among others.[11] Worksheet A of the cost reports is presented in Appendix A. As described in subsection 3.2, these data were blended with information from the claims to estimate the share of a typical hospice's labor hours in each of the occupations listed in Exhibit 2. That was then used to determine the national labor mix. For this report, we used FY2023 freestanding cost reports, which were the most recent year with complete data.

Hospice Claims

For this report, we used information from all hospice claims in FY2024. The claims data contain information on the number of visits and length of visits in minutes provided by each

[11] A link to the Medicare freestanding hospice cost report template and instructions.

discipline for each claim. This information is also used to help construct the national labor mix. Information on visits and minutes for the following disciplines is collected on hospice claims: (1) Physical Therapist, (2) Physical Therapist Assistant, (3) Occupational Therapist, (4) Occupational Therapist Assistant, (5) Speech Language Pathologist, (6) Skilled Nursing (RN), (7) Skilled Nursing (LPN), (8) Medical Social Services, and (9) Home Health Aide.

Census Bureau Population Estimates

The approach detailed in subsection 3.2 required mapping wage estimates from BLS areas to counties and then aggregating the county-level wage estimates to the CBSAs and rural areas for which wage index values are calculated. To aggregate from counties to CBSAs and rural areas, we calculated a population-weighted average of the county-level wage estimates for the counties within each CBSA or rural area. We obtained county population estimates for 2024 from the Census Bureau's Annual Estimates of the Resident Population for Counties.[12] In 2025 and 2024, the population estimates for the prior calendar year were posted to the Census Bureau website near the end of June.

3.2 Methods Used to Construct the BLS Wage Index

There were six main steps that were used to create the BLS wage index for hospice, listed below. We provide further details on each step in the subsections that follow.

Step 1. Use information from hospice claims and freestanding hospice cost reports to estimate the national labor mix for hospices.

Step 2. Use the wage estimates in the BLS data to determine CBSA-level wage estimates for each occupation listed in Exhibit 2.[13]

Step 3. Use the estimated national labor mix from Step 1 and the occupation-specific, CBSA-level wage estimates from Step 2 to calculate a cross-occupation wage estimate for each CBSA. This is the numerator for the BLS wage index value before adjustments.

Step 4. Use the estimated national labor mix from Step 1 and the occupation-specific, CBSA-level wage estimates from Step 2 to calculate a cross-occupation, national wage estimate. This is the denominator for the BLS wage index value before adjustments.

[12] A link to the county population estimates for 2024 from the Census Bureau's Annual Estimates of the Resident Population for Counties.

[13] Throughout this subsection, references to CBSAs or CBSA-level wage estimates are meant to also include the state-wide rural areas for which wage index values are calculated.

Step 5. Divide the cross-occupation, CBSA-level wage estimate by the cross-occupation, national wage estimate to calculate an initial wage index value for each CBSA.

Step 6. Recalibrate the BLS wage index. Apply the hospice floor and the five percent cap on decreases relative to the FY2024 hospice wage index to calculate the final BLS wage index value for each CBSA.

Step 1: Estimating the National Labor Mix

We define the labor mix for a healthcare provider as the share of labor hours by occupation. As noted in Section 2, the IPPS hospital wage index value is adjusted so that the area-specific labor mix for hospitals does not impact the final wage index value. This adjustment is made so that wage index values are not necessarily higher (lower) for hospitals who choose to employ a more (less) costly labor mix. Similarly, we calculated the BLS wage index for hospices based on a national labor mix so that wage index values are not necessarily higher (lower) in areas where hospices employ a more (less) costly labor mix. Instead, the BLS wage index will be higher (lower) in areas with higher (lower) wages for the occupations most relevant for an average hospice.

The most straightforward way to estimate the national labor mix would be using information on hours worked or full-time equivalents (FTEs) by occupation at hospices. However, unlike hospitals, there are no surveys that include information on hours worked or FTEs by occupation for a nationally representative group of hospices. Hospices also do not report this information on cost reports. Furthermore, while hospice claims report minutes of service for seven of the BLS labor categories listed in Exhibit 3, the claims do not report information for physicians, nurse practitioners, or administration (see Exhibit 4). As such, we blended information from hospice claims (for the disciplines listed in Exhibit 4) and freestanding cost reports (for physicians, nurse practitioners, and administration) to estimate the national labor mix across the BLS labor categories listed in Exhibit 3.

Exhibit 4: Total minutes and share of minutes by discipline (FY2024 Hospice claims)

Discipline	Total Minutes Across Claims*	Share of Minutes
Aides	2,089,358,955	48.89%
Registered Nurses	1,560,104,025	36.51%
Licensed Practical Nurses	355,592,310	8.32%
Medical Social Workers	265,170,000	6.21%
Physical Therapists	2,389,350	0.06%
Occupational Therapists	590,205	0.01%
Speech-Language Pathologists	279,855	0.01%

* We capped the per-day, per-discipline minutes from a claim at 2,880 minutes.

Exhibit 5 shows the total costs and share of costs for the cost centers that were used to estimate the national labor mix. We combine physician administrative services and physician services when determining the labor share for physicians. The BLS data do not include wage estimates for nursing administrators, so we used the wage estimates for medical and health services managers to represent the wages that hospices pay for nursing administration.

Exhibit 5: Total costs and share of costs by selected rows in worksheet A (FY2023 freestanding hospice cost reports)

Cost Center	Hospices with Data	Percent of Hospices with Data	Total Costs Across Cost Reports	Share of Costs
Registered Nurses	4,931	99.7%	$3,991,229,592	45.89%
Hospice Aide	4,946	100.0%	$1,436,530,839	16.52%
Nursing Administration	2,372	48.0%	$955,138,709	10.98%
Medical Social Services	4,946	100.0%	$665,096,480	7.65%
LPN/LVN	3,662	74.0%	$642,287,240	7.39%
Physician Services	2,681	54.2%	$404,126,425	4.65%
Physician Administrative Services	2,425	49.0%	$366,050,911	4.21%
Nurse Practitioner	1,956	39.5%	$192,410,841	2.21%
Physical Therapy	1,938	39.2%	$34,162,798	0.39%
Occupational Therapy	539	10.9%	$8,144,627	0.09%
Speech/Language Pathology	478	9.7%	$1,975,596	0.02%

The national labor mix was then estimated using a three-step process:

Labor Mix - Step 1. Calculate the sum of costs reported for each of the cost centers across all FY2023 freestanding cost reports, combining the physician administrative services and physician services cost centers into one category.

Labor Mix - Step 2. Estimate the national average labor shares for nursing administration, physicians, and nurse practitioners as the share of total costs from each of those cost centers: nursing administration (10.98%), physicians (8.86%), NPs (2.21%).

Labor Mix - Step 3. Allocate the remaining 77.95% of the labor mix to the other seven labor categories based on their respective shares of the minutes in the FY2023 hospice claims.

Exhibit 6 shows the estimated national labor mix following the above steps.

Exhibit 6: The estimated national labor mix

Occupation	Share of Costs from Cost Reports	Share of Minutes from Claims	National Labor Share Estimate
Hospice Aide	16.52%	48.89%	38.11%
Registered Nurses	45.89%	36.51%	28.46%
Nursing Administration	10.98%	N/A	10.98%
Physician Services	8.86%	N/A	8.86%
LPN/LVN	7.39%	8.32%	6.49%
Medical Social Services	7.65%	6.21%	4.84%
Nurse Practitioner	2.21%	N/A	2.21%
Physical Therapy	0.39%	0.06%	0.04%
Occupational Therapy	0.09%	0.01%	0.01%
Speech/Language Pathology	0.02%	0.01%	0.01%

Discussion Questions:

(1) Are there any concerns with using this information from cost reports to estimate the labor mix at a hospice?
(2) Can information from the freestanding hospice cost reports accurately represent cost shares for a typical hospice?
(3) Should CMS reduce the set of occupations to those reported on claims so that the labor mix could be estimated using only minutes?
(4) Should CMS estimate the labor mix using only information from cost reports?

Step 2: Calculating Occupation-Specific, CBSA-Level Wage Estimates

The BLS data includes wage estimates for metropolitan and non-metropolitan areas. The areas in the BLS data do not exactly align with the CBSAs and state-wide rural areas for which wage index values are calculated. Therefore, we first mapped the BLS wage estimates to counties. We then aggregated the county-level wage estimates to CBSA and state-wide rural areas using a population-weighted average of the county-level estimates.

County-level wage estimates were calculated using a two-step process:

County Wages - Step 1. Use the geographic area file produced by the BLS[14] to determine which metropolitan or non-metropolitan area each county is contained within. Set the county-level wage estimate equal to the mean hourly wage estimate for the appropriate metropolitan or non-metropolitan area in the OEWS data.[15]

County Wages - Step 2. Impute for county-level wage estimates when missing. Exhibit 7 shows the number and percent of counties with a missing wage estimate for each of the occupations. We imputed for missing wages using either the CBSA-level average, state-wide wage estimates, or national wage estimates.[16]

Exhibit 7: Number and percent of counties with a missing wage estimate

Occupation Title (BLS)	Number of Counties*	Number of Counties with Missing Data	Percent of Counties with Missing Data
Physicians, All Other	3,224	526	16.32%
Occupational Therapists	3,224	147	4.56%
Healthcare Social Workers	3,224	92	2.85%
Nurse Practitioners	3,224	77	2.39%
Speech-Language Pathologists	3,224	64	1.99%
Physical Therapists	3,224	43	1.33%
Medical and Health Services Managers	3,224	32	0.99%
Registered Nurses	3,224	12	0.37%
Licensed Practical and Licensed Vocational Nurses	3,224	3	0.09%
Home Health and Personal Care Aides	3,224	0	0.00%

*The number of counties includes county-equivalents, municipalities in Puerto Rico, and Guam and the Virgin Islands.

After imputing for missing wage estimates, the occupation-specific, CBSA-level wage estimate was calculated as the population-weighted average of the county-level wage estimates for all counties within a CBSA.

[14] A link to the geographic area file produced by the BLS.
[15] Please see the appendix for additional details on how this step differed for Guam and the Virgin Islands.
[16] The exact sequence of steps for the imputation are detailed in the appendix.

Discussion Questions:

(1) We imputed for missing wage estimates for a county using either the CBSA-level average, state-wide wage estimates, or national wage estimates (see appendix for details). What other alternatives should we consider for imputing for this missing data?
(2) After imputing for missing wage estimates, the occupation-specific, CBSA-level wage estimate was calculated as a population-weighted average of the county-level wage estimates for all counties within a CBSA. What other alternatives should we consider for calculating the CBSA-level wage estimate?

Step 3: Calculating Cross-Occupation, CBSA-Level Wage Estimates

We used the national labor mix estimated in Step 1 and the occupation-specific, CBSA-level wage estimates from Step 2 to calculate cross-occupation, CBSA-level wage estimates. For example, consider the state-wide rural area for Alabama (code 99901). Exhibit 8 shows the wage estimate for each occupation for rural Alabama and the labor share for each occupation from the estimated national labor mix.

Exhibit 8: Occupation-specific wage estimates for rural Alabama and labor shares from the estimated national labor mix

Occupation	Wage Estimate for Rural Alabama (Code 99901)	National Labor Share Estimate
Aides	$12.45	0.3811
RNs	$32.36	0.2846
Nursing Administration	$44.43	0.1098
Physicians	$134.15	0.0886
LPNs	$23.79	0.0649
Social workers	$26.11	0.0484
NPs	$53.67	0.0221
PTs	$46.65	0.0004
OTs	$44.42	0.0001
SLPs	$33.60	0.0001

The cross-occupation wage estimate for rural Alabama is calculated by weighting the occupation-specific wage estimates by the national labor shares as follows:

$$cross-occupation\ wage\ estimate\ for\ rural\ Alabama$$
$$= \$12.45 * 0.3811 + \$32.36 * 0.2846 + \$44.43 * 0.1098 + \$134.15 * 0.0886$$
$$+ \$23.79 * 0.0649 + \$26.11 * 0.0484 + \$53.67 * 0.0221 + \$46.65 * 0.0004$$
$$+ \$44.42 * 0.0001 + \$33.60 * 0.0001 = \$34.74$$

A similar calculation was performed for every CBSA or state-wide rural area. These cross-occupation, CBSA-level wage estimates were the numerator in Step 5 (below) when calculating the initial wage index value for each CBSA and state-wide rural area and so play an important role in determining which CBSAs had relatively high BLS wage index values and which had relatively low BLS wage index values. A higher wage estimate for any of the occupations with a non-zero labor share in the national labor mix resulted in a higher wage index value, all else equal. A relatively high wage estimate for an occupation with a high labor share had a larger impact on the wage index value than a relatively high wage estimate for an occupation with a low labor share.

Step 4: Calculating the Cross-Occupation, National Wage Estimate

We calculated the cross-occupation, national wage estimate in two steps.

1. We calculated a national weighted average of each occupation-specific, CBSA-level wage estimate from Step 2, weighting by the CBSA population.
2. We weighted these national averages of the occupation-specific wage estimates by the labor shares in the national labor mix shown in Exhibit 6.

This cross-occupation, national wage estimate was the denominator when calculating the initial wage index values in Step 5 (below).

Discussion Question:

1. We calculated a national weighted average of each occupation-specific, CBSA-level wage estimate, weighting by population. What other alternatives should we consider for calculating the national weighted average for each occupation?
2. Would it be preferable to create weighted averages using county level population estimates like discussed, or when available, should we use hospice days to calculated weighted averages?

Step 5: Calculating Initial BLS Wage Index Values

The initial BLS wage index value for a CBSA equaled the result from Step 3 divided by the result from Step 4. This calculation is done for each CBSA and state-wide rural area.

Step 6: Adjustments to the Initial Wage Index Values to Calculate the Final BLS Wage Index

We recalibrated the initial BLS wage index values as described in the appendix. The recalibration shifts the entire distribution of the BLS wage index so that the weighted distributions of the FY2026 BLS wage index and the FY2026 legacy wage index are centered

at the same place. We note that this step is intended to allow for comparison between the two indices before any other adjustments are applied. Without this step, differences between the two indices for a given CBSA could be due to a difference in where the two distributions were centered, making comparisons less meaningful.

After recalibrating the initial BLS wage index values, we applied the hospice floor and 5% cap on decreases. Because the data used for this report could have been used to create an FY2026 BLS wage index (given the timing noted above in subsection 3.1), we apply the 5% cap on decreases relative to the FY2025 legacy hospice wage index value.

3.3 Comparing the BLS Wage Index and the Legacy Wage Index

Exhibit 9 shows summary statistics for the FY2026 legacy and FY2026 BLS wage indices. Generally, the results indicate that there was less spread in the BLS wage index values across areas than in the legacy wage index values. The standard deviation of the BLS wage index was lower than the standard deviation of the legacy wage index. The BLS wage index also had a narrower range of values. In particular, the minimum BLS wage index value was considerably higher than the minimum value for the legacy wage index. **It is important to note that although the BLS wage index has a higher average value than the legacy wage index, the aggregate payments under either wage index will be equivalent as the implementation of any wage index is done in a budget neutral manner (see section 3.4).**

Exhibit 9: Summary statistics for the FY2026 BLS wage index and the FY2026 Legacy wage index after applying the floor and the cap

Wage Index	Mean	Weighted Mean*	SD	Min	Max	P25	P50	P75
FY2026 Legacy	0.9340	1.0019	0.1855	0.3127	1.8317	0.8413	0.9049	0.9869
FY2026 BLS	0.9793	1.0253	0.1501	0.5953	1.8147	0.9002	0.9593	1.0265

*Weighted by the population in the CBSA or state-wide rural area. The weighted averages are not equal because the hospice floor and cap on decreases are applied to the BLS wage index after the recalibration that results in equal weighted averages.

The BLS wage index and the legacy wage index were highly correlated after applying the floor and the cap to both indices. The Pearson correlation between the two indices was 0.9057 and the Spearman correlation (i.e., the correlation in ranks) was 0.7531. These high correlations suggest that CBSAs with a relatively high (low) legacy wage index value or ranking tended to also have a relatively high (low) value or ranking for the BLS wage index.

Exhibit 10 shows the distributions of the two indices after floor and cap were applied. The results in Exhibit 10 indicate that the BLS wage index had fewer extreme values, with no values below 0.5. The center of the distribution of the BLS wage index across areas was higher than the center of the distribution of the legacy wage index.

Exhibit 11 shows the distribution of the differences between the two indices. The results in Exhibit 11 indicate that for most areas the BLS wage index is within 0.1 of the legacy wage index. However, there were 104 areas for which the BLS wage index exceeded the legacy wage index by at least 0.1. There were nine areas for which the BLS wage index was more than 0.1 below the legacy wage index.

Exhibit 10: The distribution of the FY2026 BLS wage index and the FY2026 Legacy wage index (after applying floor and cap)

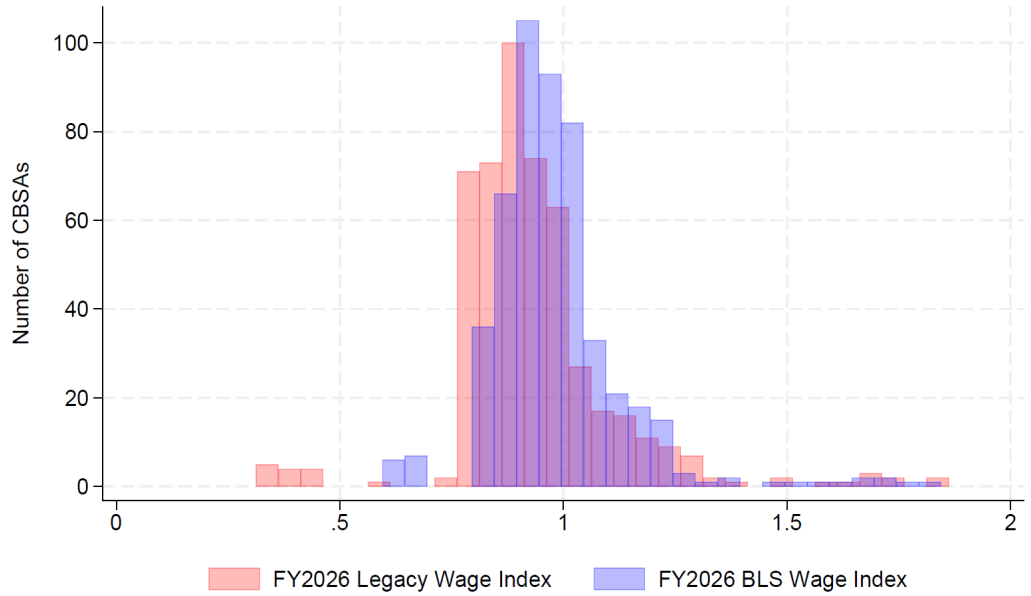
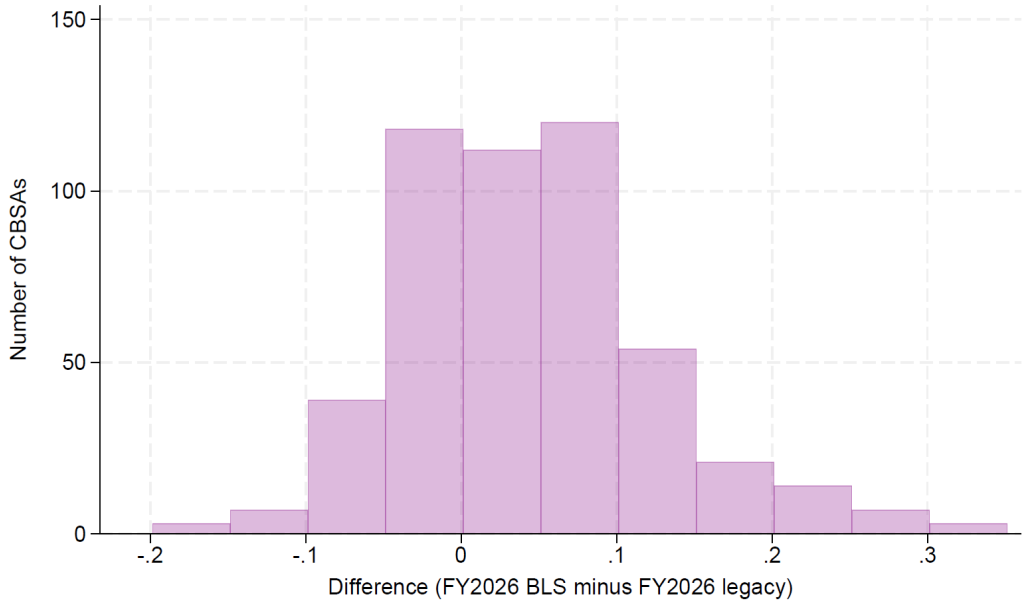


Exhibit 11: The distribution of the differences between the FY2026 BLS wage index and the FY2026 Legacy wage index (after applying floor and cap)



3.4 Estimated Impacts of the BLS Wage Index

After creating the BLS wage index, we estimated the impact of switching from the FY2025 legacy wage index to the FY2026 BLS wage index. Specifically, we used Medicare hospice claims from FY 2024 and priced them under both wage indices. Differences in payments across the wage indices are considered the **impact** of switching wage indices. **We applied a budget neutrality adjustment to the payment rate for each level of care so the aggregate payments by level of care are equivalent under each wage index (See Appendix Exhibit X)**. Although in aggregate there is no impact on payments when transitioning to a different wage index, certain hospices may have higher or lower payments depending on which wage index is applied.

Exhibit 12 below shows the impact of switching from the FY2025 legacy wage index to the FY2026 BLS wage index. We show not only the overall impact of that switch, but also intermediate impacts that isolate the application of the wage index floor and the 5% cap on wage index decrease. The leftmost impacts column in Exhibit 12 shows the impact of switching from the legacy wage index to a BLS wage index without the floor or cap applied. The next two columns show the additional impact of applying the hospice floor and the cap on decreases, respectively. The rightmost column shows the estimated overall impact of switching from the legacy wage index to the BLS wage index when the floor and cap are applied. The application of each change to the wage index (e.g., switching to the BLS wage index, the application of the wage index floor, and the application of the 5% cap on wage index decrease) was done in a budget neutral manner.

Again, by construction, the overall impact of the application of the BLS wage index is budget neutral (i.e., a 0% overall impact of implementing the BLS wage index). However, certain types of hospices do see non-neutral changes to their payments. For example, the payments of

- For-profit hospices decrease by 0.4%
- Non-profit hospices increase by 0.7%
- Hospices in the East-South Central census division increase by 2.9%
- Hospices in the Pacific census division decrease by 3.5%
- Relatively small hospices (less than 3,500 RHC days) decrease by 2.7%

The results in Exhibit 12 also show how the application of the floor and cap to the initial BLS wage index values contribute to the estimated impacts. The negative impacts on hospices in the Pacific Census division and on relatively small hospices would be significantly more negative if the cap on decreases was not applied. The positive impact on hospices in U.S. territories would be significantly less positive if the hospice floor was not applied.

Exhibit 13 shows information on the distribution of wage index changes for hospices when switching to the BLS wage index and applying the wage index floor and 5% cap on decreases. We find payments decrease by between 4.5% and 5.2% or more for 1,493 hospices and payments increase by 5.0% or more for 885 hospices.

Discussion Questions:

(1) The application of the hospice floor primarily impacts hospices in the outlying census regions (e.g., Puerto Rico). Those same hospices also have a very large increase in their wage index values due to the BLS wage index. Is the hospice floor adjustment still needed?

(2) Some hospices have large changes in payments due to the switch to the BLS-based wage index. Is this level of variation concerning? What additional information should be considered? Should CMS adopt other policies to minimize changes in payments (e.g., introduce a 5% cap on wage index increases)?

Exhibit 12 – Impacts on payments when applying alternate wage index scenarios to fiscal year 2024 hospice claims

Hospice subgroup	Hospices	(1) The FY2025 Legacy Wage Index (with floor and with cap) to (2) the FY 2026 BLS Wage Index (without floor and without cap)	(2) the FY 2026 BLS Wage Index (without floor and without cap) to (3) the FY 2026 BLS Wage Index (with floor and without cap)	(3) the FY 2026 BLS Wage Index (with floor and without cap) to (4) the FY 2026 BLS Wage Index (with floor and with cap)	Total Impact
All Hospices	6,735	0.0%	0.0%	0.0%	0.0%
Hospice Type and Control					
Freestanding Facility Type	5,479	0.0%	0.0%	0.0%	0.0%
Facility/HHA Based Facility Type	367	0.7%	0.0%	0.1%	0.7%
Non-Profit	1,067	1.0%	0.0%	-0.2%	0.7%
For Profit	5,131	-0.5%	0.0%	0.1%	-0.4%
Government	132	3.9%	0.0%	-1.3%	2.6%
Other	12	2.9%	-0.1%	-1.5%	1.3%
Hospice Location: Region of the Country (Census Division)					
New England	159	2.6%	-0.1%	-1.3%	1.2%
Middle Atlantic	280	-2.4%	-0.1%	0.5%	-2.0%
South Atlantic	650	3.5%	0.0%	-1.4%	2.1%
East North Central	654	2.6%	-0.1%	-1.4%	1.1%
East South Central	252	4.2%	0.2%	-1.5%	2.9%
West North Central	441	2.1%	-0.1%	-1.0%	1.0%
West South Central	1,251	0.4%	-0.1%	-1.2%	-0.9%
Mountain	701	0.9%	-0.1%	-0.4%	0.4%
Pacific	2,270	-8.7%	-0.1%	5.3%	-3.5%
Outlying	77	17.9%	7.4%	-1.6%	23.7%
Hospice Location: Urban or Rural					
Rural	849	4.7%	0.0%	-1.5%	3.2%
Urban	5,886	-0.5%	0.0%	0.2%	-0.3%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,751	-5.8%	-0.1%	3.1%	-2.7%
3,500-19,999 RHC Days (Medium)	3,014	-2.4%	0.0%	1.2%	-1.2%
20,000+ RHC Days (Large)	1,970	0.8%	0.0%	-0.4%	0.4%

Note: due to data availability only a subset of hospices can be classified into ownership and facility type. Hospice claims from Fiscal Year 2024 were priced out under the payment scenarios described in the table headings to determine impacts on overall payments.

Exhibit 13 – Distribution of payment impacts for hospices when transitioning from the FY2025 Legacy wage index to the FY 2026 BLS-based wage index (FY2024 Claims)

Minimum Impact	-5.2%
25th Percentile	-4.4%
Median	-2.8%
75th Percentile	2.1%
Maximum Impact	26.8%

4. Conclusions

We constructed a hospice wage index using an approach that estimates the labor mix for a typical hospice using information from hospice claims and freestanding hospice cost reports and uses BLS wage estimates to represent the price of labor in an area for the occupations most relevant to hospices. This alternative approach addresses concerns that the hospital wages do not reflect the price of labor for hospices and the occupational mix at hospitals may differ significantly from the occupational mix at hospices. The BLS data is also more timely than the hospital cost report data.

The BLS-based wage index is strongly correlated with the legacy wage index, which indicates that areas with relatively high (low) wage index values under the legacy approach tend to also have high (low) wage index values under the BLS-based approach. The BLS wage index would be implemented in a budget neutral manner so as not to cause any change in the aggregate payments under a BLS wage index compared to the legacy wage index. However, switching to the BLS wage index was estimated to result in payments decreasing by between 4.5% and 5.2% or more for 1,493 hospices and increasing by 5% or more for 885 hospices. Switching to the BLS wage index was estimated to increase payments in U.S. territories, the East South Central Census division, and rural areas, while decreasing payments in the Pacific division and urban areas.

5. Appendix

5.1 Data and Methods Details

Details on cost reports

We identified hospices using the CMS Certification Number (CCN). If multiple cost reports were submitted for the same CCN, we kept the cost report with the longest length of time, resulting in 4,946 total cost reports for FY2023. When calculating the share of costs by cost center, missing values and values below zero were treated as zero.

Details on constructing county-level wages

For Guam and the Virgin Islands, the BLS data only includes a territory-wide wage estimate and not wage estimates at the metropolitan or non-metropolitan area level. As such, we do not calculate county-level wage estimates for Guam and the Virgin Islands.

Detailed imputation steps

We used the following steps to impute missing county-level wage estimates.

1. Impute a wage estimate for Physicians, All Other (29-1229) using the OEWS wage estimate for General Internal Medicine Physicians (29-1216), whenever possible. Of the 526 counties with a missing wage estimate for Physicians, All Other, 131 had a wage estimate for General Internal Medicine Physicians.[17]
2. Calculate a CBSA-level average wage estimate for each occupation by taking the population-weighted average for counties with non-missing wage estimates within each CBSA. Impute for missing wage estimates using the CBSA-level average, whenever possible.
3. Calculate state-level urban and rural average wage estimates by taking the population-weighted average for rural or urban counties with non-missing wage estimates within each state. Impute for remaining missing wage estimates using the state-level urban or rural average depending on the urban-rural status of the county, whenever possible.
4. Calculate national urban and rural wage ratios.[18] Impute for remaining missing wage estimates using the state-level wage estimate from the OEWS data multiplied by the national urban or rural wage ratio depending on the urban-rural status of the county, whenever possible.
5. Impute for remaining missing wage estimates using the national wage estimate from the OEWS data multiplied by the national urban or rural wage ratio depending on the urban-rural status of the county.

Details on the recalibration of the BLS wage index

After calculating the initial FY2026 BLS wage index values, we calculated the weighted average across all areas, weighting by the population in each area. We also calculated the

[17] There are wage estimates for 11 other physician specialties in the OEWS data that could possibly be used to impute for missing wage estimates for Physicians, All Other. However, for most of the physician specialties, the wage estimates are missing for more than two thirds of counties and are often missing whenever the wage estimate for Physicians, All Other is missing. There is a wage estimate for Family Medicine Physicians (29-1215) for 2,594 counties (80.5%) and of the 516 counties with a missing wage estimate for Physicians, All Other, 403 had a wage estimate for Family Medicine Physicians.

[18] The urban (rural) wage ratio equals the population-weighted urban (rural) average wage divided by the population-weighted national average wage.

weighted average of the FY2026 legacy hospice wage index (before the floor and cap). The weighted average for the BLS wage index was 1.0000 (by construction – before the floor and cap are applied) and the weighted average of the legacy wage index (before floor and cap) was 0.9962.

To ensure that the weighted averages of the two wage indices were equal, we multiplied the initial BLS wage index values by the ratio of the two weighted averages (dividing the weighted average of the legacy wage index by the weighted average of the initial BLS wage index). The recalibration shifts the entire distribution of the BLS wage index to the left.

5.2 Appendix Exhibits

Appendix Exhibit 1 – Worksheet A of freestanding hospice cost reports

4390 (Cont.) FORM CMS-1984-14 02-21

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A

					SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	TOTAL (COL. 5 ± COL. 6)
					1	2	3	4	5	6	7
				OTHER GENERAL SERVICE COST CENTERS							
1	1	0100	Cap Rel Costs - Bldg & Fixt*								
2	2	0200	Cap Rel Costs - Mvble Equip*								
	3	0300	Employee Benefits Department*								
	4	0400	Administrative & General*								
	5	0500	Plant Operation & Maintenance*								
	6	0600	Laundry & Linen Service*								
	7	0700	Housekeeping*								
	8	0800	Dietary*								
	9	0900	Nursing Administration*								
	10	1000	Routine Medical Supplies*								
	11	1100	Medical Records*								
	12	1200	Staff Transportation*								
	13	1300	Volunteer Service Coordination*								
	14	1400	Pharmacy*								
	15	1500	Physician Administrative Services*								
	16	1600	Other General Service (specify)*								
	17	1700	Patient/Residential Care Services								
			DIRECT PATIENT CARE SERVICE COST CENTERS								
	25	2500	Inpatient Care - Contracted**								
	26	2600	Physician Services**								
	27	2700	Nurse Practitioner**								
	28	2800	Registered Nurse**								
	29	2900	LPN/LVN**								
	30	3000	Physical Therapy**								
	31	3100	Occupational Therapy**								
	32	3200	Speech/Language Pathology**								
	33	3300	Medical Social Services**								
	34	3400	Spiritual Counseling**								
	35	3500	Dietary Counseling**								
	36	3600	Counseling - Other**								
	37	3700	Hospice Aide and Homemaker Services**								
	38	3800	Durable Medical Equipment/Oxygen**								
	39	3900	Patient Transportation**								

* Transfer the amounts in column 7 to Wkst. B, col. 0, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. B.

Appendix Exhibit 1 continued

02-22 FORM CMS-1984-14 4390 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A

			SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	TOTAL (COL. 5 ± COL. 6)	
			1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)										
40	4000	Imaging Services**								40
41	4100	Labs and Diagnostics**								41
42	4200	Medical Supplies - Non-routine**								42
42.50	4250	Drugs Charged to Patients**								42.50
43	4300	Outpatient Services**								43
44	4400	Palliative Radiation Therapy**								44
45	4500	Palliative Chemotherapy**								45
46		Other Patient Care Services (specify)**								46
NONREIMBURSABLE COST CENTERS										
60	6000	Bereavement Program*								60
61	6100	Volunteer Program*								61
62	6200	Fundraising*								62
63	6300	Hospice/Palliative Medicine Fellows*								63
64	6400	Palliative Care Program*								64
65	6500	Other Physician Services*								65
66	6600	Residential Care *								66
67	6700	Advertising*								67
68	6800	Telehealth/Telemonitoring*								68
69	6900	Thrift Store*								69
70	7000	Nursing Facility Room & Board*								70
71		Other Nonreimbursable (specify)*								71
72	7200	Items and services under ASFRA 1997								72
100		Total								100

* Transfer the amounts in column 7 to Wkst. B, col. 0, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. B.

Appendix Exhibit 2 – Budget neutrality factors for each level of care and for each wage index change

	Budget Neutrality Adjustment Needed to go from 2025 Legacy Wage Index to 2026 BLS Wage Index Before Floor, Before Cap	Budget Neutrality Adjustment Needed to go from 2026 BLS Wage Index Before Floor, Before Cap to 2026 BLS Wage Index After Floor, Before Cap	Budget Neutrality Adjustment Needed to go from 2026 BLS Wage Index After Floor, Before Cap to 2026 BLS Wage Index After Floor, After Cap
RHC (Days 1-60)	0.9991	0.9994	0.9994
RHC (Days 61+)	1.001	0.9993	0.9993
CHC	1.0263	1.0000	1.0000
IRC	0.982	0.9997	0.9997
GIP	0.9891	0.9998	0.9998

Appendix Exhibit 3 – Full impact table

Hospice subgroup	Hospices	(1) The FY2025 Legacy Wage Index (with floor and with cap) to (2) the FY 2026 BLS Wage Index (without floor and without cap)	(2) the FY 2026 BLS Wage Index (without floor and without cap) to (3) the FY 2026 BLS Wage Index (with floor and without cap)	(3) the FY 2026 BLS Wage Index (with floor and without cap) to (4) the FY 2026 BLS Wage Index (with floor and with cap)	Total Impact
All Hospices	6,735	0.0%	0.0%	0.0%	0.0%
Hospice Type and Control					
Freestanding/Non-Profit	791	1.1%	0.0%	-0.3%	0.8%
Freestanding/For-Profit	4,654	-0.4%	0.0%	0.1%	-0.3%
Freestanding/Government	34	5.6%	-0.1%	-1.5%	4.1%
Freestanding/Other	0				
Facility/HHA Based/Non-Profit	266	0.3%	0.0%	0.3%	0.6%
Facility/HHA Based/For-Profit	4	-3.2%	-0.1%	0.2%	-3.1%
Facility/HHA Based/Government	97	2.9%	0.0%	-1.2%	1.7%
Facility/HHA Based/Other	0				

Hospice subgroup	Hospices	(1) The FY2025 Legacy Wage Index (with floor and with cap) to (2) the FY 2026 BLS Wage Index (without floor and without cap)	(2) the FY 2026 BLS Wage Index (without floor and without cap) to (3) the FY 2026 BLS Wage Index (with floor and without cap)	(3) the FY 2026 BLS Wage Index (with floor and without cap) to (4) the FY 2026 BLS Wage Index (with floor and with cap)	Total Impact
Subtotal: Freestanding Facility Type	5,479	0.0%	0.0%	0.0%	0.0%
Subtotal: Facility/HHA Based Facility Type	367	0.7%	0.0%	0.1%	0.7%
Subtotal: Non-Profit	1,067	1.0%	0.0%	-0.2%	0.7%
Subtotal: For Profit	5,131	-0.5%	0.0%	0.1%	-0.4%
Subtotal: Government	132	3.9%	0.0%	-1.3%	2.6%
Subtotal: Other	12	2.9%	-0.1%	-1.5%	1.3%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	206	5.1%	0.0%	-1.4%	3.7%
Freestanding/For-Profit	392	4.4%	0.0%	-1.5%	2.8%
Freestanding/Government	24	6.4%	-0.1%	-1.5%	4.9%
Freestanding/Other	0				
Facility/HHA Based/Non-Profit	112	6.0%	-0.1%	-1.5%	4.5%
Facility/HHA Based/For-Profit	0				
Facility/HHA Based/Government	71	5.0%	-0.1%	-1.6%	3.3%
Facility/HHA Based/Other	0				
Hospice Type and Control: Urban					
Freestanding/Non-Profit	585	0.7%	0.0%	-0.2%	0.4%
Freestanding/For-Profit	4,262	-0.9%	0.0%	0.2%	-0.6%
Freestanding/Government	10	5.4%	-0.1%	-1.5%	3.9%
Freestanding/Other	0				
Facility/HHA Based/Non-Profit	154	-0.7%	0.0%	0.6%	-0.1%
Facility/HHA Based/For-Profit	4	-3.2%	-0.1%	0.2%	-3.1%
Facility/HHA Based/Government	26	1.8%	0.1%	-1.0%	0.9%

Hospice subgroup	Hospices	(1) The FY2025 Legacy Wage Index (with floor and with cap) to (2) the FY 2026 BLS Wage Index (without floor and without cap)	(2) the FY 2026 BLS Wage Index (without floor and without cap) to (3) the FY 2026 BLS Wage Index (with floor and without cap)	(3) the FY 2026 BLS Wage Index (with floor and without cap) to (4) the FY 2026 BLS Wage Index (with floor and with cap)	Total Impact
Facility/HHA Based/Other	0				
Hospice Location: Urban or Rural					
Rural	849	4.7%	0.0%	-1.5%	3.2%
Urban	5,886	-0.5%	0.0%	0.2%	-0.3%
Hospice Location: Region of the Country (Census Division)					
New England	159	2.6%	-0.1%	-1.3%	1.2%
Middle Atlantic	280	-2.4%	-0.1%	0.5%	-2.0%
South Atlantic	650	3.5%	0.0%	-1.4%	2.1%
East North Central	654	2.6%	-0.1%	-1.4%	1.1%
East South Central	252	4.2%	0.2%	-1.5%	2.9%
West North Central	441	2.1%	-0.1%	-1.0%	1.0%
West South Central	1,251	0.4%	-0.1%	-1.2%	-0.9%
Mountain	701	0.9%	-0.1%	-0.4%	0.4%
Pacific	2,270	-8.7%	-0.1%	5.3%	-3.5%
Outlying	77	17.9%	7.4%	-1.6%	23.7%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,751	-5.8%	-0.1%	3.1%	-2.7%
3,500-19,999 RHC Days (Medium)	3,014	-2.4%	0.0%	1.2%	-1.2%
20,000+ RHC Days (Large)	1,970	0.8%	0.0%	-0.4%	0.4%