CMS Rulings

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Ruling No.: CMS-1355-R

Date: April 14, 2011

CMS Rulings are decisions of the Administrator that serve as precedential final opinions and orders and statements of policy and interpretation. They are published under the authority of the Administrator of the Centers for Medicare & Medicaid Services (CMS).

CMS Rulings are binding on all CMS components, on all Department of Health & Human Services (HHS) components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration (SSA) to the extent that components of the SSA adjudicate matters under the jurisdiction of CMS.

This Ruling provides notice of CMS's determination to grant relief to any hospice provider that has a properly pending appeal (as discussed herein) in any administrative appeals tribunal (that is, the Provider Reimbursement Review Board (PRRB), the Administrator of CMS, the Medicare fiscal intermediary hearing officer, or the CMS reviewing official) that seeks review of an overpayment determination for any hospice cap year (the period November 1 to October 31) ending on or before October 31, 2011 by challenging the validity of the beneficiary counting methodology set forth in 42 C.F.R. § 418.309(b)(1). In this regard, such a provider's hospice cap determination (as defined under 42 U.S.C. §

1395f(i)(2)) for any cap year ending on or before October 31, 2011 and for which a timely appeal has been filed and is otherwise properly pending (as discussed herein) will be recalculated using a patient-by-patient proportional methodology for counting the number of Medicare beneficiaries as opposed to the methodology currently set forth in 42 C.F.R. § 418.309. This Ruling requires the appropriate Medicare contractor to identify each covered appeal and recalculate the aggregate cap. This Ruling also holds that, in light of the required recalculation, the pertinent administrative appeals tribunal will no longer have jurisdiction over the covered appeal and, therefore, directs the pertinent administrative appeals tribunal to remand each qualifying appeal to the appropriate Medicare contractor. Moreover, the Ruling explains how CMS and the contractor will recalculate the hospice provider's cap overpayment determination to account for beneficiaries who receive hospice services from the same hospice provider in multiple cap years using a methodology (the "patient-by-patient proportional methodology") that will allocate an individual beneficiary to multiple cap years based on the number of days the beneficiary receives service from the hospice in a given cap year relative to the total number of days in all cap years the beneficiary receives services from the hospice (or any hospice).

MEDICARE PROGRAM

HOSPICE

HOSPICE APPEALS FOR REVIEW OF AN OVERPAYMENT DETERMINATION

CITATIONS: 42 U.S.C. § 1395f(i)(2) and 42 C.F.R. Parts 418 and 405

BACKGROUND

In 1982, Congress amended the Medicare statute to provide coverage for hospice care under Part A. See Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 122, 96 Stat. 356, 364 (1982). The hospice benefit was designed to provide patients who are terminally ill (i.e., life expectancy of six months or less) with comfort and pain relief, as well as emotional and spiritual support, generally in a home setting. Specifically, Medicare hospice services include nursing care, physical or occupational therapy, counseling, home health aide services, physicians' services, and short-term inpatient care, as well as drugs and medical supplies. 42 U.S.C. § 1395x(dd)(1); see also 48 Fed. Reg. 56,008, 56,008 (Dec. 16, 1983) (describing hospice benefit).

The Medicare hospice benefit reflects a patient's choice to receive palliative care rather than curative care. The individual waives all rights to Medicare payments for treatment of the underlying terminal illness and related conditions by someone other than the individual's attending physician or the chosen hospice program. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice care providers on a per diem basis. See 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year (November 1 to October 31, also known as the cap year) is limited, however, by a statutory cap. See 42 U.S.C. § 1395f(i)(2)(A). Payments made in excess of the statutory cap are considered overpayments and must be refunded by the hospice care provider. See 42 C.F.R. § 418.308.

The statutory cap is calculated for each hospice care provider by multiplying the applicable "cap amount," which is updated annually, by the "number of Medicare beneficiaries in the hospice program in that year." 42 U.S.C. § 1395f(i)(2)(A). The statute provides that the number of Medicare beneficiaries in a hospice program in an accounting year "is equal to the number of individuals who have made an election [to receive hospice care] and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program." 42 U.S.C. § 1395f(i)(2)(C).

In 1983, HHS adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (Dec. 16, 1983). The current regulation calculates the number of hospice beneficiaries as follows:

> Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with § 418.24, from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).
>
> 42 C.F.R. § 418.309(b)(1).

Once a beneficiary is counted for a given hospice, the beneficiary is not counted toward the

hospice's cap in subsequent years if he or she continues to receive services from the hospice. Thus, under this methodology, a patient who receives services in multiple years is counted as 1.0 beneficiary in a single year, rather than as some fraction less than 1.0 in multiple years (with the fractions summing to 1.0).

Since its promulgation in 1983, the vast majority of hospice providers have not objected to the current counting methodology set forth in 42 C.F.R. § 418.309(b)(1). Of the thousands of hospice providers in the Medicare program, typically only a small percentage each year exceed the statutory cap. Of those hospices that do exceed the cap and are issued notices of overpayment determinations (calculated pursuant to the methodology set forth in 42 C.F.R. § 418.309(b)(1)), only a small percentage since FY 2006 have filed administrative appeals objecting to the current counting methodology.

In the April 24, 2009 "Hospice Wage Index For FY 2010" proposed rule (74 FR 18,912, 18,920-22) and in the July 22, 2010 "Hospice Wage Index for FY 2011" notice with comment period (75 FR 42,944, 42,950-51) CMS solicited comments on various options for modernizing the hospice aggregate cap, including an option which would proportionally allocate each individual beneficiary across all the cap years in which the beneficiary received hospice care in any hospice. We received 24 comments in 2009 and 26 comments in 2010 (some on behalf of groups) about the aggregate cap. A number of commenters, including associations, urged CMS to retain the existing cap calculation methodology set forth in 42 C.F.R. § 418.309(b)(1), as any changes to the current methodology would result in additional cost and burden to providers. The major hospice associations urged CMS to defer any major changes to the cap calculation methodology until the implementation of hospice

payment reform, because of similar burden and cost concerns. Commenters also urged CMS to retain the current methodology as it results in a more streamlined and timely cap determination for providers as compared to other options considered, including any proportional methodology that allocates beneficiaries across more than one cap year. A significant advantage of the current 42 C.F.R. § 418.309(b)(1) methodology is that, once made, cap determinations can remain final without need to revise to account for situations in which the percentage of time a beneficiary received services in a prior cap year declines as his or her overall hospice stay continues into subsequent cap years. In contrast, a proportional methodology which allocates a beneficiary across more than one cap year leaves "final" determinations somewhat open-ended. Many who commented on the 2009 and 2010 final rules described above suggested that, because of these advantages, CMS adopt the current methodology as an option for providers even if CMS were to change its methodology to allow for cap determinations to be calculated on a patient-by-patient proportional basis. 75 FR at 42,950-51.

1. Current Litigation

The current method of counting beneficiaries set forth in § 418.309(b)(1) has been the subject of litigation. A small percentage of hospice providers have filed PRRB appeals challenging this methodology, seeking to have hospice overpayment determinations using this methodology invalidated. Many of these appeals have reached federal district court. To date, all federal district courts and the two courts of appeals that have directly ruled on the question have issued decisions concluding that this methodology is inconsistent with the

plain language of the Medicare statute and have set aside these overpayment determinations. Some district courts have also enjoined CMS from using the methodology to calculate the plaintiff-hospice's cap determinations in future cap years. *See, e.g., Los Angeles Haven Hospice, Inc. v. Leavitt*, 2009 WL 5868513 (C.D. Cal. 2009), *affirmed in part*, ___ F.3d ___, 2011 WL 873303 (9th Cir. Mar. 15, 2011); *Lion Health Servs., Inc. v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010), *affirmed in part*, ___ F.3d. ___, 2011 WL 834018 (5th Cir. Mar. 11, 2011); *Hospice of New Mexico, LLC, v. Sebelius*, No. CIV 09-145 (D.N.M. Mar. 5, 2010), *appeal pending*, No. 10-2136 (10th Cir.); *IHG Healthcare, Inc. v. Sebelius*, 717 F. Supp. 2d 696 (S.D. Tex. 2010), *appeal pending*, No. 10-20531 (5th Cir.); *Russell-Murray Hospice, Inc. v. Sebelius*, 724 F.Supp.2d 43 (D.D.C. 2010), *appeal pending*, No. 10-5311 (D.C. Cir.); *Affinity Healthcare Servs., Inc. v. Sebelius*, 2010 WL 4258989 (D.D.C. 2010), *appeal pending*, No. 11-5037 (D.C. Cir.).

CMS continues to believe that the methodology set forth in § 418.309(b)(1) is consistent with the Medicare statute, and in coordination with the Department of Justice it has filed appeals from adverse federal district court decisions. Nonetheless, CMS has determined that it is in the best interest of the agency and the Medicare program to take action to prevent future litigation and alleviate the litigation burden on providers, the agency, and the courts that already exists. To achieve these ends, CMS is issuing, contemporaneously with this Ruling, a proposed rule that sets forth the proposed hospice wage index for fiscal year (FY) 2012. In the FY 2012 hospice wage index proposed rule, CMS is proposing to revise the current methodology set forth at § 418.309(b)(1) to provide for application of a patient-by-patient proportional methodology (which is consistent with

the proportional methodology described below in Section 2) for cap years 2012 and beyond, or, at the provider's election, application of the current methodology set forth in § 418.309(b)(1). CMS is also proposing to allow certain hospice providers that, as of the effective date of the proposed Rule, have not received the Medicare contractor's final cap determination for one or more cap years ending on or before October 31, 2011 to elect to have that determination calculated pursuant to a patient-by-patient proportional methodology.

2. Proportional Methodology

In order to provide relief to hospices that have properly pending appeals in which they challenge the validity of the existing methodology at 42 C.F.R. § 418.309(b)(1), CMS will apply a patient-by-patient proportional methodology pursuant to the implementation procedures set forth in Section 3 below. For purposes of this Ruling only, a "properly pending" appeal is one in which a provider has met all timeliness requirements set forth in section 1878 of the Social Security Act, Medicare regulations and other agency publications, guidelines, rulings, orders or rules.

Under the proportional methodology, each Medicare beneficiary who received hospice care in a cap year will be allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction will be the number of patient days for that beneficiary in that hospice for that cap year (which will be determined after the end of the cap year and is therefore generally a fixed number) and the denominator will be the total number of all patient days for that beneficiary in all cap years in which the beneficiary

received hospice services (using the best available data at the time of the calculation). The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap will be calculated and a notice of overpayment determination will be issued for that cap year to the hospice provider.

It may be the case that, at the time of the recalculation using this patient-by-patient proportional methodology, a hospice beneficiary is still continuing to receive hospice services and his or her overall hospice stay has not ended. Because of the need to give a hospice provider prompt notice of its final payment determination and to promptly collect any newly calculated overpayment, the Medicare contractor will not wait until all patients have ended their hospice stays (that is, they have expired or otherwise left hospice care) before recalculating the final payment determination for a given year. For each beneficiary, the Medicare contractor will use the best data available at the time regarding the total number of hospice patient days in all years to perform the recalculation. The impact of this methodology will be that the fractional allocations for some patients might be overstated (never understated) in the sense that the denominator might not include patient days for services received after the date of the calculation. The cap for any cap year which includes that beneficiary would therefore be overstated as well (again, never understated).

Hospice cap determinations issued pursuant to this Ruling are subject to reopening, under CMS's normal reopening regulations, to recalculate beneficiary fractional allocations when more recent data regarding those beneficiaries are available. A particular beneficiary's fractional allocation for that cap year might decrease – and the payment cap decrease

correspondingly – because the denominator of the fraction for the beneficiary may include data regarding additional days of care received in later cap years which were not available at the date of the preceding calculation. It also should be noted that, in some cases, a hospice beneficiary may receive hospice services in three or four cap years (or more). Under the patient-by-patient proportional methodology, some proportion of a hospice beneficiary's patient days will be counted toward the hospice cap in each and every cap year he or she receives hospice services.

IMPLEMENTATION OF THIS RULING

3. Implementation by CMS and the Medicare Contractors

In order to resolve in an orderly manner timely pending administrative appeals in which hospice providers seek review of overpayment determinations by challenging the validity of the methodology set forth in 42 C.F.R. § 418.309(b)(1) and for which relief is afforded in this Ruling, the appropriate Medicare contractor shall identify each properly pending administrative appeal in which a hospice challenges an overpayment demand calculated pursuant to 42 C.F.R. § 418.309(b)(1), notify the appropriate administrative tribunal that the appeal is covered by this ruling, and recalculate the aggregate cap using the patient-by-patient proportional methodology described in Section 2 of this Ruling. As explained above, each recalculation will be performed using the best data available as to the overall number of hospice patient days for each beneficiary (the denominator of the fractional allocation) at the time the calculation is performed. The Medicare contractor will include the hospice cap overpayment determination in a new determination of program

reimbursement letter which shall serve as a notice of program reimbursement (NPR) under 42 C.F.R. § 405.1803(a)(3). The revised overpayment determination contained therein will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

Many hospice providers prefer the current methodology and have not objected to it. For all hospice providers that have never filed an administrative appeal challenging a cap overpayment determination alleging the invalidity of 42 C.F.R. § 418.309(b)(1), Medicare contractors will continue to issue hospice cap determinations based upon the methodology currently set forth in 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopts a rule providing otherwise in the hospice wage index final rule for FY 2012. This Ruling applies to cap years prior to the cap year ending October 31, 2012. The methodology for calculating cap determinations for cap years ending October 31, 2012 and later will be addressed in the hospice wage index final rule for FY 2012.

4. Implementation by the Administrative Appeals Tribunals

a. Implementation Procedure

In light of this Ruling, the administrative appeals tribunals no longer have jurisdiction over properly pending administrative appeals challenging overpayment determinations calculated pursuant to 42 C.F.R. § 418.309(b)(1). On receiving notification from a Medicare contractor that an appeal is covered by this Ruling, administrative appeals tribunals shall remand covered appeals to the Medicare contractor. If an administrative appeals tribunal determines that an appeal is covered by this ruling prior to receiving

notification from a Medicare contractor, the tribunal may, on its own motion, remand the appeal to the appropriate Medicare contractor for a recalculation of the aggregate cap as described in Section 2 of this Ruling.

However, if the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim does not challenge the existing hospice cap methodology) or an appeal is not properly pending, as described in the first paragraph of Section 2, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.

b. "Mixed" Appeals Where Some Claims Are, But Other Claims Are Not, Subject to the Ruling

We note that it is possible that a given administrative appeal might include some claims that qualify for relief under this Ruling, along with other claims that are not subject to the Ruling. If the administrative tribunal finds that only some, but not all, of the specific claims raised in a given appeal qualify for relief under this Ruling, then the appeals tribunal should remand to the contractor, for recalculation of the hospice cap, only the particular claims for which the Ruling was deemed applicable by the appeals tribunal. The other claims in such appeal which the appeals tribunal found did not qualify for relief under the Ruling should be processed in accordance with the tribunal's usual, generally applicable appeal procedures.

Similarly, if the Medicare contractor finds that some, but not all, of the particular claims at issue in an appeal are subject to the Ruling, then the contractor should recalculate the hospice's cap overpayment determination, in accordance with the applicable provisions of the Ruling. As for the remaining claims in such appeal which the contractor found were not subject to the Ruling, the provider may resume without prejudice its original appeal of such claims before the administrative tribunal that previously remanded the claims to the contractor under the alternative implementation procedure. If the provider elects to resume its original appeal of such claims, then those claims should be processed in accordance with the tribunal's usual, generally applicable appeal procedures.

c. Requests for Review of a Finding That a Claim Is Not Subject to the Ruling

We recognize that, if a specific claim were found outside the scope of, or not in compliance with all applicable timeliness requirements for, relief under this Ruling, then the provider might consider seeking administrative and judicial review of such a finding. For example, if a Medicare contractor were to find that a specific appeal seeking review of an overpayment determination was filed outside the time limits set forth in section 1878 of the Social Security Act and thus was outside the scope of the Ruling, then the provider might elect to resume its original PRRB appeal of the same claim, and ask the PRRB to review the contractor's finding that the Ruling was not applicable to the claim. Similarly, if the PRRB were to find that the Ruling did not apply to a provider's appeal because the provider did not meet one of the PRRB's procedural requirements (such as the requirement of the timely filing of appropriate position papers) or the PRRB were to find that the appeal did not challenge the validity of 42 C.F.R. § 418.309(b)(1), then the provider might seek review by

the Administrator of CMS of the PRRB's finding that its appeal did not qualify for relief under this Ruling.

This Ruling does not address whether the Medicare statute and regulations would support, under any circumstances, administrative and judicial review of a provider's challenge to a finding that a particular claim is not subject to the Ruling. Nonetheless, we believe that it is appropriate to address the timing of any administrative and judicial review of a provider's challenge to a finding that a specific claim is outside the scope of the Ruling or does not satisfy all applicable requirements for relief under the Ruling. [[[Accordingly, it is hereby held that the administrative appeals tribunals may not review or decide a provider's interlocutory appeal of a finding, whether made by an appeals tribunal or by a Medicare contractor, that a specific claim is outside the scope of the Ruling or that such claim does not satisfy all applicable timeliness requirements for relief under the Ruling. Instead of reviewing or deciding any such interlocutory appeal, the pertinent administrative appeals tribunal should address, through its usual, generally applicable appeal procedures, the provider's challenge to a finding that a specific claim is not subject to the Ruling. Moreover, the administrative appeals tribunal should not review or decide the "merits" of a provider's challenge to a finding that a particular claim is outside the scope of the Ruling or that such claim is not a properly pending appeal, unless and until the appeals tribunal were to conclude specifically that the Medicare statute and regulations support subject matter jurisdiction over the provider's challenge to a finding that the Ruling does not apply to a particular claim. Also, if the administrative appeals tribunal were to decide whether the

same appeals tribunal or a different administrative tribunal had jurisdiction over a provider's challenge to a finding that a specific claim is not subject to the Ruling, the tribunal should issue a written decision that includes an explanation of the specific legal and factual bases for the tribunal's jurisdictional ruling.

5. Appeals and Reopenings of Hospice Cap Recalculations Made Pursuant to this Ruling and Based Upon the Application of the Patient-by-Patient Proportional Methodology

Just as hospice cap determinations based on application of the existing methodology in 42 C.F.R. § 418.309 are subject to administrative appeal in accordance with 42 C.F.R. § 418.311 (which refers to 42 C.F.R. part 405, subpart R), under this Ruling hospice cap determinations that are recalculated based on application of the patient-by-patient proportional methodology are determinations subject to administrative appeal (in accordance with 42 C.F.R. § 418.311) and ultimately judicial review, after the contractor has issued a cap determination and if all applicable requirements for administrative and judicial review are met. Pursuant to 42 C.F.R. § 418.311 (which incorporates 42 C.F.R. part 405, subpart R), the provider may appeal an intermediary's cap determination in accordance with the requirements contained in either 42 C.F.R. § 405.1811 or 42 C.F.R. § 405.1835, whichever is applicable. In accordance with the applicable regulations, any such appeal must be filed to the appropriate authority no later than 180 days from the date of the contractor's determination. If a provider properly pursues and exhausts the administrative appeals process and receives a final agency decision, the final agency decision is subject to judicial review in accordance with 42 C.F.R. part 405, subpart R and 42 U.S.C. § 1395oo.

In addition, all hospice cap determinations based on application of a patient-by-patient proportional methodology are subject to reopening (for up to 3 years in accordance with the requirements of 42 C.F.R. § 405.1885). Thus, a hospice cap payment determination made pursuant to this Ruling may be reopened at a later time (e.g., to revise the proportional allocations to account for additional days of care after the year in question, which would increase the denominators of some proportions and thus decrease some fractional allocations). We recognize that this might increase uncertainty, but this concern must be balanced against other considerations such as payment accuracy and timeliness of payment determinations. Nothing in this Ruling, however, shall be construed as requiring reopening and recalculation of cap determinations for an earlier year when there is a recalculation for any given year.

RULING

First, it is CMS' Ruling that the agency and the Medicare contractors will resolve and grant relief in each properly pending appeal in which a hospice provider seeks review of a final determination of overpayment for a cap year ending on or before October 31, 2011 by challenging the validity of the methodology set forth in 42 C.F.R. § 418.309(b)(1). CMS will grant relief in each appeal by directing its Medicare contractors to recalculate the final overpayment determination in accordance with the patient-by-patient proportional methodology described in Section 2 of this Ruling.

Second, it is also CMS' Ruling that the pertinent administrative appeals tribunal (that is, the PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS

reviewing official) and the appropriate Medicare contractor will process, in accordance with the instructions set forth in Sections 3 and 4 of this Ruling, each appeal (including any interlocutory appeals) and each putative claim (in such appeal) seeking review of a hospice cap overpayment determination for a cap year ending on or before October 31, 2011 on the basis that the methodology set forth in 42 C.F.R. § 418.309(b)(1) is invalid.

Third, it is CMS' further Ruling that the agency and the appropriate Medicare contractor will process, in accordance with the instructions set forth in Section 5 of this Ruling, each properly pending appeal seeking review of a hospice cap overpayment determination for a cap year ending on or before October 31, 2011 on the basis that the methodology set forth in 42 C.F.R. § 418.309(b)(1) is invalid and that is remanded by the administrative appeals tribunal and is found to qualify for relief under this Ruling.

Fourth, it is CMS' further Ruling that, pursuant to 42 C.F.R. §§ 405.1801(a), 405.1885(c)(1), (2), this Ruling is not an appropriate basis for the reopening of final determinations of the Secretary or a Medicare contractor or of any decision by a reviewing entity, except to the extent that this Ruling provides for reopening in accordance with existing regulations and policy; accordingly, it is hereby held that this Ruling does not provide an independent basis for the administrative appeals tribunals, the fiscal intermediaries, and other Medicare contractors to reopen any final hospice cap determination in a manner inconsistent with existing regulations and policy.

Fifth, it is also CMS' Ruling that, pursuant to 42 C.F.R. § 401.108, this Ruling is a final precedent opinion and order and a binding statement of policy that does not give rise to any putative retroactive rulemaking issues; in any event, it is hereby held that, if this Ruling

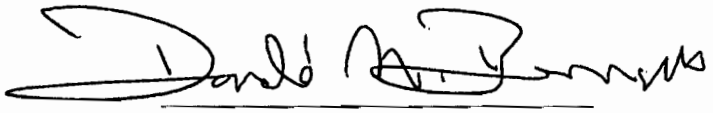
were deemed to implicate potential retroactive rulemaking issues, then, in accordance with 42 U.S.C. § 1395hh (e)(1)(A), retroactive application of this Ruling is necessary to ensure continuing compliance with 42 U.S.C. § 1395f(i)(2)) and to serve the public interest.

Sixth, it is also CMS' Ruling that, pursuant to 42 C.F.R. § 401.108, this Ruling is a final precedent opinion and order and a binding statement of policy. This Ruling is not a substantive or legislative rule requiring notice and comment; to the extent that this Ruling is deemed to be a substantive or legislative rule, it is CMS's Ruling that good cause exists to dispense with rulemaking procedures pursuant to 42 U.S.C. § 1395hh (b)(2)(C) and 5 U.S.C. § 553(b)(B) to ensure continued compliance with 42 U.S.C. § 1395f(i)(2).

EFFECTIVE DATE

This Ruling is effective April 14, 2011.

Dated: APR 14 2011



Donald Berwick,

Administrator,

Centers for Medicare & Medicaid Services