Charles N. Kahn III
President and CEO

February 5, 2013

Martique Jones
Director, Regulations Development Group
Centers for Medicare and Medicaid Services
Division B, Office of Strategic Operations and Regulatory Affairs
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Hospital Wage Index Occupational Mix Survey and Supporting Regulations;
Document Identifier: CMS-10079 (OMB#: 0938-0907)

Dear Ms. Jones:

The Federation of American Hospitals ("FAH") is the national representative of more than 1000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") revisions to the hospital wage index occupational mix survey, published as an information collection activity in the December 7, 2012 Federal Register.

The FAH commends the agency's decision to set the survey due date for six months following the survey consistent with the 2010 survey. This should provide adequate time to complete the survey.

The FAH also commends the agency's decision to continue to require and limit the breakdown in nursing subcategories to only employees working in specific cost centers. We believe this contributes to consistency in reporting by hospitals.

The FAH recommends that CMS add two occupational categories to the survey.

* The unit secretary category is needed because a significant number of hospitals utilize this position on their nursing units for the express purpose of enabling RNs and others in clinical care-oriented positions to focus more of their time and attention on direct patient care and less on the strictly clerical duties that otherwise consume an increasing amount of their time. The compensation for this position, however, is typically significantly less than that of an RN. As a result, the hospital operates more efficiently, but is, paradoxically, penalized with a lower average hourly rate, that ultimately lowers hospital payment. Including this position on the occupational mix survey and calculation would reduce this unintended payment penalty.

* The all-other nursing category would be helpful in refining the survey in the future. It should include all employees in the specified cost centers who are not in the specific categories. This will allow CMS and others to quantify the percent of nursing cost center employees that are not covered under the survey categories, by hospital, as well as nationally. Positions that would fall into this category include EMT, Supervisor Administrative and Instrument Technician. This can direct future efforts to identify whether additional categories should be added to later surveys.

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The FAH appreciates the opportunity to comment on the Occupational Mix data and again expresses its appreciation for the positive changes in the instrument and the Agency's responsiveness to hospital comments. If you have any questions about our comments or need further information, please contact me or Steve Speil of my staff at (202) 624. 1529.

Sincerely,

Health Financial Systems

February 5, 2013

Attn: Gerry Mondowney

Re: **Form Number: CMS-10079 (OMB: 0938-0907)**

CMS should consider a streamlined and more automated approach to the Occupational Mix Survey data collection. This data collection should be incorporated into the Medicare Cost Report (MCR) electronic data submission for the following reasons;

1. **The provider reporting burden would be reduced.**
   Per the Supporting Statement it is estimated that 480 provider hours are associated for each hospital filing. The Occupational Mix Survey data is filled out by the same people that fill out the Medicare Cost Report. These people are very familiar with the MCR data and submission requirements. In reviewing the Occupational Mix Survey data instructions, there are areas of overlap between the MCR data and the Occupational Mix Survey data such as the identification and exclusion of salaries and hours associated with areas not paid under the Inpatient Prospective Payment System. In addition, if added to the MCR, edit comparisons could be made the wage data reported in the MCR resulting in improved data.

2. **Medicare Administrative Contractor processing would be more automated and therefore less expensive.**
   Per the Supporting Statement it is estimated that 17,500 MAC audit hours are associated with the reviewing and audit of the occupational mix surveys at a cost of approximately $714,000. Currently, MAC's have an automated acceptance process, edit process and audit tools in place for the Medicare Cost Report. By incorporating this data collection into the MCR process and using the same tools, MACs will not need new systems, processes or training. Adjustments/Audits to the Wage data are being done by MAC's now. If this data was in the MCR format then it could be audited using the same tools the MAC uses for Wage Reviews/Adjustments. It would be documented and automated.

3. **CMS would have access to the electronic data and the quality of data could be improved.**
   Existing CMS system could be used to track and study data. The submitted Occupational Mix Survey data could be tracked and "autoloaded" just like MCR data is in the CMS Hospital Cost Report Information System (HCRIS) database. This data could be used internally by CMS or made public using the same processes that are already in place for filing the MCR and reviewing the Wage Index data (ECR and HCRIS).

4. **This approach does not require additional fees to providers, MAC's or CMS as this data collection is in place, working and successful.**

8109 Laguna Boulevard, Elk Grove, CA 95758 (916) 686-8152 FAX: (916) 683-2378

The Occupational Mix Survey forms and instructions could be incorporated into the current Medicare Cost Report. Vendors could incorporate the additional data within the MCR software and CMS approval process. This could be accomplished with no additional fees to providers, MACs or CMS.

Health Financial Systems is aware that the MCR filing requirement is yearly and the Occupational Mix Survey data collection is every three years. Health Financial Systems is also aware that the Occupational Mix Survey data is a calendar year collection and many providers do not have a calendar year MCR reporting cycle. The forms could be in vendor MCR systems and available for use without requiring an entire MCR. Another option would be to change the timing of the Occupational Mix Survey data. If the Occupational Mix data collection followed the providers MCR reporting cycle, more edits could be in place to check and improve the quality of the data and reduce preparation, reporting and audit time for Hospitals and MACs. Regardless of timing, the MCR collection would still work, improve the quality of submitted at no additional costs to providers or CMS.

Health Financial Systems has done a detailed analysis of the data and would be willing to submit a draft of the required MCR and related electronic specifications. Thank you for the opportunity to comment on this data collection effort and please feel free to contact me at becky.dolin@hfssoft.com or Eric Swanson of my staff eric.swanson@hfssoft.com for more details.

Thank you,

Becky Dolin

Becky Dolin
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February 5, 2013

Via Electronic Submission

Martique Jones
Director, Regulations Development Group
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Division B, Office of Strategic Operations and Regulatory Affairs
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

Attention: CMS – 10079 (OMB #: 0938-0907)

Dear Ms. Jones:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) notice entitled *Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64.* 77 *Fed. Reg.* 73032 (Dec. 7, 2012). The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

CMS is required to collect data every three years on the occupational mix of employees for each short-term acute care hospital participating in the Medicare program to construct an occupational mix adjustment to the wage index.

The proposed 2013 Occupational Mix Survey provides for the collection of occupational mix data for a 12 month period (that is, pay periods ending between January 1, 2013, and December 31, 2013). The data from this survey will be used to adjust the wage index in fiscal years 2016 through 2018. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index.

While the AAMC understands the statutory nature of this data collection, the Association encourages CMS to consider modifying the adjustment the Agency makes to take into account the unique occupational needs of teaching hospitals. Teaching hospitals, particularly major teaching hospitals, consistently treat more complex patients and have case mix indexes (CMI) higher than those of non-teaching hospitals. Based on 2011 data, the average CMI of major teaching hospitals is approximately 1.8, compared to 1.6 for other teaching hospitals and 1.5 for non-teaching hospitals. Mission-related staffing needs associated with patient acuity and standby capacity for the provision of complex services, such as Level 1 trauma centers and burn units, require teaching hospitals to hire more specialized staff with higher training and wages. AAMC urges CMS to consider these unique needs when constructing an adjustment that is meant to control for the effect of hospitals' employment *choices* on the wage index.

The Association also recommends that CMS add two additional categories to the survey for future collection periods: one for "unit secretaries" and one for "all other nursing."

1) Unit Secretaries. Although they do not provide clinical care, unit secretaries perform clerical duties that free up nursing staff to spend more time on clinical duties. Furthermore, they are paid significantly less than registered nurses (RNs) and enable the hospital to operate more efficiently, which in turn lowers the hospital's average hourly rate.

2) All Other Nursing. This category should include all nursing employees such as emergency medical technician, supervisor administrative, instrument technician, and nurses working in the Radiology-Diagnostic cost center who do not fit into the cost centers listed in the current survey. The addition of this category would allow CMS to determine the percentage of the nursing employees who are not included in the survey categories and help the Agency identify additional categories that should be included in the survey.

AAMC commends the Agency's previous decision to exempt hospitals that terminated participation in the Medicare program before the beginning of the collection period, that is, January 1, 2013, from completing the survey. The Association encourages CMS to further alleviate unnecessary administrative burden by only including in the survey hospitals that are participants in the Medicare program for the entire year. This would mean exempting hospitals that terminate participation in the Medicare program at any time during 2013 from completing the survey. AAMC also encourages the Agency to seek other ways of reducing the administrative burden of completing the survey, so that hospital resources can instead be directed toward the provision of quality patient care.

We appreciate CMS' ongoing efforts to design an effective occupational mix survey instrument and to ensure that the data being collected are as accurate as possible.

If you have any questions concerning these comments, please contact Lori Mihalich-Levin at 202-862-0599 or at lmlevin@aamc.org or Allison Cohen at 202-862-6085, acohen@aamc.org.

Sincerely,

Joanne M. Conroy, M.D.
Chief Health Care Officer

cc: Ivy Baer, JD, MPH AAMC
Allison Cohen, JD, LLM AAMC
Lori Mihalich-Levin, JD, AAMC

Hennepin County Medical Center

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February 5, 2013

Via Electronic Submission www.regulations.gov

Martique Jones
Director, Regulations Development Group
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Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

Attention: CMS – 10079 (OMB #: 0938-0907)

Dear Ms. Jones:

Hennepin County Medical Center (HCMC) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) notice entitled *Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64.* 77 *Fed. Reg.* 73032 (Dec. 7, 2012). Located in downtown Minneapolis, Minnesota, HCMC is a safety net teaching hospital providing health care for many Medicare and Medicaid patients. We are a Level 1 Adult Trauma Center and Level 1 Pediatric Trauma Center, providing care for low-income, uninsured, and vulnerable populations. We are committed to provide the best possible care to every patient we serve and to ensure access to healthcare for all.

CMS is required to collect data every three years on the occupational mix of employees for each short-term acute care hospital participating in the Medicare program to construct an occupational mix adjustment to the wage index.

The proposed 2013 Occupational Mix Survey provides for the collection of occupational mix data for a 12 month period (that is, pay periods ending between January 1, 2013 and December 31, 2013). The data from this survey will be used to adjust the wage index in fiscal years 2016 through 2018. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index.

While HCMC understands the statutory nature of this data collection, we encourage CMS to consider modifying the adjustment the Agency makes to take into account the unique occupational needs of teaching hospitals. Teaching hospitals, particularly major teaching hospitals, consistently treat more complex patients and have case mix indexes (CMI) higher than those of non-teaching hospitals. Based on 2011 data, the average CMI of major teaching hospitals is approximately 1.8, compared to 1.6 for other teaching hospitals and 1.5 for non-teaching hospitals. HCMC's mission-related staffing

needs associated with patient acuity and standby capacity for the provision of complex services, such as Level 1 Adult and Pediatric trauma and burn services require us to hire more specialized staff with higher training and wages. HCMC urges CMS to consider these unique needs when constructing an adjustment that is meant to control for the effect of hospitals' employment *choices* on the wage index.

We also recommend that CMS add two additional categories to the survey for future collection periods: one for "unit secretaries" and one for "all other nursing."

- The unit secretary is category is needed because some hospitals utilize this position to allow RNs and other positions to spend more of their time on clinical duties, instead of clerical duties. Unit secretaries are paid significantly less than registered nurses (RNs) and enable the hospital to operate more efficiently, which in turn lowers the hospital's average hourly rate.

- The addition of the all other nursing category would allow CMS to determine the percentage of the nursing employees who are not included in the survey categories and help the Agency identify additional categories that should be included in the survey. This category should include all nursing employees such as emergency medical technician, supervisor administrative, instrument technician, and nurses working in the Radiology-Diagnostic cost center who do not fit into the cost centers listed in the current survey.

We join the Association of American Medical Colleges (AAMC) in supporting CMS' previous decision to exempt hospitals that terminated participation in the Medicare program before the beginning of the collection period, that is, January 1, 2013, from completing the survey. In addition, we encourage CMS to further alleviate unnecessary administrative burden by only including in the survey hospitals that are participants in the Medicare program for the entire year. This would mean exempting hospitals that terminate participation in the Medicare program at any time during 2013 from completing the survey. In addition, we encourage the Agency to seek other ways of reducing the administrative burden of completing the survey, so that hospital resources can instead be directed toward the provision of quality patient care.

We appreciate CMS' ongoing efforts to design an effective occupational mix survey instrument and to ensure that the data being collected are as accurate as possible.

If you have any questions concerning these comments, please contact Amy Tepp at amy.tepp@hcmed.org or Marie Davis at marie.davis@hcmed.org.

Sincerely,

David Jones
Chief Executive Officer
Hennepin County Medical Center

PUBLIC SUBMISSION

As of: February 11, 2013
Received: January 22, 2013
Status: Pending_Post
Category: Hospital - HPA35
Tracking No. 1jx-8394-2mse
Comments Due: February 05, 2013
Submission Type: Web

Docket: CMS-2013-0021
Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64 (CMS-10079)

Comment On: CMS-2013-0021-0001
Hospital Wage Index Occupational Mix Survey and Supporting Regulations in42 CFR, Section 412.64 (CMS-10079)

Document: CMS-2013-0021-DRAFT-0002
NE

Submitter Information

Name: Erin Mass
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General Comment

In the attached "Medicare Wage Index Occupational Mix Survey" it appears the cost report line numbers for some of the cost centers are incorrect.

Electrocardiology, Renal Dialysis, and Ambulatory Surgical Center (Non-Distinct Part) are listed as cost center lines 66, 71, and 75 respectively.

However, per cost reporting form 2552-10 the lines numbers for these cost centers are 69,74, and 75.