June 8, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–PN2
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: CMS–1488–P2
May 17, 2006, IPPS Occupational Mix Proposed Rule
Submission of Comments

Dear Sir or Madam:

We appreciate this opportunity to comment on the proposed rule published in the May 17, 2006, **Federal Register** revising the methodology for calculating the occupational mix adjustment announced in the FY2007 IPPS proposed rule by applying the occupational mix adjustment to 100% of the wage index using the new occupational mix data collected from hospitals. We are a regional CPA firm serving approximately 400 hospitals nationwide. Our comments are as follows:

Calculation of the Proposed FY2007 Occupational Mix Adjustment

CMS proposes four options for treating the occupational mix data for non-responsive hospitals:

(1) Assign the hospital an occupational mix adjustment factor of 1.0000
(2) Assign the hospital the average occupational mix adjustment factor for its labor market area
(3) Assign the hospital the lowest occupational mix adjustment factor for its labor market area
(4) Assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix.

We believe Option (2) is the most objective option and most reasonable alternative for handling non-responsive hospitals. Option (1) may reward non-responsive hospitals that had estimated

Hammons Tower
901 E. St. Louis Street, Suite 1000
P.O. Box 1190
Springfield, MO 65801-1190
417 865-8701 Fax 417 865-0682

3230 Hammons Boulevard
P.O. Box 1824
Joplin, MO 64802-1824
417 624-1065 Fax 417 624-1431

1034 W. Main Street
P.O. Box 1277
Branson, MO 65615-1277
417 334-5165 Fax 417 334-4823

Commerce Bank Building
100 S. Broadway Street
P.O. Box 1448
Pittsburg, KS 66762-1448
620 231-7380 Fax 620 231-1226

bkd.com

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they might have an adjustment factor below 1.0000. Option (3) may be unnecessarily punitive for hospitals unable to complete the occupational mix survey in the exceptionally short timeframe provided by CMS. Option (4) adds a degree of subjectivity that could lead to disputes and unnecessary uncertainty in an already difficult process.

CMS is unclear as to whether the assigned factor for a non-responsive hospital would be included in the overall adjustment factor computed for the hospital's labor market area. We do not believe other hospitals in the area should be penalized because of a non-responsive hospital. For example, if Option (1) or (3) is chosen for a hospital in a labor market area which otherwise has an adjustment factor above 1.0000, this could reduce that factor, penalizing the other hospitals in the area. We request CMS clarify its intent in this area, but this would also be a reason to choose Option (3), such that the non-responsive hospital's assigned factor would not change the factor for its labor market area.

Reclassification for FY2008

CMS notes that hospitals must file MGCRB requests by September 1, 2006, to be effective October 1, 2007, while also noting that the wage data necessary to file such requests may not be available by September 1, 2006. CMS proposes that hospitals file incomplete MGCRB applications by September 1, 2006, and supplement such application with official wage data no later than 30 days after the data is made available on the CMS website.

As an initial comment, we request that CMS change the allowed time to 45 days to supplement an application. Hospitals will have other immediate concerns to address once the final data is published. As the MGCRB reclassifications would not be effective until October 1, 2007, an additional 15 days this fall would be helpful for hospitals to more adequately analyze the final wage data.

We appreciate the difficult position CMS faces in analyzing a substantial amount of occupational mix data in an extremely short timeframe, in order to develop wage index tables to be effective October 1, 2006. We also understand why this means such tables might not be available by September 1, 2006. However, CMS places hospitals in the unenviable position of "guessing" whether they will qualify for MGCRB reclassification by September 1, 2006, in order to file an incomplete application by this date.

In particular, we would estimate there are several hundred hospitals that, based on data in the proposed rule, are close but slightly below the threshold needed to file an MGCRB application. Should all of these hospitals file applications under the unlikely scenario that the occupational

mix data might bring their adjusted average hourly wage to a level that would qualify them for reclassification?

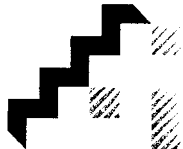
If CMS is unable to make wage data available sufficiently in advance of September 1, we believe CMS has discretion to deem hospitals as having filed incomplete applications by that date, to be completed 30 days after the wage data is made available. For example, by virtue of having completed the appropriate wage survey from their FY2003 Medicare cost reports, all hospitals with a FY2003 average hourly wage published in the April 25, 2006, **Federal Register** could be deemed to have filed a preliminary, or incomplete, MGCRB application for FY2008.

As an alternative, CMS could provide a list of all PPS hospitals to the MGCRB, as potential reclassification candidates, thereby allowing the hospitals time to finalize an application.

We appreciate this opportunity to comment on these important proposals. If you have questions concerning our comments or need further information, please contact Tim Wolters at 417-865-8701.

BKD, LLP

BKD, LLP



CATHOLIC
HEALTHCARE
PARTNERS

615 Elsinore Place
Cincinnati, Ohio
45202

Phone ▪ 513 ▪ 639 ▪ 2800
Fax ▪ 513 ▪ 639 ▪ 2700

June 08, 2006

Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

REF: CMS-1488-P and CMS-1488-P2

RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Payment Rates; Proposed Rule.

Dear Dr. McClellan:

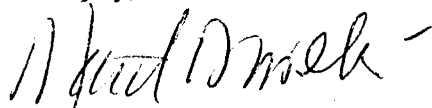
On behalf of Catholic Healthcare Partners (CHP) and our affiliated twenty-nine acute care hospitals and fourteen Long Term Care facilities, we appreciate the opportunity to comment on the proposed rule for the 2007 Medicare Prospective Payment System (PPS) for inpatient admissions. This year's proposed rule contains pivotal policy changes that not only have the potential to significantly impact our hospitals' financial position, but also impact operations especially in Health Information Management, Quality, and Financial Analysis departments. We appreciate CMS willingness to provide clarifications to existing definitions and policies that have been problematic for hospitals regarding EMTALA related-transfers to specialty hospitals and proper tracking of Graduate Medical Education and Allied Health training. The proposed 2007 Inpatient Prospective Payment System (IPPS) rule again provides a "mixed-bag" of changes to our member hospitals which include teaching hospitals, Critical Access Hospitals, Sole Community Hospitals, Medicare-Dependent Hospitals and Long Term facilities. Specifically we want to comment regarding the following proposed changes:

1) DRG Reclassifications
2) Cost Based Weights: Outlier Threshold
3) DRGs: Hip and Knee Replacements
4) CBSAs
5) Occupational Mix Adjustment
6) Hospital Quality Data
7) EMTALA
8) Blood Clotting Factor Payment Rate

Attached you will find our specific comments and recommendations on the topics contained within the proposed rule.

Catholic Healthcare Partners appreciates the opportunity to submit comments for your consideration. If your staff has any questions about these comments, please feel free to contact me at 513-639-0129 or Cheryl Rice, CHP Corporate Director of Corporate Responsibility at 513-639-0116 clrice@health-partner.org.

Sincerely,



Matthew D. Williams
Vice President, External Relations
Catholic Healthcare Partners

Attachment
Clr

DRG Reclassifications

The proposed rule, if adopted, would result in the most significant change to the Inpatient Prospective Payment System (IPPS) since its implementation in the 1980s. Changes of this nature can not be taken lightly or rushed into without proper planning and analysis. We recognize that in order to expand care access to beneficiaries, provide equitable reimbursement for rendered services, and improve overall health care quality to Medicare beneficiaries and others, the current methodology of payment needs to be adjusted to account for changes in the healthcare delivery. Our overall concern, however, is that the proposed rule initiates so many policy changes that their "collective" impact is difficult to quantify from both a financial and operational perspective. Catholic Healthcare Partners (CHP) is willing to work toward implementing a refined DRG payment methodology, however our hospitals need sufficient time and information to understand DRG remapping, validate cost-based calculations, plan for financial changes to operations, train staff on coding policy and retool our hospital information systems in order to accurately and successfully transition to cost-based and severity-adjusted DRGs. Specifically we recommend the following considerations:

1. Delay the implementation of hospital specific relative values (HSRVs) and cost-based weights (HSRVcc) until at least FY 2008. The proposed rule offered two different methodologies for arriving at hospital specific relative values and cost-based weights. Upon review, the simplified CMS proposed methodology had the benefit of focusing costs into ten manageable cost centers for national cost-to-charge ratio development and supported an annual update process. Hospitals frequently encounter annual fluctuations in costs for drugs, supplies, and staff that are driven by market forces beyond their control. The annual update process provides some flexibility in adjusting for those unexpected costs particularly in markets prone to shortages and recalls that drive up costs. Unfortunately, the American Hospital Association notified its member hospitals that the CMS methodology had several serious calculation errors which could result in unintended financial consequences. **We recommend CMS work with the AHA to identify and address the areas of concern, and once resolved re-issue the respective cost-based calculation methodologies along with a comparative schematic of each calculation methodology and an example of how cost would be calculated under each methodology using a common set of same data. This information should be released in time for adequate analysis and comment for FY 2008.**

2. Amend the ten Cost Centers proposed under the CMS recommendation to include inpatient costs from Medicare Cost Report Worksheet C Part I Column 5 line 62 – Observation to fully capture clinical costs associated with direct patient care. In reviewing the services to be considered in cost-based DRG weighting, it appears CMS excluded line 62 – Observation costs. Although Observation services are typically considered an "outpatient" service, inpatients can legitimately spend up to 48 hours (i.e. 2 days) prior to their inpatient admission in Observation status. By excluding inpatient costs reported for line 62, CMS would be understating associated DRG costs for medically necessary nursing services. CMS has repeatedly instructed hospitals to

appropriately prepare complete Cost Reports by separating routine and ancillary by inpatient and outpatient costs. The CMS proposed cost-based methodology will finally recognize those hospitals which have been compliant in completing their Cost Reports as instructed. Worksheet C Part I Column 5 line 62 allows hospitals to distinguish between costs associated with "pure" outpatient Observation cases versus costs associated with patients who were placed in Observation prior to an inpatient admission. **As such, CMS should include the costs of care spent in Observation that ultimately results in an inpatient admission as reported in line 62 in the overall DRG cost-based weighting.**

3. Delay the implementation of the severity-adjusted DRG methodology until at least FY 2008. We understand and share CMS concern regarding charge-driven biases and "DRG complication-co morbidity creep" that has been occurring since the inception of DRGs. We also support the decision to move to DRGs that are more reflective of intensity of service and severity of illness as demonstrated by the presence of underlying complications, multiple co-morbidities and secondary diagnoses. However we are concerned that hospitals have not been given sufficient information and/or time to evaluate the impact of either proposed MedPAC APR-DRGs or CMS Consolidated DRGs. Specifically, hospitals have not been given sufficient cross-maps from the current 526 DRGs to each of the respective proposed 1258 APR-DRGs or 861 Consolidated DRGs. Without the cross-maps, a true financial impact analysis can not be completed. Many DRGs can be intuitively matched based on description, but there are a significant number of DRGs that can regroup to numerous severity-adjusted DRGs depending upon the reclassification of specific ICD-9 diagnosis and procedures codes under the severity-adjusted DRG grouper. We are also concerned that hospitals will not have sufficient time to purchase and implement a new DRG Grouper that will be required to generate the severity-adjusted DRGs on a daily basis to support hospital inpatient billing, effective October 1, 2006. According to the proposed rules, only one vendor, 3M, was identified as having access to the grouper. With over 4,000 hospitals requiring a new severity-adjusted DRG Grouper, it is not feasible or reasonable to expect that one vendor could service all the hospitals nationally in the few months between the posting of the final IPPS rule and an October 1, 2006 implementation. We are concerned that new coding requirements associated with the reporting of secondary diagnoses and hospital acquired infections will require additional coding staff training and some reprogramming of internal software and claims processing to allow for the additional codes to appear on hospital claims. **Hospitals need additional time to be able to verify that coders understand and implement crucial coding policy changes, new groupers are functioning, programming and claim processing functions are reporting necessary ICD-9 and DRG information properly to ensure financial and operational stability during the transition to severity-adjusted DRGs.**

4. Implement simultaneously, but not earlier than FY 2008, the proposed cost-based DRG relative weight determination policy and the proposed severity adjustment policy. The simultaneous implementation approach should help to smooth out the major redistributive effects on hospital payments.

5. Limit the severity-adjusted DRG methodology to a 3-digit DRG to minimize extra costs associated with reprogramming and retooling information systems to handle a 4-digit DRG. Under the MedPAC proposal, hospitals would have to reprogram existing health information, claims processing, and decision-support systems to accommodate a 4-digit

DRG. A field length change is an extremely expensive customization to most existing information systems and the fact that the DRG number is such a key data element in most software systems only compounds the problem. Essentially moving to a 4-digit DRG could result in the same level of reprogramming and operational changes as Y2K. Hospitals do not have enough time to prepare by October 1, 2006 and may not be enough time by October 1, 2007 to make all the necessary software changes. **CHP supports the decision to use the consolidated DRGs as it would avoid 4-digit DRGs. Every provider or entity that collects or evaluates DRG information would have to make programming changes if a 4-digit DRG, as proposed by MedPAC APR-DRG, is adopted. Moving to a 4-digit DRG would add undue programming costs to health care and related healthcare markets and move limited financial resources away from initiatives focused on improving quality care and access to healthcare.**

6. Consider transitioning to severity-adjusted DRGs at the same time as implementation of ICD-10 potentially in FY 2009. Although this option was not presented in the proposed rule, it could reduce the overall cost in the long term for severity-adjusted DRG changes and provide a significant improvement to the current system. As hospitals move to severity-adjusted DRGs, coding and claims processing systems will need to be revised to factor expanded code ranges, new coding algorithms and revised code fields within system software and forms. Exactly the same type of coding and software changes would have to be adjusted for the implementation of ICD-10. Migrating to new severity-adjusted DRGs and to new ICD-10 codes simultaneously would allow hospitals to update their encoders, groupers, and internal software systems once and thereby reducing overall costs associated with reprogramming, retraining, and re-installations. A simultaneous transition would also consolidate staff downtime or unproductive training time. **The end result would include an updated ICD-10 coding structure that matches to the rest of the world and an updated DRG structure that accommodates severity of illness, multiple complications and co-morbidities. We recommend that CMS give serious consideration to finalizing all these changes no later than July 1, 2007, for an October 1, 2009 implementation, to provide adequate time for transition, training, systems re-design and testing.**

Cost-Based Weights: Outlier Threshold

According to the proposed rule, cases would qualify for outlier payments in FY 2007 if costs exceed the inpatient PPS rate for the DRG, including indirect medical education, disproportionate share hospital, and new technology payments and a fixed-loss threshold of $25,530. CMS has consistently budgeted a higher outlier payment amount for each fiscal year that has exceeded amounts actually paid (i.e. versus 5.1% budgeted for both years versus 4.1% and 4.7% paid in 2005 and 2006 respectively).
We are concerned that the increase in the fixed-loss threshold amount from $23,600 to $25,530 is unwarranted and would further reduce the payment to our associated hospitals for the medically necessary care provided. Presently our hospitals receive approximately $12 million dollars in inpatient outlier payments, which is a very small portion of our overall total revenue, but is vital payment especially to our smaller facilities. **We would like to see an analysis of the proposed changes to the 2007 DRGs and rationale for the increased outlier threshold.**
In addition we recommend the following considerations for outlier payment as CMS moves forward with severity-adjusted DRGs:

1. Maintain current fixed-loss outlier threshold of $23,600 for FY 07 and at least FY08 to ensure payment stability during this transition period until the full impact and disclosure of severity-adjusted DRGs in provided. We are also concerned that the impact of severity-adjusted DRGs relative to outlier payment has not been fully analyzed and disclosed to hospitals in the proposed rule. Without more detail on how specific severity-DRGs would be adjusted to incorporate payment that normally would be paid as a separate outlier, hospitals are unable to determine if the higher severity of illness DRG payment will be sufficient to offset the need for a separate outlier payment in the future. Furthermore, the elimination of a separate outlier payment would require a legislative change which may not be accomplished by the FY07 Final Rule timeframe.

2. Continue to provide a separate outlier payment after the transition to severity-adjusted DRGs to provide a stop-gap for unusual cases that require intensive interventions. Outlier payments were designed to provide some financial protection for providers who treat "extraordinary" or intensive cases beyond the normal care protocol. Hospitals need the assurance that financial assistance will be available to serve "all" beneficiaries, not just beneficiaries that fall within the norm. Although severity-adjusted DRGs can account for some of the outlier cases, the fact remains that there will always be cases that do not fit the norm due to the individuality of patients. If outlier payments are eliminated altogether, Medicare beneficiaries could face unintended consequences like care rationing or withholding of needed services. We do not believe that Medicare desires this outcome for their beneficiaries or the public in general.

DRGs: Hip and Knee Replacements

We support CMS in the movement of ICD-9 procedure codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, 81.55 from DRG 471 to DRG 545 and the corresponding correction to the Medical Code Editor (MCE) for the Bilateral Procedure Edit.

CBSAs

We continue to be deeply concerned about the manner in which the Medicare wage index negatively impacts hospitals in our communities – not just those who are part of CHP. With that said, our analysis of the FY'07 proposed rule indicates that the wage index changes will result in an overall reduction of almost half of the total Medicare inpatient update for CHP. A reduction of this magnitude creates severe hardships in our ability to carry out our mission to serve our communities with a particular emphasis on those who are poor and underserved. We believe that a reduction of this size is unwarranted and that it should be reversed in the final rule.

Perhaps most troubling from our perspective is that the manner in which Medicare wage index changes are made is inconsistent with the agency's stated public policy goals. For instance, on June 1, CMS Administrator Mark McClellan was quoted in a release by the Department of Health and Human Services as saying, "In all areas of care -- hospitals, physicians, nursing homes, health plans, and prescription drugs -- we are supporting collaborative efforts that are providing unprecedented information to help people get **the best quality care for the best**

price." (emphasis added.) The Medicare wage index ensures that the higher the cost as part of a nationwide comparison, the more a hospital in a given area receives through its wage index.

To that end, a hospital in Knoxville, Tennessee is competing with a hospital in San Francisco, California for its Medicare wage index increase. And while we are not submitting that the wage indexes in Knoxville and San Francisco should be identical, a hospital in Knoxville should not see its Medicare wage index reduced year-on-year when its wages are increasing year-on-year. The practical effect of the current wage index policy ensures that a hospital in Knoxville is penalized for increasing wages at rates that are reasonable for their market.

The use of CBSAs continues to fall short of the need for a real-time measurement of the marketplace for those individuals whose salaries determine the Medicare wage index.

The most poignant example of this reality for us is St. Vincent Mercy Medical Center (SVMMC), located in downtown Toledo, Ohio. The hospital employs a richer blend of clinicians with higher levels of education and training based on the high acuity of those individuals we serve, including a high mix if Medicare patients. Our average hourly wage continues to be more than 108 percent above that of the Toledo, Ohio CBSA. Yet, due to a change in the CBSAs in the FY'05 hospital inpatient rule, SVMMC no longer meets the 15-mile test for the Ann Arbor CBSA. At the same time, there are numerous advertisements in the Sunday issues of *The Toledo Blade* placed by health care institutions located in the Ann Arbor MSA. There are shuttles running clinicians up the Interstate from Toledo to Ann Arbor where higher wages are offered, due at least in part to the higher Medicare wage index.

It is with this background that we would offer the following policy recommendations for the final FY'07 inpatient hospital rule:

1. There should be a stop-loss for hospitals whose average hourly wage increases from one year to the next. In other words, a hospital should not receive a lower wage index while its average hourly wage is increasing.

2. A hospital that is currently re-classed into a CBSA should be allowed to maintain their re-class in subsequent three-year increments through the Medicare Geographic Classification Review Board if they continue to meet the 108 percent test regarding their CBSA and the CBSA to which they are currently re-classed. In addition, there should be a one-time, one-year grace period with the creation of such a policy for those facilities whose 3-year reclassification has just expired.

3. The use of CBSAs continues to fall short of recognizing markets for those individuals whose salaries contribute to the measurement of the Medicare wage index. The agency is not required to use CBSAs as the measure of determining the Medicare wage index and should seek an alternative that is a better reflection of the real-time marketplace.

Occupational Mix Adjustment

The acceleration of the due date for the data submission of the Occupational Mix Survey information to June 1, 2006 has caused undo hardship upon calendar year reporting facilities for which 2005 Medicare Cost Reports were due on May 31, 2006. Many facilities had planned on preparing the Occupational Mix Survey information during the month of May 2006. The announcement of the accelerated due date has not given hospitals adequate time to plan and budget for the required additional resources. The strain on resources could potentially impact the results reported by hospitals both for the submitted Cost Report as well as Occupational Mix Survey. Since the Cost Reports are the key to underlying proposed changes for 2007 IPPS proposal, hospitals should be allowed adequate time to focus on accuracy and compliance. Staff were not afforded sufficient time to review findings of either report as allowed in past years. We recognize that the change in due dates were the result of a Federal court decision beyond CMS' control, however, we wanted to voice our disappointment in a decision that benefited a few hospitals but severely inconvenienced a greater number of hospitals across the nation. **We appreciate CMS providing an alternative proposed rule to address the handling of the fully implemented Occupational Mix Survey and look forward to submitting comments. However we are concerned that the accelerated and constrained reporting period could result in the filling of inadequate reports which could impact national figures as well as individual facility rates.**

Hospital Quality Data

CHP supports CMS' drive toward achieving greater accuracy in the validation process and its requirement of hospitals to meet chart validation by combining samples proposed for federal fiscal year (FFY) 2007. The combining of 15 cases from the first, second, and third quarters into a single sample to determine whether or not the 80% reliability test is met is an improvement in current program procedures. However, CHP would be supportive of an even more statistical robust methodology. Moving beyond the proposed threshold to a higher level of hospital data validation by as many as 25 cases would foster Centralized Data Abstraction Center (CDAC) standards, increased statistical reliability, provide hospitals with needed flexibility, as well as mitigate the effect that a random error could place on a hospital from receiving its full update for FFY 2007. Moreover, CHP is supportive of the CMS proposal that hospitals would attest to the completeness and accuracy of the quarterly data submitted to the Quality Improvement Organization (QIO) clinical warehouse.

EMTALA

Currently Physicians and Non-Physician Practitioners are authorized by hospital medical staff bylaws as "qualified medical personnel" and are able to determine when a woman is in "labor" under current EMTALA regulations. However, only a Physician is able to certify that a woman is in "false labor" and may be released from the Emergency Room without further EMTALA obligations. It is ironic that specially trained Non-Physician Practitioners can deliver a baby, but under current Conditions of Participation provisions for EMTALA are not able to determine that a woman is not in labor; particularly when the current requirement permits physicians to phone in their certification of "false labor" without physically viewing the patient. **We support CMS' proposal to amend the Conditions of Participation for EMTALA which would allow Non-Physician Practitioners to certify "false labor."**

This privilege is a reasonable service to permit within State scope of practice and State law for the specially trained staff and can be easily accommodated in our affiliated hospitals medical staff bylaws.

Blood Clotting Factor Payment Rate

Over the years, CMS has made payment policy changes impacting the coverage of blood clotting factors provided to inpatient hemophiliac patients. The blood clotting factors are necessary for patient health and healing. **We support CMS in their quest for a uniform approach for drug payment. We recommend CMS continue to provide the additional Medicare Part B drug payment for blood clotting factors in the future even if severity-adjusted DRGs are implemented. This is a vitally important medical treatment for hemophiliacs.**

UPMC | University of Pittsburgh Medical Center

5

Edward T. Karlovich
Chief Financial Officer
Academic and Community Hospitals

UPMC Montefiore, Suite N-739
200 Lothrop Street
Pittsburgh, PA 15213-2582
412-647-8280
Fax: 412-647-5551
karlovichet@upmc.edu

June 12, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8012

via: UPS Delivery

Attention: CMS-1488-PN2

RE: CMS-1488-PN2
Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

Dear Sir or Madam:

On behalf of the University of Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule (71 *FR* 28644-28653, 05/17/2006) "Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index".

The following is a summary and a detailed explanation of UPMC concerns and issues with the FY 2007 proposed rules.

I. CALCULATION OF THE PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

In the calculation of the salaries and wage-related costs that will be adjusted as a result of the occupational mix factor, the proposed rule under step#7 states: "...calculate the occupational mix adjusted salaries and wage-related costs ... for the total nursing category by multiplying the hospital's total salaries and wage-related costs by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category hours by the hospital's total hours for 'nursing and all other') and by the total nursing category's occupational mix adjustment factor."

Issue – Estimation of Salaries and Wage-Related Cost by Occupation

By using the occupational mix survey hours, using nursing as the example, it is being assumed that the percentage of nursing hours to total hours from the three month period of January 2006 – March 2006, bears the same proportional relationship to the salaries and wage-related costs reported on the cost report beginning in federal fiscal 2003. Even if the source for this information were to come from the same period of time (i.e. the salaries and wage-related costs for nursing will be utilized from the cost reports beginning in federal fiscal 2003), the relationship of nursing hours to total hours applied to total salaries and wage-related costs assumes that the nursing staff is paid the average hourly wage of the provider from the respective cost report. Stated in another way, the percentage of nursing hours to total hours does not have the same relationship as actual nursing salaries and wage-related costs have to total salaries and wage-related costs. This proxy method of calculating nursing salaries and wage-related costs for application of the occupational mix factor, will result in a higher or lower wage index than appropriate, which is illustrated in the attached example. Attachment "A" is a summary of the impact of the proxy method of calculating salaries compared to actual, and attachment "C" is the detailed calculation. In terms of a verbal summary, the following would occur, again, using nursing as the example:

1) A provider with a richer mix of RNs and an average hourly nursing staff wage which is lower than the hospital average hourly wage, with an occupational mix less than 1.0000, will result in a less than appropriate wage index.
2) A provider with a richer mix of Aides and an average hourly nursing staff wage which is lower than the hospital average hourly wage, with an occupational mix greater than 1.0000, will result in a higher than appropriate wage index.
3) A provider with a richer mix of RNs and an average hourly nursing staff wage which is higher than the hospital average hourly wage, with an occupational mix less than 1.0000, will result in a higher than appropriate wage index.
4) A provider with a richer mix of Aides and an average hourly nursing staff wage which is higher than the hospital average hourly wage, with an occupational mix greater than 1.0000, will result in a lower than appropriate wage index.

Solution

1) Long-term Solution – Incorporate the Occupational Mix Survey into the Medicare Cost Report, requesting the Nursing Salaries, Wage-Related Costs, and Hours by occupation. The result would be that the occupational mix of the Nursing Staff would be the actual mix for the period for which the cost report data was being taken for Nursing Salaries and Wage-Related Costs. In addition, the situation with using an estimation of the Nursing Salaries and Wage-Related Costs would not be an issue.
2) Short-term Solution – For federal fiscal 2007, for those providers with a wage index less than 1.0000 and an occupational mix factor of less than

1.0000, hold those providers harmless, limiting the change to the federal fiscal 2007 wage index so that it cannot be less than the federal fiscal 2006 wage index. For federal fiscal 2008, 2009, and 2010, or until the current wage index system can be assessed, analyzed, and redesigned, those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000 will receive a blended wage index transitioning over a 3 year period, which starting with federal fiscal 2008, would be a blend of the federal fiscal 2006 wage index at 67% and the occupationally adjusted wage index of 33%. As a second alternative, opposed to holding harmless those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000, the hold harmless provision would be applied to those providers that can demonstrate that their wage index has decreased over 8% based upon their federal fiscal 2002 wage index, and can demonstrate that their wage index has decreased annually for at least 4 out of the 5 federal fiscal years. The occupationally adjusted wage index at 100% would still be implemented, but would not drastically impact those facilities that have been subjected to the downward spiral of their wage index as a result of their operating efficiency and staffing choices. In the August 31, 1991 Federal Register, it was noted that in the September 4, 1990 final rule (55 FR 36041), "we implemented a 1-year phase-in of the updated wage index for FY 1991 to lessen the impact of the most significant changes in wage index value. We limited the percentage change in the wage index to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." In the August 31, 1991 Federal Register, page 43197, it was noted that for discharges occurring on or after January 1, 1991, and before October 1, 1993, it was initially proposed that "the wage index would have a 1-year phase-in of the updated wage index that would have limited the percentage change in a wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." Although the second proposal for discharges on or after January 1, 1991 was not implemented, these types of phase-in periods for items like the wage index have been considered in the past. Another example of a phase-in period was for federal fiscal 2005, when the change in going from the MSA to CBSA area was a blend of the two wage index values. In the August 11, 2004 Federal Register, page 49028, it was noted, "...given the scope and drastic implications of these new boundaries and to buffer the subsequent negative impact on numerous hospitals, we have decided to provide, during FY 2005, a blend of wage indexes to those hospitals that would experience a drop in their wage indexes because of the adoption of the new labor market areas. Any hospital experiencing a decrease in their wage index relative to its FY 2005 wage changes will receive 50 percent of the wage index using the new labor market definitions and 50 percent of the wage index that the provider would have received under the old MSA standards." These calculations would be performed within the confines of budget neutrality.

II. BACKGROUND

In the background section of the proposed rule, Part C., Revised Proposed Changes to the Occupational Mix Adjustment for the Proposed FY 2007 Wage Index, it states: "Section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program…". The applicable section of the Social Security Act states: "…the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years …".

Issue-Using the Occupational Mix Survey Over a 3-Year Period

By using the occupational mix survey for a 3-year period, the calculation of the wage index is subject to manipulation, and will result in a wage index that does not match what is actually occurring as an occupational mix within the provider. As providers change their occupational mix of staff over the 3-year period, a historically occupational mix factor will not accurately reflect the occupational adjusted wage index salaries and wage related costs as the calculation moves forward in subsequent years. This situation will result in a higher or lower wage index than appropriate, which is illustrated in the attached example. Attachment "B" is a summary of the impact of the second year with and without an annual update to the occupational mix factor, and attachment "D" is the detailed calculation for a facility with no occupational mix update in the second year, and attachment "E" is the detailed calculation for a facility with an occupational mix update in the second year. In terms of a verbal summary, the following would occur, again, using nursing as the example:

1) Without an occupational mix update in the second year - A provider with a lower mix of RNs in the 1st year, with an increase in their RN usage in the 2nd year, and an occupational mix factor greater than 1.0000, will receive an increase in their wage index in the 2nd year, to the further determent of the provider that had a higher mix of RNs in the 1st year, but no change to their RN mix in the 2nd year, and an occupational mix of less than 1.0000.
2) With an occupational mix update in the second year - A provider with a lower mix of RNs in the 1st year, with an increase in their RN usage in the 2nd year, and an occupational mix factor greater than 1.0000, will receive a decrease in their wage index in the 2nd year (as appropriate), allowing the provider that had a higher mix of RNs in the 1st year, but no change to their RN mix in the 2nd year, and an occupational mix of less than 1.0000, to receive an appropriate increase to their wage in their 2nd year.

Solution

1) Long-term Solution – Incorporate the Occupational Mix Survey into the Medicare Cost Report, requesting the Nursing Salaries, Wage-Related Costs, and Hours by occupation. The result would be that the occupational mix of the Nursing Staff would be the actual mix for the period for which the cost report data was being taken for Nursing Salaries and Wage-Related Costs, with an update to the occupational mix factor being performed annually.

2) Short-term Solution – For federal fiscal 2007, for those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000, hold those providers harmless, limiting the change to the federal fiscal 2007 wage index so that it cannot be less than the federal fiscal 2006 wage index. For federal fiscal 2008, 2009, and 2010, or until the current wage index system can be assessed, analyzed, and redesigned, those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000 will receive a blended wage index transitioning over a 3 year period, which starting with federal fiscal 2008, would be a blend of the federal fiscal 2006 wage index at 67% and the occupationally adjusted wage index of 33%. As a second alternative, opposed to holding harmless those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000, the hold harmless provision would be applied to those providers that can demonstrate that their wage index has decreased over 8% based upon their federal fiscal 2002 wage index, and can demonstrate that their wage index has decreased annually for at least 4 out of the 5 federal fiscal years. The occupationally adjusted wage index at 100% would still be implemented, but would not drastically impact those facilities that have been subjected to the downward spiral of their wage index as a result of their operating efficient and staffing choices. In the August 31, 1991 Federal Register, it was noted that in the September 4, 1990 final rule (55 FR 36041), "we implemented a 1-year phase-in of the updated wage index for FY 1991 to lessen the impact of the most significant changes in wage index value. We limited the percentage change in the wage index to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." In the August 31, 1991 Federal Register, page 43197, it was noted that for discharges occurring on or after January 1, 1991, and before October 1, 1993, it was initially proposed that "the wage index would have a 1-year phase-in of the updated wage index that would have limited the percentage change in a wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." Although the second proposal for discharges on or after January 1, 1991 was not implemented, these types of phase-in periods for items like the wage index have been considered in the past. Another example of a phase-in period was for federal fiscal 2005, when the change in going from the MSA to CBSA area was a blend of the two wage index values. In the August 11, 2004 Federal Register, page 49028, it was noted, "...given the scope and drastic implications of these new boundaries and to buffer the subsequent negative impact on numerous hospitals, we have decided to provide, during FY 2005, a blend of wage indexes to those hospitals that would experience a drop in their wage indexes because of the adoption of the new labor market areas. Any hospital experiencing a decrease in their wage index relative to its FY 2005 wage changes will receive 50 percent of the wage index using the new labor market definitions and 50 percent of the wage index that the provider would have received under the old MSA standards." These calculations would be performed within the confines of budget neutrality.

III. TIMELINE

In the proposed rule for the implementation of the Fiscal Year 2007 Occupational Mix Adjustment, specific timelines were outlined for the completion and implementation of a new occupational mix survey to be used for federal fiscal 2007. The hospitals are to submit the occupational mix data by June 1, 2006. The Fiscal Intermediary must review the data submitted by June 22, 2006. The publishing deadline on the CMS website is June 29, 2006. The deadline for providers to request corrections to the published data is July 13, 2006. And the deadline for the Fiscal Intermediary to submit corrections to the published data is July 27, 2006.

Issue – Accuracy of Data Submitted by Providers

Based upon the short timeframe outlined above, the reasonableness and the accuracy of the data to be used is questionable. For both federal fiscal 2005 and 2006, even with the implementation of the initial occupational mix survey at only 10%, to-date, the data remains unaudited. With the use of unaudited data, there is no assurance that the information currently being used is reasonable, accurate, or consistently reported by all providers. The rush to implement the new occupational mix survey based upon the timeframes established, only this time with the implementation of 100% of the occupational mix, would raise the same concerns.

Solution

For federal fiscal 2007, for those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000, hold those providers harmless, limiting the change to the federal fiscal 2007 wage index so that it cannot be less than the federal fiscal 2006 wage index. For federal fiscal 2008, 2009, and 2010, or until the current wage index system can be assessed, analyzed, and redesigned, those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000 will receive a blended wage index transitioning over a 3 year period, which starting with federal fiscal 2008, would be a blend of the federal fiscal 2006 wage index at 67% and the occupationally adjusted wage index of 33%. As a second alternative, opposed to holding harmless those providers with a wage index less than 1.0000 and an occupational mix factor of less than 1.0000, the hold harmless provision would be applied to those providers that can demonstrate that their wage index has decreased over 8% based upon their federal fiscal 2002 wage index, and can demonstrate that their wage index has decreased annually for at least 4 out of the 5 federal fiscal years. The occupationally adjusted wage index at 100% would still be implemented, but would not drastically impact those facilities that have been subjected to the downward spiral of their wage index as a result of their operating efficient and staffing choices. In the August 31, 1991 Federal Register, it was noted that in the September 4, 1990 final rule (55 FR 36041), "we implemented a 1-year phase-in of the updated wage index for FY 1991 to lessen the impact of the most significant changes in wage index value. We limited the percentage change in the wage index to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." In the August 31, 1991 Federal Register,

page 43197, it was noted that for discharges occurring on or after January 1, 1991, and before October 1, 1993, it was initially proposed that "the wage index would have a 1-year phase-in of the updated wage index that would have limited the percentage change in a wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value." Although the second proposal for discharges on or after January 1, 1991 was not implemented, these types of phase-in periods for items like the wage index have been considered in the past. Another example of a phase-in period was for federal fiscal 2005, when the change in going from the MSA to CBSA area was a blend of the two wage index values. In the August 11, 2004 Federal Register, page 49028, it was noted, "...given the scope and drastic implications of these new boundaries and to buffer the subsequent negative impact on numerous hospitals, we have decided to provide, during FY 2005, a blend of wage indexes to those hospitals that would experience a drop in their wage indexes because of the adoption of the new labor market areas. Any hospital experiencing a decrease in their wage index relative to its FY 2005 wage changes will receive 50 percent of the wage index using the new labor market definitions and 50 percent of the wage index that the provider would have received under the old MSA standards." These calculations would be performed within the confines of budget neutrality.

IV. CALCULATION OF THE PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

Issue – Non Responsive Providers

In the proposed rule outlining the calculation of the FY 2007 occupational mix adjustment, the issue of non-responsive providers was raised. Non-responsive providers to the initial request for an occupational mix survey were assigned an occupational mix of 1.0000 for both federal fiscal 2005 and 2006. In the FY 2007 proposed rule, 4 options are being considered. Those options include (1) assign the hospital an occupational mix adjustment factor of 1.0000; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix.

Solution

As a general rule, providers in a given CBSA area should not be placed in a position of disadvantage or advantage if a provider within their CBSA area is non-responsive in submitting data for use in the occupational mix adjustment that is required by statute. The non-responsive provider should be assigned the average occupational mix adjustment factor for its labor market area, so that providers within their CBSA area are nether advantaged or disadvantaged by the non-responsive provider's non-compliance with the statute. However, the wage index for the non-responsive provider should be reduced because of the non-compliance, after using the average

occupational mix adjustment factor for its labor market area to calculate the wage index value for those providers that did comply. The following two options could be utilized: 1) drop the non-responsive provider's wage index value to the next lowest wage index in the contiguous CBSAs that border their CBSA or the rural wage index if necessary; 2) the wage index value for the non-responsive provider could be reduced in the same manner as the Medicare DRG is adjusted for the quality initiative program by reducing their wage index value by some percentage (i.e. 1% to 2%).

Summary

The Medicare wage index is the starting basis for the Medicare Inpatient Prospective Payment System (IPPS). Since the Medicare wage index is budget neutral, alterations to the wage index calculations result in the shift of dollars among IPPS facilities nationwide. This shift not only impacts the base Medicare DRG, but also impacts the Medicare add-ons such as Indirect Medical Education (IME) and Disproportionate Share (DSH). As opposed to the wage index amendments such as the One-Time Wage Index Classification, Section 508 of the Medicare Improvement and Modernization Act (MIMA); the Wage Index Adjustment Reclassification Reform, Section 505 of MIMA; and the implementation of the occupational mix survey for federal fiscal years 2005 and 2006; CMS should consider major reforms to the Medicare wage index system since this system does not fairly distribute the available funds based upon the provider's cost, labor market, and geographic location. In addition to the above legislation, regulatory fixes to the wage index values have been implemented in an attempt to account fairly for the wage index value of an area such as the GAF out-migration factor, and differences in the proportion of the DRG prospective payment rate subject to adjustment for the area's wage level (proposed 62% and 69.7%). Currently, there is also legislative consideration being given to extend the section 508 reclassification to those limited facilities that were originally approved and funded. However, there is no consideration being given to those facilities that received approval under section 508 but to-date remains unfunded. These fixes do not address the inequities in the current wage index system. And those inequities extend to the basic data that is used to calculate the wage index values, in that the data is not based upon accurate and consistent data nationwide. This is evident with the implementation of the occupational mix survey at 10% for federal fiscal years 2005 and 2006, since this information was based upon submitted but unaudited data. Even with the new occupational mix survey and the proposed timelines, the implementation of the occupational mix at 100% for federal fiscal 2007 is likely to be based upon submitted but unaudited data, since given the limited time frames; the Intermediary's review would be reduced to basic variance analysis. An example of the inconsistency of data is the exclusion of contracted labor cost as it relates to such positions as housekeeping, dietary, administration, medical records, and maintenance, when those facilities that staff these low pay positions as employees have the cost included in the average hourly wage used for the calculation of the wage index. While we appreciate CMS' attempts to compensate providers fairly and adequately via legislative/regulatory fixes, long-term, we do not believe that can

be accomplished without re-evaluating and reforming the current wage index system or coming up with some alternative allocation process.

We appreciate the opportunity to submit these comments/suggestions on your proposed 2007 inpatient PPS implementation of the Fiscal Year 2007 Occupational Mix adjustment to the wage index. If you have any questions, please telephone either Chris Lewandowski, Director, Reimbursement at (412) 647-2306 or myself at (412) 647-8280.

Sincerely,

Edward T. Karlovich
CFO, Academic & Community Hospitals

Cc: Elizabeth Concordia
David M. Farner
George Huber
Robert Kennedy
Chris Lewandowski
System CFOs

Attachment A

UPMC
Impact Occupational Mix

Impact - Salary Calculation Estimation versus Actual
Attachment A

Purpose: To summarize the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Salary Calculation (AHW for Nursing Staff Lower than Hospital Average)

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$125,000	$125,000
Administrative Salaries	$100,000	$100,000	$100,000	$100,000
Total Salaries	$275,000	$275,000	$225,000	$225,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$275,000	$175,000	$225,000	$125,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$220,000	$175,000	$180,000	$125,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$217,835	$173,278	$268,655	$186,566
Total Salaries	$275,000	$100,000	$225,000	$100,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$55,000	$100,000	$45,000	$100,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$55,000	$100,000	$45,000	$100,000
Occupational Mix Salaries	$272,835	$273,278	$313,655	$286,566
Total Hours	10,400	10,400	10,400	10,400
Average Hourly Wage	$26.2341	$26.2767	$30.1592	$27.5544
National Average Hourly Wage	$28.1966	$26.9156	$28.1966	$26.9156
Wage Index	0.9304	0.9763	1.0696	1.0237

In the above example, nursing salaries are $175,000 for hospital "A" and $125,000 for hospital "B", not $220,000 and $125,000 respectively, and administrative fees are not $55,000 for hospital "A" and $45,000 for hospital "B", but $100,000 for both.

Observation: CMS' calculation assumes that the staff at each hospital, whether nursing or administrative, are paid at the hospital's average hourly wage for all staff from the cost report being utilized to develop salaries.

	Hospital "A"	Hospital "B"
Total Salaries	$275,000	$225,000
Total Hours	10,400	10,400
Hospital Average Hourly Wage	$26.44	$21.63
Nursing Hours	8,320	8,320
Assumed Nursing Salaries	$220,000	$180,000
Administrative Hours	2,080	2,080
Assumed Administrative Salaries	$55,000	$45,000

11

12

UPMC
Impact Occupational Mix

Impact - Salary Calculation Estimation versus Actual
Attachment A

Purpose: To summarize the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Salary Calculation (AHW for Nursing Staff Higher than Hospital Average)

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$125,000	$125,000
Administrative Salaries	$20,000	$20,000	$20,000	$20,000
Total Salaries	$195,000	$195,000	$145,000	$145,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$195,000	$175,000	$145,000	$125,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$156,000	$175,000	$116,000	$125,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$154,465	$173,278	$173,133	$186,566
Total Salaries	$195,000	$20,000	$145,000	$20,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$39,000	$20,000	$29,000	$20,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$39,000	$20,000	$29,000	$20,000
Occupational Mix Salaries	$193,465	$193,278	$202,133	$206,566
Total Hours	10,400	10,400	10,400	10,400
Average Hourly Wage	$18.6024	$18.5844	$19.4359	$19.8621
National Average Hourly Wage	$19.0191	$19.2233	$19.0191	$19.2233
Wage Index	0.9781	0.9668	1.0219	1.0332

In the above example, nursing salaries are $175,000 for hospital "A" and $125,000 for hospital "B", not $156,000 and $116,000 respectively, and administrative fees are not $39,000 for hospital "A" and $29,000 for hospital "B", but $20,000 for both.

Observation: CMS' calculation assumes that the staff at each hospital, whether nursing or administrative, are paid at the hospital's average hourly wage for all staff from the cost report being utilized to develop salaries.

	Hospital "A"	Hospital "B"
Total Salaries	$195,000	$145,000
Total Hours	10,400	10,400
Hospital Average Hourly Wage	$18.75	$13.94
Nursing Hours	8,320	8,320
Assumed Nursing Salaries	$156,000	$116,000
Administrative Hours	2,080	2,080
Assumed Administrative Salaries	$39,000	$29,000

Attachment B

14

UPMC
Impact Occupational Mix

Impact - 2nd Year with and without occupational mix change
Change in the 2nd year to a hospitals mix of staff
Attachment B

Purpose: To summarize the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Hospital	UNADJUSTED WAGES	UNADJUSTED AHW	UNADJUSTED WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Base Calculation (AHW for Nursing Staff Lower than Hospital Average)						
A	$275,000	$26.4423	1.1000	$272,835	$26.2341	0.9304
B	$225,000	$21.6346	0.9000	$313,655	$30.1592	1.0696
	$500,000	$24.0385	1.0000	$586,490	$28.1966	1.0000
Increase to salaries for hospital "B" with no occupational mix change (2nd year)						
A	$275,000	$26.4423	1.0476	$272,835	$26.2341	0.8782
B	$250,000	$24.0385	0.9524	$348,506	$33.5102	1.1218
	$525,000	$25.2404	1.0000	$621,341	$29.8722	1.0000
Increase to salaries for hospital "B" with occupational mix change (2nd year)						
A	$275,000	$26.4423	1.0476	$272,835	$26.2341	0.9728
B	$250,000	$24.0385	0.9524	$288,103	$27.7023	1.0272
	$525,000	$25.2404	1.0000	$560,938	$26.9682	1.0000
Base Calculation (AHW for Nursing Staff Higher than Hospital Average)						
A	$195,000	$18.7500	1.1471	$193,465	$18.6024	0.9781
B	$145,000	$13.9423	0.8529	$202,133	$19.4359	1.0219
	$340,000	$16.3462	1.0000	$395,598	$19.0191	1.0000
Increase to salaries for hospital "B" with no occupational mix change (2nd year)						
A	$195,000	$18.7500	1.0685	$193,465	$18.6024	0.8989
B	$170,000	$16.3462	0.9315	$236,984	$22.7869	1.1011
	$365,000	$17.5481	1.0000	$430,449	$20.6947	1.0000
Increase to salaries for hospital "B" with occupational mix change (2nd year)						
A	$195,000	$18.7500	1.0685	$193,465	$18.6024	0.9937
B	$170,000	$16.3462	0.9315	$195,910	$18.8375	1.0063
	$365,000	$17.5481	1.0000	$389,375	$18.7200	1.0000

Observation: If the occupational mix is not changed for each year there is a change to the actual occupational mix for providers, providers that increase the richness of their RN staffing, as an example, in subsequent years, with no change to the provider that had a richer mix of RNs during the occupational mix survey year, will result in an inappropriate increase to the wage index for those facilities that initially received an occupational mix of over 1.0000 due to the low staffing of RNs, with a corresponding decrease to the provider that remains unchanged in the second year.

Attachment C

UPMC
Impact Occupational Mix

Attachment C

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

	Hours					Staffing % Based Upon Hours	
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing	Admin
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	2,080	6,240	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

	Salaries							Hospital
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Average Hourly Rate
A	$150,000	$25,000	$175,000	$100,000	$275,000	$21.03	$48.08	$26.44
B	$50,000	$75,000	$125,000	$100,000	$225,000	$15.02	$48.08	$21.63

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$100,000	$48.08

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	2,080
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	6,240
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage	Provider "A" Rate	Provider "B" Rate
RN's	$23.62	75.00%	25.00%	$17.72	$5.91
LPN's	$14.65	0.00%	0.00%	$0.00	$0.00
Aides	$10.01	25.00%	75.00%	$2.50	$7.51
Med Asst	$11.79	0.00%	0.00%	$0.00	$0.00
		100.00%	100.00%	$20.22	$13.41
Nursing Adjustment Factor				0.9902	1.4925

16

17

UPMC
Impact Occupational Mix

Attachment C

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$275,000	10,400	0.9921	$26.4423	1.1000	$274,784	$26.4215	1.0804	$272,835	$26.2341	0.9304
B	2	$225,000	10,400	1.3940	$21.6346	0.9000	$233,866	$22.4871	0.9196	$313,655	$30.1592	1.0696
		$500,000	20,800		$24.0385	1.0000	$508,649	$24.4543	1.0000	$586,490	$28.1966	1.0000
Based Upon Actual Salaries												
A	1	$275,000	10,400	0.9937	$26.4423	1.1000	$274,828	$26.4257	1.0863	$273,278	$26.2767	0.9763
B	2	$225,000	10,400	1.2736	$21.6346	0.9000	$231,157	$22.2266	0.9137	$286,566	$27.5544	1.0237
		$500,000	20,800		$24.0385	1.0000	$505,984	$24.3262	1.0000	$559,844	$26.9156	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a lower than appropriate wage index.
2) Using nursing staff only and one administrative staff member in the above example, a lower mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$125,000	$125,000
Administrative Salaries	$100,000	$100,000	$100,000	$100,000
Total Salaries	$275,000	$275,000	$225,000	$225,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$275,000	$175,000	$225,000	$125,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$220,000	$175,000	$180,000	$125,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$217,835	$173,278	$268,655	$186,566
Total Salaries	$275,000	$100,000	$225,000	$100,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$55,000	$100,000	$45,000	$100,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$55,000	$100,000	$45,000	$100,000
Occupational Mix Salaries	$272,835	$273,278	$313,655	$286,566

18

UPMC
Impact Occupational Mix

Attachment C

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

	Hours					Staffing % Based Upon Hours	
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing	Admin
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	2,080	6,240	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

	Salaries							
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Hospital Average Hourly Rate
A	$150,000	$25,000	$175,000	$20,000	$195,000	$21.03	$9.62	$18.75
B	$50,000	$75,000	$125,000	$20,000	$145,000	$15.02	$9.62	$13.94

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$20,000	$9.62

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	2,080
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	6,240
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage	Provider "A" Rate	Provider "B" Rate
RN's	$23.62	75.00%	25.00%	$17.72	$5.91
LPN's	$14.65	0.00%	0.00%	$0.00	$0.00
Aides	$10.01	25.00%	75.00%	$2.50	$7.51
Med Asst	$11.79	0.00%	0.00%	$0.00	$0.00
		100.00%	100.00%	$20.22	$13.41
Nursing Adjustment Factor				0.9902	1.4925

19

UPMC Attachment C
Impact Occupational Mix

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$195,000	10,400	0.9921	$18.7500	1.1471	$194,846	$18.7352	1.1277	$193,465	$18.6024	0.9781
B	2	$145,000	10,400	1.3940	$13.9423	0.8529	$150,713	$14.4917	0.8723	$202,133	$19.4359	1.0219
		$340,000	20,800		$16.3462	1.0000	$345,560	$16.6135	1.0000	$395,598	$19.0191	1.0000
Based Upon Actual Salaries												
A	1	$195,000	10,400	0.9912	$18.7500	1.1471	$194,828	$18.7334	1.1262	$193,278	$18.5844	0.9668
B	2	$145,000	10,400	1.4246	$13.9423	0.8529	$151,157	$14.5343	0.8738	$206,566	$19.8621	1.0332
		$340,000	20,800		$16.3462	1.0000	$345,984	$16.6339	1.0000	$399,844	$19.2233	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a higher average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.
2) Using nursing staff only and one administrative staff member in the above example, a lower mix of RN's versus Aides with the nursing staff having an higher average hourly rate than the hospital average hourly rate will result in a lower than appropriate wage index.

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$125,000	$125,000
Administrative Salaries	$20,000	$20,000	$20,000	$20,000
Total Salaries	$195,000	$195,000	$145,000	$145,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$195,000	$175,000	$145,000	$125,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$156,000	$175,000	$116,000	$125,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$154,465	$173,278	$173,133	$186,566
Total Salaries	$195,000	$20,000	$145,000	$20,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$39,000	$20,000	$29,000	$20,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$39,000	$20,000	$29,000	$20,000
Occupational Mix Salaries	$193,465	$193,278	$202,133	$206,566

Attachment D

UPMC
Impact Occupational Mix

2nd year — increase to salaries for hospital "B" with no occupational mix change
(replaced an aide with an RN)
Attachment D

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

	Hours					Staffing % Based Upon Hours	
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing	Admin
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	4,160	4,160	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

	Salaries							
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Hospital Average Hourly Rate
A	$150,000	$25,000	$175,000	$100,000	$275,000	$21.03	$48.08	$26.44
B	$100,000	$50,000	$150,000	$100,000	$250,000	$18.03	$48.08	$24.04

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$100,000	$48.08

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	2,080
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	6,240
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage
RN's	$23.62	75.00%	25.00%
LPN's	$14.65	0.00%	0.00%
Aides	$10.01	25.00%	75.00%
Med Asst	$11.79	0.00%	0.00%
		100.00%	100.00%

	Provider "A" Rate	Provider "B" Rate
	$17.72	$5.91
	$0.00	$0.00
	$2.50	$7.51
	$0.00	$0.00
	$20.22	$13.41
Nursing Adjustment Factor	0.9902	1.4925

21

UPMC
Impact Occupational Mix

2nd year

increase to salaries for hospital "B" with no occupational mix change
(replaced an aide with an RN)
Attachment D

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$275,000	10,400	0.9921	$26.4423	1.0476	$274,784	$26.4215	1.0279	$272,835	$26.2341	0.8782
B	2	$250,000	10,400	1.3940	$24.0385	0.9524	$259,851	$24.9856	0.9721	$348,506	$33.5102	1.1218
		$525,000	20,800		$25.2404	1.0000	$534,634	$25.7036	1.0000	$621,341	$29.8722	1.0000
Based Upon Actual Salaries												
A	1	$275,000	10,400	0.9937	$26.4423	1.0476	$274,828	$26.4257	1.0328	$273,278	$26.2767	0.9153
B	2	$250,000	10,400	1.2955	$24.0385	0.9524	$257,388	$24.7488	0.9672	$323,879	$31.1422	1.0847
		$525,000	20,800		$25.2404	1.0000	$532,216	$25.5873	1.0000	$597,157	$28.7095	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a lower than appropriate wage index.
2) Using nursing staff only and one administrative staff member in the above example, a lower mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.
3) By increasing the salaries for provider "B", by replacing an aide with an RN, with no change to the occupational mix, the wage index for provider "B" will increase with a decrease for all others (result of a salary increase and occupational mix impact), with the occupational mix compounding the impact.

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$150,000	$150,000
Administrative Salaries	$100,000	$100,000	$100,000	$100,000
Total Salaries	$275,000	$275,000	$250,000	$250,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$275,000	$175,000	$250,000	$150,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$220,000	$175,000	$200,000	$150,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$217,835	$173,278	$298,506	$223,879
Total Salaries	$275,000	$100,000	$250,000	$100,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$55,000	$100,000	$50,000	$100,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$55,000	$100,000	$50,000	$100,000
Occupational Mix Salaries	$272,835	$273,278	$348,506	$323,879

22

UPMC
Impact Occupational Mix

2nd year — increase to salaries for hospital "B" with no occupational mix change
(replaced an aide with an RN)
Attachment D

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Staffing % Based Upon Hours: Nursing	Admin
	Hours						
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	4,160	4,160	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Hospital Average Hourly Rate
	Salaries							
A	$150,000	$25,000	$175,000	$20,000	$195,000	$21.03	$9.62	$18.75
B	$100,000	$50,000	$150,000	$20,000	$170,000	$18.03	$9.62	$16.35

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$20,000	$9.62

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	2,080
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	6,240
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage	Provider "A" Rate	Provider "B" Rate
RN's	$23.62	75.00%	25.00%	$17.72	$5.91
LPN's	$14.65	0.00%	0.00%	$0.00	$0.00
Aides	$10.01	25.00%	75.00%	$2.50	$7.51
Med Asst	$11.79	0.00%	0.00%	$0.00	$0.00
		100.00%	100.00%	$20.22	$13.41
Nursing Adjustment Factor				0.9902	1.4925

23

24

UPMC
Impact Occupational Mix

2nd year

increase to salaries for hospital "B" with no occupational mix change
(replaced an aide with an RN)
Attachment D

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$195,000	10,400	0.9921	$18.7500	1.0685	$194,846	$18.7352	1.0488	$193,465	$18.6024	0.8989
B	2	$170,000	10,400	1.3940	$16.3462	0.9315	$176,698	$16.9902	0.9512	$236,984	$22.7869	1.1011
		$365,000	20,800		$17.5481	1.0000	$371,545	$17.8627	1.0000	$430,449	$20.6947	1.0000
Based Upon Actual Salaries												
A	1	$195,000	10,400	0.9912	$18.7500	1.0685	$194,828	$18.7334	1.0469	$193,278	$18.5844	0.8842
B	2	$170,000	10,400	1.4346	$16.3462	0.9315	$177,388	$17.0565	0.9531	$243,879	$23.4499	1.1158
		$365,000	20,800		$17.5481	1.0000	$372,216	$17.8950	1.0000	$437,157	$21.0172	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a higher average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.
2) Using nursing staff only and one administrative staff member in the above example, a lower mix of RN's versus Aides with the nursing staff having an higher average hourly rate than the hospital average hourly rate will result in a lower than appropriate wage index.
3) By increasing the salaries for provider "B", by replacing an aide with an RN, with no change to the occupational mix, the wage index for provider "B" will increase with a decrease for all others (result of a salary increase and occupational mix impact), with the occupational mix compounding the impact.

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$150,000	$150,000
Administrative Salaries	$20,000	$20,000	$20,000	$20,000
Total Salaries	$195,000	$195,000	$170,000	$170,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$195,000	$175,000	$170,000	$150,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$156,000	$175,000	$136,000	$150,000
Adjustment Factor	0.9902	0.9902	1.4925	1.4925
	$154,465	$173,278	$202,984	$223,879
Total Salaries	$195,000	$20,000	$170,000	$20,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$39,000	$20,000	$34,000	$20,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$39,000	$20,000	$34,000	$20,000
Occupational Mix Salaries	$193,465	$193,278	$236,984	$243,879

Attachment E

26

UPMC
Impact Occupational Mix

2nd year — increase to salaries for hospital "B" with occupational mix change (replaced an aide with an RN)
Attachment E

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

	Hours					Staffing % Based Upon Hours	
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing	Admin
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	4,160	4,160	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

	Salaries							
Hospital	RN's	Aides	Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Hospital Average Hourly Rate
A	$150,000	$25,000	$175,000	$100,000	$275,000	$21.03	$48.08	$26.44
B	$100,000	$50,000	$150,000	$100,000	$250,000	$18.03	$48.08	$24.04

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$100,000	$48.08

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	4,160
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	4,160
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage	Provider "A" Rate	Provider "B" Rate
RN's	$23.62	75.00%	50.00%	$17.72	$11.81
LPN's	$14.65	0.00%	0.00%	$0.00	$0.00
Aides	$10.01	25.00%	50.00%	$2.50	$5.01
Med Asst	$11.79	0.00%	0.00%	$0.00	$0.00
		100.00%	100.00%	$20.22	$16.82
Nursing Adjustment Factor				0.9902	1.1905

UPMC
Impact Occupational Mix

2nd year

increase to salaries for hospital "B" with occupational mix change
(replaced an aide with an RN)
Attachment E

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$275,000	10,400	0.9921	$26.4423	1.0476	$274,784	$26.4215	1.0397	$272,835	$26.2341	0.9728
B	2	$250,000	10,400	1.1524	$24.0385	0.9524	$253,810	$24.4048	0.9603	$288,103	$27.7023	1.0272
		$525,000	20,800		$25.2404	1.0000	$528,594	$25.4132	1.0000	$560,938	$26.9682	1.0000
Based Upon Actual Salaries												
A	1	$275,000	10,400	0.9937	$26.4423	1.0476	$274,828	$26.4257	1.0416	$273,278	$26.2767	0.9904
B	2	$250,000	10,400	1.1143	$24.0385	0.9524	$252,858	$24.3132	0.9584	$278,578	$26.7863	1.0096
		$525,000	20,800		$25.2404	1.0000	$527,686	$25.3695	1.0000	$551,855	$26.5315	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a lower than appropriate wage index.
2) Using nursing staff only and one administrative staff member in the above example, a lower mix of RN's versus Aides with the nursing staff having a lower average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.
3) By increasing the salaries for provider "B", by replacing an aide with an RN, with a change to the occupational mix, the wage index for provider "B" will increase as a result of the salary increase but will decrease with the impact of the occupational mix, with the other provider's wage indice changing in portion to their occupational mix and salary levels.

Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$150,000	$150,000
Administrative Salaries	$100,000	$100,000	$100,000	$100,000
Total Salaries	$275,000	$275,000	$250,000	$250,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$275,000	$175,000	$250,000	$150,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$220,000	$175,000	$200,000	$150,000
Adjustment Factor	0.9902	0.9902	1.1905	1.1905
	$217,835	$173,278	$238,103	$178,578
Total Salaries	$275,000	$100,000	$250,000	$100,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$55,000	$100,000	$50,000	$100,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$55,000	$100,000	$50,000	$100,000
Occupational Mix Salaries	$272,835	$273,278	$288,103	$278,578

27

UPMC
Impact Occupational Mix

2nd year

increase to salaries for hospital "B" with occupational mix change
(replaced an aide with an RN)
Attachment E

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

Nursing Mix and Staffing Hours

Hospital	RN's	Aides	Hours: Total Nursing	Admin	Total Staff	Staffing % Based Upon Hours: Nursing	Staffing % Based Upon Hours: Admin
A	6,240	2,080	8,320	2,080	10,400	80%	20%
B	4,160	4,160	8,320	2,080	10,400	80%	20%

Nursing & Administrative Salaries and Hourly Rates

Hospital	RN's	Aides	Salaries: Total Nursing	Admin	Total Staff	Nursing Hourly Rate	Admin Hourly Rate	Hospital Average Hourly Rate
A	$150,000	$25,000	$175,000	$20,000	$195,000	$21.03	$9.62	$18.75
B	$100,000	$50,000	$150,000	$20,000	$170,000	$18.03	$9.62	$16.35

Rates:	Annual Salary	Hourly Rate
RN's	$50,000	$24.04
Aides	$25,000	$12.02
Admin	$20,000	$9.62

Occupational Mix Adjustment Factor

	BLS AHW	National Hours	National Percentage	National Rate	Provider "A" Hours	Provider "B" Hours
RN's	$23.62	1,429,939,709	70.51%	$16.65	6,240	4,160
LPN's	$14.65	152,076,000	7.50%	$1.10	0	0
Aides	$10.01	373,013,762	18.39%	$1.84	2,080	4,160
Med Asst	$11.79	72,930,629	3.60%	$0.42	0	0
		2,027,960,100	100.00%	$20.02	8,320	8,320

	BLS AHW	Provider "A" Percentage	Provider "B" Percentage
RN's	$23.62	75.00%	50.00%
LPN's	$14.65	0.00%	0.00%
Aides	$10.01	25.00%	50.00%
Med Asst	$11.79	0.00%	0.00%
		100.00%	100.00%

	Provider "A" Rate	Provider "B" Rate
	$17.72	$11.81
	$0.00	$0.00
	$2.50	$5.01
	$0.00	$0.00
	$20.22	$16.82
Nursing Adjustment Factor	0.9902	1.1905

28

29

UPMC
Impact Occupational Mix — 2nd year — increase to salaries for hospital "B" with occupational mix change (replaced an aide with an RN)
Attachment E

Purpose: To illustrate the impact of the occupational mix using the staffing mix and the salary levels (hourly rate) as variables, comparing estimated occupational staffing salaries per the CMS calculation & actual occupational staffing salaries.
Source: CMS Occupational Mix Calculation

PROVIDER #	CBSA	UNADJUSTED WAGES	PROVIDER HOURS	Occ Mix Factor	UNADJUSTED AVERAGE HOURLY WAGE	UNADJUSTED WAGE INDEX	BLENDED WAGES At 10%	BLENDED AVERAGE HOURLY WAGE	Blended WAGE INDEX	TOTAL OCCUPATIONAL MIX WAGES AT 100%	OCCUPATIONAL MIX AVERAGE HOURLY WAGE	100% WAGE INDEX
Based Upon CMS Estimation of Salaries (percentage of hours to total hours)												
A	1	$195,000	10,400	0.9921	$18.7500	1.0685	$194,846	$18.7352	1.0606	$193,465	$18.6024	0.9937
B	2	$170,000	10,400	1.1524	$16.3462	0.9315	$172,591	$16.5953	0.9394	$195,910	$18.8375	1.0063
		$365,000	20,800		$17.5481	1.0000	$367,438	$17.6653	1.0000	$389,375	$18.7200	1.0000
Based Upon Actual Salaries												
A	1	$195,000	10,400	0.9912	$18.7500	1.0685	$194,828	$18.7334	1.0598	$193,278	$18.5844	0.9865
B	2	$170,000	10,400	1.1681	$16.3462	0.9315	$172,858	$16.6209	0.9402	$198,578	$19.0940	1.0135
		$365,000	20,800		$17.5481	1.0000	$367,686	$17.6772	1.0000	$391,855	$18.8392	1.0000

Conclusion:
Using the CMS methodology of calculating salaries will not result in an accurate split of salaries. The methodology of dividing staffing hours by total hours will make the assumption that all staff are paid the same hourly rate (the hospital average hourly rate). That inaccuracy will result in the following:
1) Using nursing staff only and one administrative staff member in the above example, a higher mix of RN's versus Aides with the nursing staff having a higher average hourly rate than the hospital average hourly rate will result in a higher than appropriate wage index.
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Illustration of Salary Calculation:	CMS Hospital "A"	Actual Hospital "A"	CMS Hospital "B"	Actual Hospital "B"
Nursing Salaries	$175,000	$175,000	$150,000	$150,000
Administrative Salaries	$20,000	$20,000	$20,000	$20,000
Total Salaries	$195,000	$195,000	$170,000	$170,000
Calculation Nursing & Admin Salaries for Occupational Mix				
Total Salaries	$195,000	$175,000	$170,000	$150,000
Nursing Staff Percentage	80%	100%	80%	100%
Nursing Salaries	$156,000	$175,000	$136,000	$150,000
Adjustment Factor	0.9902	0.9902	1.1905	1.1905
	$154,465	$173,278	$161,910	$178,578
Total Salaries	$195,000	$20,000	$170,000	$20,000
Admin Staff Percentage	20%	100%	20%	100%
Admin Salaries	$39,000	$20,000	$34,000	$20,000
Adjustment Factor	1.0000	1.0000	1.0000	1.0000
	$39,000	$20,000	$34,000	$20,000
Occupational Mix Salaries	$193,465	$193,278	$195,910	$198,578

6

Charles N. Kahn III
President

June 12, 2006

Dr. Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS Proposed Rule with Comment Period

Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

File Code **CMS-1488-P2**

Dear Dr. McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in rural and urban America, and they provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services ("CMS") proposed rule ("NPRM") regarding the implementation of the Fiscal Year ("FY") 2007 occupational mix adjustment to the wage index for the hospital inpatient prospective payment system ("IPPS").

Before commenting on the specific provisions of the NPRM, the FAH wishes to note the extremely difficult and unprecedented situation imposed on CMS by the court order in *Bellevue Hosp. Ctr. v. Leavitt*, 443 F. 3d 163 (2d Cir. 2006) ("*Bellevue*"). Considering the short time frame necessitated by the court order and by CMS's decision to follow that order nationwide, CMS has done an admirable job of quickly drafting a proposed rule and establishing a reasonable process to collect, process and apply the occupational mix data to create newly-calculated adjustments for FY 2007. The FAH appreciates CMS's effort to maximize the time that hospitals

801 Pennsylvania Ave., NW, Suite 245 • Washington, DC 20004-2604 • 202-624-1500 • Fax: 202-737-6832

had to complete the survey and to remove time pressures that hospitals are under, such as the 30-day extension for filing 12/31/2005 cost reports.

Unfortunately, despite CMS's effort to devise a workable process within such a short time frame, the FAH does not believe that there is sufficient time to obtain accurate and complete results. The FAH has already noted in previous comments its concerns about the fairness and utility of the occupational mix adjustment in general and the difficulties in collecting accurate data. Considering the problems with the initial occupational mix data survey, acknowledged by CMS, the FAH was in full agreement with CMS's original proposal, as stated in the IPPS Proposed Rule, to again apply the occupational mix adjustment factor to only 10 percent of the wage index. Despite its underlying concerns about the occupational mix adjustment, the FAH was pleased with the significant improvements that CMS had made in the survey tool as compared to the one that was used to collect data in 2003 and was hopeful that this new survey would produce better results.

Now, considering the extremely rushed process that has been proposed, the FAH expects that a higher percentage of hospitals will fail to submit data and that the data submitted will be considerably less accurate than if hospitals had sufficient time to respond. Further, the limitation of data to only one quarter will more likely cause a distortion in the data. (The FAH already had concerns, which it expressed in its comments on the proposed revisions to the occupational mix survey, that the collection of six months of data, rather than a full year, would lead to distorted results.) Therefore, we have serious concerns about the likely inconsistent and unfair impact that the adjustments resulting from this rushed process will have on hospitals around the country.

The FAH does think that CMS has been thoughtful in identifying many of the problematical issues that will result from the proposed process and proposing solutions for these issues. Nonetheless, undesirable effects are unavoidable, including the following:

- The unavailability of nearly all rate and payment information when the Final Rule is published, violating the statutory mandate that it be published by August 1 and causing great uncertainty for the industry.
- The excessive and unnecessary number of geographic reclassifications that will be requested, since, without published wage indexes, hospitals will not know which, if any, reclassifications would be in their best interest.
- The abrupt redistribution of payments to hospitals, without any transition period as is usually applied in such situations, likely causing significant financial hardship for some hospitals.

Because these significant negative impacts are unavoidable under the strict time frame imposed by the *Bellevue* decision, the FAH urges CMS to reconsider its decision to use this newly-collected data to devise an occupational mix adjustment applicable to 100 percent of the wage index for the entire nation. The decision of the Second Circuit need only be applied in the three states therein (New York, Connecticut and Vermont). Therefore, to avoid the more widespread negative consequences that will result from the 100% application of the occupational mix adjustment as proposed nationwide, the FAH recommends that CMS limit the full 100%

application to those three states, even if it is necessary to balance that with a budget neutrality adjustment nationwide. CMS should return to its original proposal to utilize the existing adjustment and continue to apply that at the 10% level in all other states. Then, CMS would have a full six months data, with sufficient time to thoroughly review and correct that data, which could be applied nationwide for FY 2008.

The FAH also believes that a payment change of this magnitude should be transitioned over two or more years. We believe that CMS made a good policy decision initially and encourage the Agency to transition the adjustment based on the full six month's data beginning in FFY 2008. We would also encourage CMS to approach Congress for authority to transition occupational mix and to set the adjustment at a level it deems appropriate.

Further, the FAH notes that its members, as they have developed data for the survey that was due on June 1, have become more convinced than ever before that capturing meaningful data for an occupational mix adjustment is far more difficult than Congress could have anticipated when it enacted this requirement. Moreover, as CMS itself has noted, its initial application has not had the intended results, benefiting fewer rural hospitals and more large urban hospitals than anticipated. Accordingly, and particularly in light of the pressure that has been placed on CMS by the decision in *Bellevue*, the FAH would like CMS to consider approaching Congress about repealing the mandate for the occupational mix adjustment.

I. BACKGROUND

A. General Background

In this section, CMS references the *Bellevue* decision and states that the Court of Appeals for the Second Circuit ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. Further, CMS noted that the Court ordered CMS to "immediately...collect data that are sufficiently robust to permit full application of the occupational mix adjustment" and to complete this process by September 30, 2006 "at which time the agency is to immediately apply the adjustment in full."

CMS fails to acknowledge that the decision of the Second Circuit, unlike the decisions of the United States Supreme Court, is only binding on CMS in the three states within the Second Circuit. *See, e.g., Ruppert v. Bowen,* 871 F.2d 1172 (2d Cir. 1989) (in a case involving the Social Security Administration, court held that a federal agency is only required to acquiesce to circuit court decision within that circuit). *See also, Frock v. U.S.R.R. Retirement Bd.,* 685 F. 2d 1041, 1046 (7th Cir. 1982) ("An unappealed circuit court decision concerning agency action, however, does not have the effect of setting a nationwide agency standard.") CMS is well aware of the fact that it is not bound to follow the Second Circuit throughout the country. For example, in its notable ruling, HCFAR 97-2, pertaining to the inclusion of "eligible but unpaid" Medicaid days in the disproportionate share ("DSH") calculation, CMS agreed to change its policy nationwide, after first only applying the rulings of certain Circuit Courts to hospitals in the circuits in which they are located. Thus, though Medicare is a federal program, CMS has a history of applying different rules to hospitals in different states, if it has been ordered to do so

by a court. Accordingly, as stated above, the FAH believes that CMS should only follow *Bellevue* in the Second Circuit states and should return to its original intention in the remaining states, applying the occupational mix adjustment at 10% as it did in FYs 2005 and 2006.

The only arguable difference in the application of the occupational mix adjustment as compared to the application of other policies that CMS has chosen to apply differently in different states, such as policies relating to DSH, is that the occupational mix adjustment is supposed to be budget neutral. The FAH believes that the budget neutrality requirement can be addressed by an adjustment applicable to all hospitals outside the Second Circuit. Because the occupational mix adjustment would be applied at 100 percent to a minority of hospitals, the adjustment necessary to make it budget neutral, spread over all the rest of the hospitals in the country, would not have too great an impact on any one hospital. The impact would be far less than that which would likely result from the full application of the occupational mix adjustment. This solution would lessen the impact on hospitals around the country which is resulting just from the court action brought solely by New York City hospitals, and it would be consistent with CMS's views, as originally expressed in the IPPS Proposed Rule.

B. Legislative History

The FAH has no comments on this section.

C. Revised Proposed Changes to the Occupational Mix Adjustment for the Proposed FY 2007 Wage Index

1. DEVELOPMENT OF DATA FOR THE PROPOSED OCCUPATIONAL MIX ADJUSTMENT

The FAH agrees with CMS that the six month survey process, which it had originally planned for use in FY 2008, would have been an improvement over the previous process.[1] In light of CMS's decision to follow *Bellevue* nationwide, we agree that it would be impossible to do a six-month survey in time for use at the beginning of FY 2007. However, the FAH believes that CMS's decision to shorten its originally intended survey period to 3 months and collect this data by June 1 will lead to inaccurate results for numerous reasons, such as:

- Many hospitals were just beginning or had not yet begun the planning to collect the occupational mix data for the scheduled 6 month collection.
- Resources needed to complete the survey were unavailable in many cases for part or all of this time period, because of the lack of advance notice.

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[1] As noted above, the FAH had stated in previous comments that it believes a one-year survey period is optimal for collecting data that will not show an seasonal bias. Although the FAH realizes that CMS has rejected this option for FY 2008, when it first intended to apply new survey data, the FAH urges CMS to exercise its discretion and initiate a survey with a full year of data to be used in FY 2009.

- The new survey, though improved over the previous survey, is more complicated, and thus it entails more effort to complete. An example of this is the required allocation of overhead information to excluded areas, which necessitated information to be collected for total overhead separately and then allocated to the proper percentage of excluded activities.

- Even though CMS notified the hospitals of its change of plans quickly via the April 21st Joint Signature Memorandum and gave the hospitals as much time as the order would allow to complete the survey by June 1, much of the hospitals' time was spent developing the process and tools to complete the survey. FAH members were significantly challenged to meet this deadline, and some normal review processes were eliminated to meet this timeframe.

2. TIMELINE

The FAH believes that the timeline for collection, review and correction of the data is inadequate and will result in many unfortunate consequences. The time allowed from data collection to implementation of the information is only 4 months. By its previous statements, it is clear that CMS itself must recognize that such a collection and review period is far too short to produce an accurate result. On page 5 of the "Comments to the Proposed 2006 Wage Index Mix Survey," CMS reported its decision to use a six month collection period that was due 14 months prior to implementation versus a full year data that could have been submitted 8 months prior to implementation. Since CMS had concerns that even an 8 month review period would not be adequate for accurate survey results, there can be no question that a 4 month period is inadequate.

CMS recognized that the occupational mix data from the first survey, currently in use, was not completely reliable, which led to its decision to apply the resulting adjustments to only 10 percent of the wage index. The FAH expects the occupational data from the new survey to have even more potential data issues, in part because this is a new survey and only the second time the process has been completed. The short notice for collecting the data will only exacerbate the problem. Many hospitals will not exert the effort they do for normal cost reporting since this is an infrequent and unfamiliar process, and they may underestimate its importance. It is our understanding that normally more than 30% of hospitals submit changes during the normal wage index development process, which has become familiar and is conducted on a yearly basis. The occupational data collected in this survey will likely be far less accurate, but there will not be time to allow for the types of corrections that can be made during the annual wage index survey process.

The streamlined process also does not allow for hospital groups to review individual hospitals in their area. This can often raise questions that many times lead to more accurate data. Since the occupational mix adjustments will affect all hospitals within an area, it is only fair to allow for sufficient time for affected hospitals to at least have a chance to recognize errors that might significantly affect their finances. The abridged process will not allow for that.

C. CALCULATION OF THE PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

In this section, CMS has proposed 4 options for treating the occupational mix data for non-responsive hospitals: (1) Assign the hospital an occupational mix adjustment factor of 1.0000 as was done for FYs 2005 and 2006; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix. CMS has specifically requested comments on these or other alternatives for equitably addressing the situation of hospitals that are not responsive to the occupational mix survey.

- The FAH does not believe that a hospital should be penalized for failing to complete and submit the occupational mix information for the first quarter of 2006. Due to the unexpected timing of the notification and very short notice given, many hospitals may not have had the resources or time to complete the survey for this period. We think CMS should recognize the unique problems that may have arisen this year and should assign these hospitals an adjustment factor of 1.0000.[2]

- For future years, we reiterate out previous recommendations that the impact should be facility-specific and should not impact the wage index amounts for other hospitals in the area. Other hospitals should not suffer negative financial consequences because another facility failed to comply with its obligations. One way to accomplish this would be to reduce the non-responsive hospital's wage index by a set percentage (e.g., 1%) lower than the rest of the hospitals in the area or a set percentage of the standardized rate, whichever is more administratively feasible.

D. IMPLEMENTATION OF PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

CMS here acknowledges that much of the data that is normally published in the IPPS Final Rule will not be available for publication by August 1, 2006 due to the rushed effort to develop occupational mix adjustment factors based on new survey data. This means that the wage index tables, and likely the standardized rates and outlier threshold, will not be available when the Final Rule is published. In addition, if the DRG weights are developed under the current charge-based methodology or a blend that includes it, we would not expect CMS to be able to provide weights given that wage index amounts are utilized to normalize the charges. In addition, since all of this information would not be available, we would not expect to see the type of impact information to be provided as normally is done in the Final Rule. Further, under

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[2] We note that hospitals that have failed to submit first quarter data by the June 1 deadline should be given the opportunity to submit this data when the second quarter data is due. Similarly, hospitals that submitted data, but realize that it is not fully accurate because of the rushed conditions under which it was gathered, should be given the opportunity to correct this data when the six months of data for January through June 2006 is due.

CMS's proposal, it is possible that this data will not be published until just prior to the beginning of FY 2007, as CMS has only stated that it will publish it "after the final rule, but in advance of October 1, 2006."

CMS recognizes its statutory obligation to publish a final rule with certain information included by August 1, but states "We believe these procedures would comply with section 1886(d)(6) of the Act because, by August 1, we would describe our data and methods for calculating the wage index and IPPS rates in the FY 2007 IPPS final rule, but the actual rates and wage tables would not be issued until a later date." While recognizing that CMS has been placed in a difficult position by the court order in *Bellevue*, the FAH believes that there is no basis in the law for CMS's position that it may legally delay publication of final IPPS data. Since the beginning of the IPPS, CMS (or its predecessor, HCFA) has been required by 42 U.S.C. 1395ww(d)(6) to publish "a description of the methodology and data" to be used in the IPPS in advance of the following federal fiscal year. CMS was originally required to publish this by September 1 each year, but, as part of the Balanced Budget Act of 1997, Public Law 105-33, Congress moved the deadline earlier, to August 1.

CMS contends that, to comply with this requirement, it would be sufficient for it to describe the data and methods, but it could publish the "actual rates and wage tables" at a later date. However, the FAH believes that it was Congress's intention that the actual rates, wage indexes, outlier thresholds and other pertinent data be published in advance. It has certainly always been CMS's practice to do so, never before taking the position that it could leave some of these details until later than the prescribed deadline. A general description of the methodology and the sources of the data only, without specifically setting forth what the data is, would not assist hospitals to plan ahead for what they can expect financially from the Medicare program in the coming year. Without this actual data, there is really no use for the hospitals to have information in advance. If the final data was not to be published, there would have been no reason for Congress to move the deadline back from September 1 to August 1, as, without the actual data, the earlier publication date is of no practical use to hospitals.

Accordingly, the FAH believes that CMS will be in violation of this Social Security Act requirement if it publishes a Final Rule in incomplete form, which it will by necessity have to do if it intends to apply this newly-collected occupational data in FY 2007. While CMS cites the *Bellevue* decision as its basis for speeding up the process, it is equally subject to the publication requirement of section 1886(d)(6), which it will perforce violate if it moves ahead as proposed. The FAH believes that CMS can resolve these two competing requirements by following its suggestion to not acquiesce to the *Bellevue* decision and only follow it as it applies to hospitals located within the Second Circuit.

E. Impact of the Proposed FY 2007 Occupational Mix Adjusted Wage Index on the Out-migration Adjustment and Hospital Reclassifications

1. OUT-MIGRATION

The FAH commends CMS for recognizing that hospital eligibility for the out-migration adjustment will be impacted by its decision to apply the new occupational mix adjustments to 100 percent of the wage index in FY 2007, necessitating a revaluation of the qualifying counties

that were published in the Proposed Rule. Because of the delay in determining the occupational mix adjustments, this will be another set of data that cannot be determined in time for publication in the Final Rule. This will create further complications, because of the fact that hospitals must decide whether to accept geographic reclassification or an available out-migration adjustment, but the time to make such decisions will now be significantly delayed, creating confusion and the inability to properly plan.

2. WITHDRAWING RECLASSIFICATIONS

CMS here recognizes that, because the information published in the Proposed Rule, normally the basis for hospital decisions whether or not to withdraw reclassification requests, is obsolete, the normal timetable of 45 days after the publication of the Proposed Rule for hospitals to withdraw their requests cannot apply. CMS has proposed to make this determination for hospitals, based on what it believes would be most advantageous for each hospital, with the hospitals then having the opportunity to reverse CMS's decision by the earlier of 30 days after the date when the final data is released or October 1, 2006.

The FAH commends CMS for recognizing this problem and devising this solution, which is as fair as possible under the circumstances. The FAH supports this proposal. Further, even if CMS agrees to reverse course and follow the FAH's principal proposal herein to only apply the new wage survey data to the hospitals within the Second Circuit, we suggest that the proposed procedure for withdrawal of reclassifications be followed. It will be too late to apply the originally proposed deadline of 45 days after the publication of the Proposed Rule, as many hospitals, due to this alternate proposal, will not have reviewed the data and made a decision as to whether or not to request withdrawal.

The FAH requests CMS to clarify, in the Final Rule, that it will follow this procedure (i.e., review applicable data and make the most advantageous decision for each hospital, and then allow hospitals time to request reversal of that decision) in all possible situations, whether pursuant to 42 C.F.R. § 412.273 or otherwise, where a hospital would normally be required to make a decision about a geographic reclassification within 45 days of the annual IPPS Proposed Rule.

3. RECLASSIFICATION FOR FY 2008

CMS here recognizes another statutory requirement that will be impacted by its decision to apply the *Bellevue* decision nationwide: the requirement that hospitals submit their applications for geographic reclassification for FY 2008 by September 1, 2007. These requests for reclassification must be based on the wage data used to develop the FY 2007 wage index, but now the 3-year average hourly wage of hospitals will not be available for the FY 2007 Final Rule. Because CMS has no authority to waive the September 1 deadline, it has proposed that hospitals must still file their requests for reclassification by that deadline, but then will be able "to supplement the reclassification application with official data used to develop the FY 2007 wage index after filing their initial application." The same procedure would apply to those hospitals wishing to withdraw their previously-granted requests for reclassification based on the new data.

The FAH commends CMS for devising this solution to a difficult problem. The FAH also notes that these circumstances will likely result in an enormous number of additional requests for reclassification being submitted, since hospitals will not be able to determine in advance what their best course might be. Hospitals may file applications to all areas to which they may might meet the criteria, since they will not know which option may turn out to be most advantageous for them. This will create a lot of unnecessary paperwork, confusion for hospitals and extra work for CMS. This problem could be avoided if CMS chose not to apply the new occupational adjustments as proposed.

V. WAIVER OF 60-DAY COMMENT PERIOD

The FAH fully understands the practical reasons that resulted in CMS's decision to shorten the 60-day comment period for this Proposed Rule. However, we are concerned that the shortened period will reduce the thoughtfulness and quality of the comments submitted. We note that, during this entire comment period, many of our members' staffs were deeply involved in the preparation of the occupational mix data that was due on June 1 and subsequent responses to Fiscal Intermediary requests. In many cases, these are the same persons that are reviewing this proposal, so the time available to devote to careful review and drafting of comments has been severely limited.

Because of the limited time that was available for this comment period, the FAH requests that CMS publish the occupational mix regulations and data as an interim final rule with comment period, with a full 60-day comment period, so that providers will have an opportunity to comment further. Considering the newness of the occupational mix survey and the difficulties that have occurred in implementing it, we believe that a further comment period would be beneficial for both CMS and the industry. The FAH also encourages CMS to create an opportunity for hospitals to submit comments to CMS on the data and survey, prior to beginning any revisions to the survey after the 2nd quarter 2006 collection is complete.

SURVEY

The FAH appreciates CMS's efforts to improve the occupational mix survey and process and feels that progress has been made in this area. However, during the preparation and review of the first quarter 2006 information, areas for possible improvement have been identified. The items could include adding additional cost centers to the listing of nursing cost centers, adding additional nursing categories and revising positions that are included or excluded from the survey. The FAH has not had adequate time to review these items and offer specific recommendations by the comment deadline. We request CMS provide us an opportunity to provide suggestions prior to changing the current survey and instructions, either during a comment period or sooner if requested by CMS. We strongly suggest that CMS follow these principles should CMS determine that the survey needs to be changed prior to the second quarter 2006 collection.

- All the national hospital associations should be contacted and CMS should request they provide specific suggestions and or data to assist CMS in its decision making. The FAH would make every effort to respond very quickly.

- The changes should be finalized and communicated to the hospitals on or before July 5, 2006. Many hospitals will begin working on the 2nd quarter information around this date and changes to the requirements would place undue burden on them.

- The survey would need to cover the entire six month period since the first quarter information would no longer be comparable.

The FAH discourages CMS from changing the second quarter survey unless these issues cause significant distortions in the occupational mix adjustment.

CONCLUSION

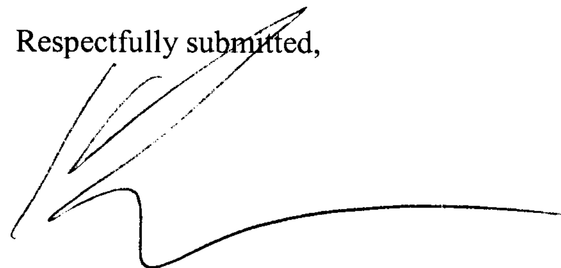
As discussed herein, the FAH is very concerned about unknown and possibly unintended impacts that will result from the gathering of survey data and application of a full occupational mix adjustment on such short notice. Considering that CMS insisted that a thirteen month review period was necessary to have a successful and accurate survey, and thus rejected the idea of collecting data for a full year for use in FY 2008, it is self-evident that a three month review period cannot possibly result in accurate survey data. The FAH thus urges CMS to seriously consider its suggestion that the *Bellevue* decision be applied only in the three states covered by the Second Circuit. This will undeniably produce a fairer wage index for hospitals throughout the country, while still complying with the court order.

In addition, the FAH requests the opportunity to comment further on the occupational mix survey itself, as the FAH's members have not yet had sufficient time to consider recommendations drawn from their recent experience completing the survey.

* * * *

FAH appreciates CMS's review and careful consideration of the comments in this letter, and would be happy to meet, at your convenience, to discuss them. If you have any questions, please feel free to contact Steve Speil, Senior Vice President at 202-624-1529.

Respectfully submitted,



June 12, 2006

BY HAND DELIVERY

Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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Re: **CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.**

Dear Dr. McClellan:

On behalf of the 1,400 leading not-for-profit hospitals and health systems allied in Premier, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the FY'07 Medicare Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 *Federal Register*. Premier is a strategic alliance of approximately 200 independent, not-for-profit health systems that operate or are affiliated with more than 1,400 hospitals and healthcare sites nationwide. Our comments primarily reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in the effective operation of the IPPS.

DRG CHANGES

Given the complexities of CMS' proposal to revise the diagnosis-related group (DRG) system and the magnitude of impact this could have on our member hospitals and on all hospitals in the country, we strongly urge a one-year delay in implementing these policy proposals. More time is needed to review these complex proposals and to offer viable alternatives to the proposed changes discussed in the *Federal Register*.

CMS proposes to move from the historical charge-based DRG system to a cost-based system and to implement hospital-specific relative weights by October 1, 2006. CMS also proposes modifying the DRG classification system to account for differences in patient severity and allow for a payment amount that more closely tracks the cost of providing

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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care. In its proposal, CMS states that it would replace the current 526 DRGs with either the proposed 861 consolidated severity-adjusted DRGs by FY'08 or a similar system that accounts for the level of patient severity, developed in response to public comments that it receives.

The magnitude of these changes cannot be minimized. CMS would re-distribute about $1.5 billion in Medicare payments across U.S. hospitals. Many of the hospitals that would lose revenues are among the leading institutions in the country, providing the best care available today as well as leading innovation to improve future healthcare.

Premier supports meaningful improvement to Medicare payments for inpatient services and applauds the tremendous effort CMS has put forth to devise a DRG system that more accurately reflects the costs of providing inpatient services. We wholeheartedly support your initiative to make payments more accurate and fairer to hospitals and to assure beneficiary access to services in the most appropriate setting. We have several serious concerns and comments, however, with the CMS proposal for calculating DRG weights and the proposed modifications to the DRG classification system.

Methodological Concerns

- CMS does not follow the cost-based methodology recommended by the Medicare Payment Advisory Commission (MedPAC) or the methodology used to calculate cost-based weights in the outpatient prospective payment system. Instead, CMS proposed a new and complex methodology which has not been tested or subjected to external review and analysis.

- The methodology proposed by CMS raises two very serious concerns. First, CMS trimmed the data in a crucial step of the calculation, with the result that hospitals representing 25 percent of total charges for routine care were thrown out even though they were retained in other parts of the calculation. Second, in computing national average cost-to-charge ratios, CMS did not weight by hospitals' volume of cases or charges. Not accounting for volume leads to a serious distortion of the national average.

- The proposed patient classification system incorporating severity adjustment needs refining for implementation and some details of the proposal were not available for review and comment. The grouping software should be made available so that hospitals can review how the proposed changes would affect their caseload, but this was not done apparently because the software is proprietary. We strongly believe that the grouping sofware used by Medicare should be in the public domain.

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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- Because of the methodological concerns and the unavailability of the severity DRG grouper, hospitals and the public have not had the opportunity to review the proposals adequately and assess their financial impact. The table below illustrates our concerns regarding the methodology and the impact it would have on selected types of hospitals and selected DRGs.

IMPACT OF HSRVcc ON HOSPITALS, BY TYPE		CMS	Corrected
	Urban (2,517)	-0.5%	-0.3%
	Large Urban (1,391)	-0.2%	-0.2%
	Other Urban (1,126)	-1.0%	-0.5%
	Urban, At Least 300 Beds (580)	-1.4% to -2.1%	-0.8% to -1.2%
	Rural (1,005)	+3.0%	+1.6%
	Major Teaching (237)	-1.5%	-0.9%
	Specialty Cardiac (54)	-10.4%	-5.8%
	Specialty Orthopedic (73)	-3.3%	+2.9%
	Specialty Surgical (151)	-3.6%	-1.6%
IMPACT ON SELECTED DRGs OF HSRVcc		**CMS**	**Corrected**
558	Percutaneous Cardiovascular Proc W Drug-Eluting Stent W/O Maj Cv Dx	-35%	-21%
557	Percutaneous Cardiovascular Proc W Drug-Eluting Stent W Major Cv Dx	-26%	-15%
125	Circulatory Disorders Except Ami, W Card Cath W/O Complex Diag	-28%	-20%
124	Circulatory Disorders Except Ami, W Card Cath & Complex Diag	-19%	-14%
535	Cardiac Defib Implant W Cardiac Cath W Ami/Hf/Shock	-26%	-16%
536	Cardiac Defib Implant W Cardiac Cath W/O Ami/Hf/Shock	-25%	-13%

Weight Calculation Methodology

- Premier supports a change from charge-based to cost-based weights accompanied by specific actions to address known limitations in the accuracy of the Medicare cost report data. Two shortcomings are particularly important. First is the problem of charge compression. To determine the cost of individual items and services, CMS generally takes hospitals' charges for an individual item or service and converts them to an estimated cost. Specifically, CMS converts charges to costs by "backing out" the *average*

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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mark-up calculated for each department. Thus, if a department had an average mark-up in which charges averaged twice the department's costs, then a charge of $1,000 would be reduced to a cost of $500 after adjusting for the mark-up.

Basing the estimate of the cost for each item and service on the average mark-up in a particular department implicitly assumes that hospitals apply the same percentage mark-up to set the charge level of each item in the department. Many experts and studies have noted, however, that hospitals generally do not apply a uniform percentage mark-up and that, in fact, the percentage mark-up for high cost items is less than the one used for lower cost items. According to a study commissioned by MedPAC, hospitals may reduce the mark-ups for higher-cost items to avoid "sticker shock". This phenomenon is called charge compression. To the extent that charge compression is present, the current CMS rate-setting methodology underestimates the cost of more expensive items and over-estimates the cost of less expensive ones, resulting in a systematic distortion of prospective payment rates. Premier strongly believes that changing to cost-based weights must address the distortion caused by charge compression.

- The other major issue with cost report information is the accuracy of the estimates of routine and ancillary costs. Studies comparing cost report information with information from sophisticated hospital accounting systems raise questions about the accuracy of the cost report data. An earlier ProPAC study, for example, found that the cost report overstated routine costs by more than 12 percent and understated ancillary costs by nearly 5 percent. This significant issue should be addressed as CMS implements cost-based weights. A one-year delay will provide the time needed to make improvements in the cost report system.

- Premier questions the accuracy of the hospital relative value (HSRV) method. We believe that accurately determined cost-based weights are the gold standard and that HSRV, distorts the cost-based weights. We note that cardiac surgery and cardiology services, especially interventional cardiology services, are performed primarily in the type of hospitals that are disadvantaged by the HSRV methodology. The weights for these services are disadvantaged by HSRV even though the hospitals performing them tend to mark up their charges for these services less than they mark up their charges for other services. In fact hospitals losing under HSRV have lower charges for these cardiac services than do hospitals which win under HSRV. HSRV disadvantages cardiac services because hospitals performing the preponderance of these services tend to charge more than average for typical

cases, therefore their charges for the very expensive cardiac cases are down-weighted in calculating the HSRV weights. In addition, cardiac services tend to be higher weighted services and thus are disadvantaged by the compression of the DRG weights that is a hallmark of the HSRV methodology.

Consolidated Severity-Adjusted DRGs

12225 El Camino Real
San Diego, CA 92130
T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800
T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523
T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511
T 202 393 0860
F 202 393 6499

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In the proposed rule, CMS seeks input on the proposed methodologies and solicits alternatives to the consolidated severity-adjusted DRG (CS-DRG) model. While we welcome the opportunity to work with CMS and other stakeholders in ensuring that any system implemented accomplishes the stated goals, we are extremely concerned with the tight timeline provided for developing comments and the implementation dates outlined in the proposal. A change of this magnitude warrants a thoughtful and thorough review by hospitals, a task not easily accomplished during a 60-day comment period, given the complexity of the proposals. We especially note that numerous recent changes to improve the DRG classification of particular types of cases are not carried over to CS-DRGs. **We also note that case complexity, a significant factor in driving hospital resources, is not considered by the CS-DRG approach proposed by CMS. Page 24014 of the *Federal Register* notes that CMS will develop a plan to address this issue. We believe this should be addressed before implementation vs. after.** Hospitals need to know how resource use will effect payments. Also, we oppose a "behavioral" offset which will reduce payments even further before implementation of the consolidated severity-adjusted DRG and note that CMS should release details of any behavioral offset in any case.

Given the number and magnitude of issues in the proposed changes in DRG classification and weight calculation, Premier strongly urges CMS to delay implementing both the proposed DRG reclassification and the changes to the relative weights until FY'08. The additional time will allow hospitals to more thoroughly evaluate the proposals and offer constructive feedback to your agency.

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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NEW TECHNOLOGY

Section 503 of the MMA provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS. This important provision was enacted to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **Premier also is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology, as we have previously requested.**

We also are concerned about CMS' ability to implement add-on payments for new services and technologies in the near future or to make appropriate DRG classifications for new technologies. Unique procedure codes must be created and assigned to recognize new technologies and the ICD-9-CM classification system is close to exhausting codes to identify new health technologies. The ICD-9 system is in critical need of upgrading.

Since the early 1990s, there have been many discussions regarding the inadequacy of ICD-9-CM diagnoses and inpatient procedure classification systems. ICD-10-CM and ICD-10-PCS (collectively referred to as ICD-10) were developed as replacement classification systems.

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

To date, despite these recommendations, as well as the recommendations of several federal healthcare agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

At the April 2005 ICD-9-CM Coordination and Maintenance (C&M) committee meeting, there were many impassioned discussions on the need to start limiting the

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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creation of new procedure codes in order to allow the classification system to last at least two more years. ICD-9-CM procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories represented a deviation from the normal structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g. musculoskeletal system, circulatory system, etc.) were available. The plan was to use codes in category 00 first and then begin populating chapter 17.

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

Thus, Premier strongly recommends that the Secretary undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously. HHS should take the necessary steps to avert this crisis and avoid being unable to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than respond to a crisis that will likely result in unreasonable implementation timeframes. **It is imperative that the rulemaking process start immediately.**

Additional Payment for New Technologies

Premier supports CMS' proposal to continue to make new technology add-on payments for Endovascular Graft Repair of the Thoracic Aorta and for the Restore® Rechargeable Implantable Neurostimulator. We also urge CMS to approve new technology add-on payments for NovoSeven® for Intracerebral Hemorrhage. The technology is a drug that promotes hemostasis by activating clotting factors. Because the technology is not currently FDA approved, in the proposed rule CMS does not present an analysis on whether the technology meets the criteria for the new technology add-on payment in this proposed rule. However, CMS summarizes information submitted by the applicant on the cost and substantial clinical improvement criteria. Similar to the previous approval of Xigris, we believe that the availability of an add-on payment would help to facilitate patient access to this important and costly therapy.

12225 El Camino Real
San Diego, CA 92130
T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800
T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523
T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511
T 202 393 0860
F 202 393 6499

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PROPOSED CHANGES TO DRG CLASSIFICATIONS

1. Carotid Artery Stents

Medicare covers percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with carotid stent placement when furnished in accordance with the Federal Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. Most cases of carotid artery stents are assigned to DRGs 533 (Extracranial Procedures with CC) and 534 (Extracranial Procedures without CC). **Premier supports the idea that all carotid stenting cases should be assigned to DRG 533 only, bypassing DRG 534 and we disagree with the CMS decision not to make this change.**

2. Insertion of Epicardial Leads for Defibrillator Devices

The ICD-9-CM Coordination and Maintenance Committee expanded the category of codes for defibrillators and pacemakers so that the codes for leads would no longer be restricted to pacemakers. This change would guide coders to use code 37.74 for the insertion of epicardial leads for both defibrillators and pacemakers. This change was adopted for the ICD-9-CM and will become effective on October 1, 2006.

Subsequently a commenter noted to CMS that this coding advice would restrict some defibrillator cases from being assigned to the defibrillator DRGs. The commenter recommended that the following combinations be added to DRGs 515, 535, and 536 so that all types of defibrillator device and lead combinations would be included: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98. **Premier agrees with the CMS proposal to make this change.**

3. Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs

In the FY 2006 IPPS final rule, CMS published a list of "major cardiovascular conditions (MCVs)". A patient with a condition on this list was expected to have a more complicated patient stay requiring greater resource use. An MCV can be present as either a principal or secondary diagnosis. In the same rule, CMS also adopted new DRGs 547 through 558 as an interim step to better recognize severity in the DRG system for FY 2006 until a more comprehensive analysis of the APR DRG system could be completed.

A commenter has questioned why CMS did not apply the MCV list to the defibrillator DRGs (515, 535, and 536) in addition to the pacemaker DRGs. CMS, however, did not propose additional refinements of the DRGs based on MCVs for FY 2007 in part because of their efforts to propose a broader refinement of the DRG system that would

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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focus on consolidated severity-adjusted DRGs. **Premier recommends that CMS reconsider recognizing MCVs in defining the defibrillator DRGs.**

4. Hip and Knee Replacements

In the FY 2006 final rule, CMS deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement) because they found revisions of joint replacements to be significantly more resource intensive than original hip and knee replacements. After publication of the final rule, a number of hospitals and coding personnel advised CMS that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) also includes codes that describe procedures that are not bilateral or that do not involve multiple major joints. The commenters recommended removing codes from DRG 471 that do not specifically identify bilateral or multiple joint procedures. **Premier agrees with the CMS proposal to make this change for FY 2007.**

5. Spinal Fusion

In the FY 2006 IPPS final rule, CMS created new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). After publication of the final rule, CMS received numerous suggestions including:

- Incorporate Bone Morphogenic Protein (BMP), code 84.52 into DRG 546.
- Apply a clinical severity concept to all back and spine surgical DRGS.
- Subdivide the spine DRGs based on the use of specific spinal devices such as artificial discs.
- Create 10 new spine DRGs.

Premier disagrees with the CMS position that it is premature to make changes at this time and we urge CMS to make the suggested changes in the final rule for FY 2007.

EXTERNAL DATA

Premier continues to be concerned about CMS' refusal to make use of external data, especially since these data sometimes are more complete and reliable than program data. We urge CMS to make greater use of external data as well as to facilitate public access to MEDPAR data. Although we very much appreciate timely release of the MedPAR file this year coincident with public availability of the proposed rule, Premier is very concerned that CMS does not make these data available quarterly as it has done

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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previously. We made similar comments last year and are hopeful that this year CMS will have a favorable response.

QUALITY

Date for Beginning Collection of Expanded Measures

CMS should delay implementation of the expanded set of measures until July 1, 2006 discharges. The rule, as proposed, is problematic in that it would require hospitals to retroactively collect data on the expanded quality measures for patients who were discharged prior to the rule's implementation—as far back as January of this year. A delay would allow hospitals to allocate resources for this expanded data collection. Not all hospitals participating in Hospital Quality Alliance currently submit the Surgical Infection Prevention measures. A delay until July 1, 2006 discharges would allow hospitals to begin with the Surgical Care Improvement Project revised specifications.

Proposed Measure Expansion

The Institute of Medicine (IOM) report and the proposed rule discuss three measures from The Leapfrog Group (computerized provider order entry, intensive care intensivists, and evidence-based hospital referrals). On behalf of our hospitals, we support consideration of structural measures that meet quality measure standards such as evidence-based, clear operational definitions, delineated process for validation and auditing that ensures reliability (both within and across hospitals) and measure an area of quality within the control of the provider. **We do not believe the three Leapfrog Group measures discussed in the IOM report meet the quality measure standards necessary for inclusion in CMS national quality measurement initiatives.**

Validation

The parameters of the validation process should be stated explicitly and documented. This includes clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly *what* is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter's validation, they have already moved onto the next quarter's data collection and can not make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well- documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. **Premier proposes that any modifications to the technical processes be published 120 days prior to the effective/implementation date.**

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

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Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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Further, Premier believes that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period.

An alternative method of data validation would be to use the monthly data points of each clinical measure and not rely on chart abstract. A proposed method of validation is to use a process similar to the quarterly Outlier validation Joint Commission requires of the core measure vendors. A monthly data point that exceeds three (3) standard deviations is considered an outlier. When an outlier is identified the hospital is requested to verify the data is accurate. This validation process relies on inter-hospital variability

Joint Commission Initiated Outlier Analysis After Data Transmission

A negative outlier is defined by the Joint Commission as a quarterly data point that is greater than three standard deviations from the national average in a direction that indicates substandard performance. The national average and the standard deviation for the national hospital quality measures are calculated for the quarter using only those data points in the period that have a sample size greater than or equal to 30. The performance measure means and standard deviations will be made available quarterly to measurement systems and hospitals on the Joint Commission's extranet to use for quality improvement activities.

The type of standard deviation described above is based on what is known as inter-hospital variability. The inter-hospital variability is most useful for identifying data points that are "outliers" relative to a population of hospitals.

Since standard deviations and upper limits change from quarter to quarter based on the processing of retransmitted historical data for the hospital or other hospitals using the same measure, a past quarter may become an outlier that was not considered an outlier in a previous quarter's calculations.

Each quarter, after data transmission, the Joint Commission will identify any extreme outlier values that are of significant concern. Before we follow up with individual hospitals, it is critical that the accuracy of these extreme values is verified with the measurement systems. For this reason, measurement systems will review the identified outlier data points and identify one of three possible outcomes. They will confirm either that the values accurately represent the performance of each hospital, indicate that the values may be a result of the measurement systems computation issues, or verify that the values may be a result of hospital data quality issues, all of which will need to be addressed.

This process is efficient and can be completed in one month.

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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PLAN FOR HOSPITAL VALUE-BASED PURCHASING PROGRAM

Section 5001(b) of Public Law 109-171 (Deficit Reduction Act of 2005) requires the Secretary of Health and Human Services to develop a plan to implement a value based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009. Such a plan shall include consideration of the following issues:

(A) The on-going development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (B) the reporting, collection, and validation of quality data; (C) the structure of value based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value based payments and; (D) The disclosure of information on hospital performance.

In developing such a plan, the DRA states the Secretary shall consider experience with such demonstrations that are relevant to the value based purchasing program. Premier is please to be collaborating with CMS on the Premier Hospital Quality Incentive Demonstration and looks forward to evaluating and reviewing the issues with CMS.

HEALTH INFORMATION TECHNOLOGY

While the need for automating the measurement process into electronic medical records (EMR) is a desired goal, the Premier HQI demonstration project is being implemented without the use of EMR. **It is more important to fix ineffective processes than to implement technology that supports retention of broken process systems.** Any lack of automation across the sector is no excuse for delaying quality process improvement. Finally, **any federal funding for physician or hospital information technology should come from "new money/funds" and not be mandated through the hospital conditions of participation.**

HOSPITAL-ACQUIRED INFECTIONS

Premier welcomes the increasing attention to the prevention of hospital-acquired infections (HAI), particularly the transparency of efforts involving both healthcare providers and consumers—we welcome evidence-based approaches to the prevention of adverse events in any healthcare setting. We believe that every effort should be made to eliminate HAIs by applying state-of the-art science even as our hospitals care for sicker patients in an increasingly complex environment. We also recognize this is only accomplished in a culture of safety that promotes fixing systems over assigning blame.

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

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F 630 368 5310

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Suite 625
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T 202 393 0860
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While zero tolerance of HAIs is a goal all our members endorse, it is important to be aware that systematic review of several studies demonstrates that the preventable proportion of HAIs ranges between 10 to 70 percent; for surgical site infections in particular, this range of preventable infections is between 40 to 60 percent.[1] We note the CMS Surgical Care Improvement Project (SCIP) goal in this regard is a target of 25 percent reduction in morbidity and mortality associated with surgical care.

After studying CMS' proposal, Premier agrees with the intent of the proposed change. We do not think that HAIs which could be prevented based on interventions developed from scientifically sound, evidence-based practices should receive higher payments.

As Premier participates in a variety of infection prevention strategies, we are pleased as well to acknowledge dramatic successes in infection reduction achieved by implementing an entire group (i.e., bundle) of evidenced-based practices. This strategy results in better outcomes than when each practice is implemented individually. There are numerous well publicized initiatives that demonstrate improved outcomes when all the right processes occur together. In areas specifically measuring HAI incidence, unprecedented reductions in rates of central line-associated bloodstream infections (CLA-BSI) and ventilator-associated pneumonia (VAP) for example, have been reported by hospitals participating in local, regional, state and national initiatives such as the Pittsburgh Regional Health Initiative, Maryland Patient Safety Center, Michigan's Keystone Center and others. However, even within these successful collaborations, HAIs occur despite near complete adherence with high quality, validated processes of care in the participating facilities. These findings suggest that additional studies are needed to elucidate other modifiable risk factors for HAIs. Such limitations of science-based interventions have implications for providers even with payer incentives for prevention.

Premier would like to focus on one of the most notable initiatives related to surgical site infection (SSI) –namely CMS's success using bundling in the Surgical Infection Prevention Project SIPP-- now developed into CMS's SCIP. SCIP has built its processes for preventing SSI from a series of widely accepted evidence-based (EB) guidelines including (1) the *CDC Guidelines for the Prevention of Surgical Site Infection* in which the literature is reviewed and categorized based on the weight of evidence in the recommendations[2]; (2) peer-reviewed guidelines on surgical antibiotic prophylaxis[3]; and

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[1] Harbarth S,Saxa H, Gastmeier P. The preventable proportion of nosocomial infections: an overview of published reports. Journal of Hospital Infection (2003) 54, 258–266

[2] CDC. The "Guideline for Prevention of Surgical Site Infection, 1999" is available online at www.cdc.gov/ncidod/dhqp Published simultaneously in Infection Control and Hospital Epidemiology; AJIC: American Journal of Infection Control 1999;27:97-134

12225 El Camino Real
San Diego, CA 92130

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F 858 481 8919

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(3) guidelines for antibiotic prophylaxis in cardiac surgery[4]. SCIP has already demonstrated that in *certain* patients, in *certain* procedures, SSIs *can* be prevented, and rates certainly reduced when such guidelines are applied. For example, in the initial SIP collaborative, a one-year demonstration project sponsored by CMS concluded that "the infection rate decreased 27 percent, from 2.3 percent to 1.7 percent in the first versus last three months."[5]

Limitations

What we do *not* know from applying even the best of EB guidelines in prospective controlled trials is –*how many can truly be prevented* as such initiatives continue over time throughout all of our hospitals. Therefore, cases which could *reasonably have been prevented are only those in whom all evidence based practices have been followed and indeed no infection develops.*

We *do* know that thousands of our hospitals are demonstrating their determination to reduce infections by applying these guidelines systematically through participation in SCIP. In the selection of two conditions involving just surgical procedures, conditions already demonstrating good results when bundles are applied properly, the challenge will remain to avoid penalizing hospitals for a specific DRG grouping which cannot separate an identified HAI from associated co-morbidities associated with patients' underlying conditions such as diabetes.

Using the example of SCIP, if a hospital-associated SSI was identified in a patient, the direct method to identify whether it was truly preventable would involve a review process to determine if the case met *all* the EB SCIP surgical measures currently applicable to that specific patient. If this SSI case analysis shows that the hospital did not implement and document all SCIP measures, the hospital would not receive the reimbursement rate for the associated CC.[6] However, if the hospital documented that all possible processes were

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[3] Bratzler et al. Antimicrobial Prophylaxis for Surgery: An Advisory Statement from the National Surgical Infection Prevention Project. CID 2004:38 (15 June) 1706.

[4] Antibiotic Prophylaxis in Cardiac Surgery - Duration of prophylaxis. *Report from the Society of Thoracic Surgeons Workforce on Evidence Based Surgery.* ©2005 The Society of Thoracic Surgeons. approved exception for discontinuance of antibiotic prophylaxis. Available from http://www.sts.org/sections/aboutthesociety/practiceguidelines/antibioticguideline/

[5] Dellinger EP, Hausmann SM, Bratzler DW, et al Hospitals collaborate to decrease surgical site infections. Am J Surg. 2005 Jul;190(1):16-7.

[6] Nolan T,Berwick.D. All-or-None Measurement Raises the Bar on Performance JAMA, March 8, 2006—Vol 295,1178-1171

12225 El Camino Real
San Diego, CA 92130

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F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

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F 630 368 5310

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applied, the hospital should not carry the financial burden for the patient's SSI, since the hospital has complied with the 'state of the art' in terms of infection prevention. This approach would provide incentives to hospitals to apply all recommended practices, and would fairly reimburse cases for which a HAI develops *despite* adherence to such practices.

Such a process would permit learning more about what those "unknown factors" are that lead to infection even when there is adherence to all known EB practices. Hospitals could continue to use tools like root cause analysis to determine why some patients still develop infection despite applying all current scientific practices known to prevent infections. This approach would be viewed positively by patients, would encourage hospital staff to work even harder to improve, and most importantly would teach us even more than we currently know about infection prevention. This approach would also support accountability to the patient –the most important factor in this equation - while still promoting a learning environment in the hospital with regard to infection prevention.

However, this approach is impractical for numerous reasons; including the data analysis burden to CMS, as well as a hospital appeals process which would have to be defined and developed in order to fairly exclude individual cases from payment.

CMS will be challenged to determine the truly preventable infections and would not, and should not, penalize hospitals for what they cannot prevent or control. We would therefore suggest developing other approaches that do not rely on patient level data, but function as a proxy for patient-level review.

Recommended Approach

Premier proposes a measurement system that emphasizes adherence with systems and processes of care that have achieved a high quality of evidence demonstrating correlations with reduction in infection rates. Documentation of systems or processes is typically straightforward and subsequent analyses can be employed to determine correlation. These systems and the frequency of outcomes, such as SSIs, should use aggregate data to establish thresholds for when the DRG CC change is actually applied.

We recommend as one possible approach that hospitals should:

- Accept that patients with the selected condition may be identified as having a specific HAI (that may or may not be preventable).
- Accept that such identified cases will result in maintaining the lower-payment DRG *unless* they can provide measurable achievements that demonstrate the application of EB practices in a variety of initiatives. These can include any

number of practices in the local, regional, state or federal levels. Thresholds could be developed not just for participation and reporting but actual levels of performance—even as CMS moves forward in its stated direction of "pay for performance." Once again we refer to initiatives like PRHI, Keystone, and SCIP to learn what thresholds would be reasonable based on each community's success and local patient populations.

12225 El Camino Real
San Diego, CA 92130

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F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

700 Commerce Drive
Suite 100
Oak Brook, IL 60523

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F 630 368 5310

444 N Capital Street NW
Suite 625
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T 202 393 0860
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This may not be the optimum moment to suggest the initial conditions that most closely correlate with preventable HAIs given CMS's proposal to move to a consolidated DRG system, the complexities of coding and the need for expertise on coding and the DRG GROUPER. Premier is prepared to provide input as these processes develop and are implemented. CMS is aware of the multiple EB guidelines from CDC, and without listing them all at the moment, we offer a few other recent resources beyond the prevention of surgical site infections noted earlier.[7] [8]

What Premier has learned and can share is that the need to continually improve our members' safety culture, working closer as teams and applying the evidence gained in studies are all key strategies to improve safety and quality of care. The processes are critical, intensive, and complex but rewarding in the achievement of greatly reduced incidence of infection.

We urge CMS to consider in this federal mandate continuation of CMS' current direction that *rewards good performance*, supports hospital efforts to develop and maintain a non-punitive culture of safety, and yet provides the necessary accountability implied in the current Congressional budget language. Premier would ask that CMS link the proposed language to its current successful implementation of *process measurement* –even as the outcome of such processes is being validated in various methods.

We are eager to participate with CMS in the development of the final rule and more specifically with the development of indicators and systems to implement the rule once finalized. We are committed to improving the safety of healthcare and look forward to working with CMS toward this goal.

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[7] McKibben L, Horan, T, Tokars JI, Fowler G, Cardo DM, Pearson ML, Brennan PJ. and the Healthcare Infection Control Practices Advisory Committee* Guidance on Public Reporting of Healthcare-Associated Infections: Recommendations of the Healthcare Infection Control Practices Advisory Committee. Am J Infect Control 2005;33:217-26.

[8] McKibben L, Fowler G, Horan T, Brennan PJ. Ensuring rational public reporting systems for health care–associated infections: Systematic literature review and evaluation recommendations Am J Infect Control 2006;34:142-9.

In closing, Premier appreciates the opportunity to comment on the FY '07 IPPS proposed rule. Please do not hesitate to contact me, Margaret Reagan, corporate vice president of Premier at 202-879-8003 if you would like to discuss these comments further.

Sincerely,

Margaret Reagan

Margaret Regan
Corporate Vice President

12225 El Camino Real
San Diego, CA 92130

T 858 481 2727
F 858 481 8919

2320 Cascade Pointe Blvd (28208)
P.O. Box 668800
Charlotte, NC 28266-8800

T 704 357 0022
F 704 357 6611

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Suite 100
Oak Brook, IL 60523

T 630 891 4100
F 630 368 5310

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

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Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

Jordan J. Cohen, M.D.
President

June 12, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-1488-P2**

Dear Dr. McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index*" 71 FR 28644 (May 17, 2006). The AAMC represents approximately 300 major teaching hospitals and health systems that will be completing the 2006 survey for purposes of implementing an occupational mix adjustment to the wage index.

Our letter comments on the proposed changes to the Medicare wage index calculation. We comment on the methodology used in calculating the fiscal year (FY) 2007 occupational mix adjustment. We also provide a recommendation for an occupational mix adjustment factor that CMS could assign to a non-responding hospital.

I. Background

A portion of the Medicare hospital inpatient standardized payment amount for each hospital is adjusted by the "wage index," which reflects relative differences in costs across geographic areas that are due to local labor markets. The portion of the standardized amount that is adjusted is referred to as the "labor related share."

The Benefits Improvement and Protection Act of 2000 (BIPA) mandates that the hospital wage index be adjusted to reflect the occupational mix of employees. The intent of this adjustment is to ensure that the wage index reflects only geographic differences in the prices hospitals pay for labor and not differences in the mix of their employees. Pursuant to the statute, data on the occupational mix of employees for each hospital is to be collected every three years.

The initial occupational mix survey data were collected in 2003. These data were used to calculate the occupational mix adjustment for FY 2005 and FY 2006. Due to a number of concerns, CMS decided in the FY 2005 final rule (69 Fed Reg at 49052) to implement a blended wage index that would consist of 10 percent of an average hourly wage adjusted for occupational mix, and 90 percent of an average hourly wage unadjusted for occupational mix. Specifically, CMS was concerned about the validity of the data and the potential financial impact on hospitals given that the 2003 survey was being used for the first time and hospitals had a relatively short timeframe to collect and submit the data.

Given the "every three years" requirement, CMS initiated another survey this past January. The survey contained a number of beneficial changes that could improve the accuracy of the survey data collected. Under the survey timeframe, hospitals were to submit data for a six month period (from January 1 to June 30, 2006) by July 31, 2006.

In the FY 2007 inpatient proposed rule, published on April 25, 2006, CMS stated that it would continue to use the 2003 survey data to calculate the occupational mix adjustment for FY 2007 and continue to apply a 10 percent occupational mix adjustment to the wage index (71 FR at 24081). The rule also noted that the data collected in the 2006 survey would be incorporated into the FY 2008 hospital wage index.

II. Proposed Rule Changes

The May 17 proposed rule implements a court mandate (*Bellevue Hosp. Ctr v. Leavitt*, April 3, 2006) that requires hospitals to apply the occupational mix adjustment to 100 percent of the wage index beginning in FY 2007 with new survey data.

Due to the short time frame to collect and implement a 100 percent adjustment with new data, CMS is proposing to use occupational mix survey data for the first calendar quarter of 2006 (January 1, 2006 through March 31, 2006) to calculate the wage index adjustment for FY 2007. Pursuant to previous communications to hospitals and fiscal intermediaries, hospitals were required to submit these data by June 1, 2006. CMS is requiring that hospitals submit the data for the second calendar quarter (April 1, 2006, through June 30, 2006), by August 31. The combined six months of data from the 2006 survey will be used to calculate the occupational mix adjustment for FY 2008.

III. The Methodology For Calculating The Occupational Mix Adjustment Should Be Reevaluated

To calculate an occupational mix adjustment, both wage and number of hours data are needed. For FYs 2005 and 2006, the occupational mix adjustment was calculated using the 2003 survey data. The survey collected the number of hours, but not the wages, for employees working in seven service categories. National average hourly wage data were obtained from the Bureau of Labor Statistics. The 2006 survey collects both hours and wages but only for two general occupational categories – nursing and "all other

occupations". The nursing category is broken down into four subcategories: RNs, LPNs, Aides, Orderlies, Attendants, and Medical Assistants.

Because wage data were not collected in the previous survey, CMS used the number of hours as a proxy to determine the share of wages for a particular service category to total wages for all employees in the hospital. These data came from the hospitals' Medicare cost reports. This methodology is reasonable given that the relevant wage data were not available. However, to the extent that the actual share of wages for a service category relative to total hospital wages calculated based on the proxy method differs from what it would be if actual wages were used, the occupational mix adjustment would be inaccurate. This is particularly true if there is a great deal of variation in wages at the hospital level. Since CMS is now collecting wage data, we believe the methodology should be reevaluated to determine if a more appropriate method would be to use wage data directly as reported in the survey.

IV. Assigning An Occupational Mix Adjustment To Non-Responding Hospitals

In order for CMS to calculate an accurate national average hourly wage, the Agency needs to collect data from all hospitals paid under the Medicare inpatient PPS. For hospitals that do not submit data (non-responding hospitals), CMS must assign an occupational mix adjustment factor that would be applied to the FY 2007 wage index. For FY 2005 and FY 2006, CMS assigned non-responding hospitals an occupational mix adjustment factor of one. In the proposed rule, CMS requests comments on four options it is considering for assigning an occupational mix adjustment to non-responding hospitals. These options are:

(1) assign the hospital an occupational mix adjustment factor of 1.0000 as CMS did for FYs 2005 and 2006;
(2) assign the hospital the average occupational mix adjustment factor for its labor market area;
(3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or
(4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus nonteaching status and case mix.

Although we believe that hospitals that do not participate in data submission should not benefit from the participation of others, we are concerned that the option that would punish non-responding hospitals – option three – would also have a negative effect on the occupational mix adjustment factor of hospitals that submit their data and are in the same labor market area as the non-responding hospitals. Furthermore, we also are concerned that given the short time frame for submitting data for FY 2007, some hospitals may be unable to fully and accurately complete the survey.

Given the short time frame that hospitals had to submit survey data for this year's wage index calculation, we recommend that CMS give a non-responding hospital an occupational mix factor calculated from its 2003 survey. For hospitals that did not submit data in 2003, CMS could implement option two, thereby giving a non-responding hospital the average occupational mix adjustment factor for its labor area.

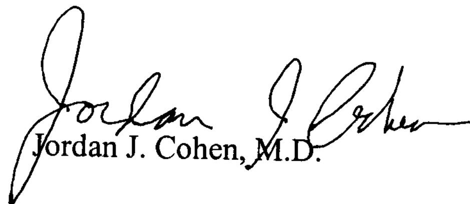
Since hospitals will have until August 31 to submit data for the full six months of calendar year 2006 that will be used for the occupational mix adjustment next year (FY 2008), we recommend that CMS implement a policy that discourages hospitals from not responding, but does not penalize responding hospitals in the same labor area. We would be happy to work with CMS staff to develop a methodology that would address these issues.

V. Conclusion

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please contact Karen Fisher at kfisher@aamc.org, or 202-862-6140, or Diana Mayes, at dmayes@aamc.org, 202-828-0498.

Sincerely,



Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC
Diana Mayes, AAMC

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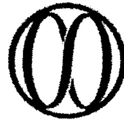


Wake Forest University Baptist
MEDICAL CENTER

Len B. Preslar, Jr.
President and Chief Executive Officer
North Carolina Baptist Hospital
Telephone: (336) 716-4750
Fax: (336) 716-2067

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1500-P
P. O. Box 8010
Baltimore, MD 21244-1850

HAND DELIVERY

Dear Dr. McClellan:

**Subject: CMS-1488-P and P2, Medicare Program
Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007; Proposed Rule**

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Service' (CMS) proposed rule entitled, "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). NCBH is part of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,106 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

NCBH commends CMS for its ongoing efforts to ensure adequate reimbursement for all clinical services. Moreover, it recognizes the extremely complex issues involved in establishing appropriate reimbursement for procedures performed in the inpatient setting. However, NCBH is extremely concerned that these proposed sweeping changes will have a negative financial impact on our institution and believes further study, and likely changes, to the proposed rule are needed.

Background:

In the Notice of Proposed Rulemaking (NPRM), CMS is proposing to make the most significant changes to the calculation of DRG weights and the patient classification system since the beginning of the Inpatient Prospective Payment System. The proposed changes appear to have their roots in the Medicare Payment Advisory Commission's (MedPAC)

2005 Report to Congress on Medicare payments for a certain subset of "specialty" hospitals. The MedPAC report raised concerns that the specialty hospitals were selecting the most profitable cases in their area and leaving the other acute care hospitals with less profitable services. Rather than addressing this issue of specialty hospitals in independent fashion, MedPAC recommended changing the payments for ALL acute care hospitals to reduce the incentives in the overall inpatient payment system that fueled the growth of specialty hospital facilities.

Proposed Changes:

Specifically, CMS proposes major changes to the DRG weights for FY 2007—use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights rather than charged-based weights. The combination of these two changes is referred to as the hospital-specific relative value cost center (HSRVcc) methodology. CMS also proposes major changes to the patient classification system, refining the DRGs to account for patient severity, through the creation of a new patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

Analyzing the Proposed Changes:

Despite the obvious complexity associated with the methodology, combined with the major financial impacts associated with the resultant DRG weight changes, NCBH, along with other hospitals, was given only 60 days to review and comment on the proposed rule changes. During this period, NCBH has worked with the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), participated in many telephone conferences, and has conducted numerous analyses to try to understand the policy goal of the proposals, the underlying methodologies, and the resulting impacts.

Overall Impact of the Proposed Changes:

These analyses have revealed the areas negatively affected to include Cardiac Surgery, Interventional Cardiology, General Cardiology, Orthopedics, and Vascular. The payment decrease expected from these services lines will total $6 million dollars. Specifically, we are estimating the following amounts for each service line: Cardiac Surgery – $1.2 million; Interventional Cardiology - $4.2 million; General Cardiology - $446,000; Orthopedics - $86,000; and Vascular - $213,000. Patients in these areas account for over 37% of our annual Medicare discharges and a $6 million payment reduction is very significant for our institution. With a growing elderly population, patients needing Cardiac and Orthopedic services will only continue to increase. Because of the age of the cost data, the proposed methodology does not adequately account for the cost related to the newest technology that hospitals are providing to Medicare patients.

DRGs from which we may see some payment increase account for 40% of our annual discharges. These aggregate payment increases fall substantially short of covering the losses stated above. This is not a budget neutral event. The remaining 23% of our discharges will remain neutral in terms of payment changes.

Concerns with the Proposed Rule

NCBH does not oppose moving from a charge to a cost-based DRG weighting methodology, but believes that a one-year postponement is necessary to allow for further analyses. This is necessary in order to address our concern that the new proposed DRG weights would be based on cost data that are three to five years old. These data are neither current nor accurate and do not include the costs associated with many important and commonly used technologies. Also, the hospital charges are not weighted by volume, so a smaller hospital of 50 beds would carry as much weight as our 1,106 beds.
CMS needs to address these data and computation issues to ensure that the best possible methodology is implemented.

We also support refinement of the DRGs, but believe that the proposed consolidated severity-adjusted DRGs (CS-DRGs) require further examination and likely modifications before implementation. Severity adjustments have potential, but must account for both complexity and severity, not just severity. As a major teaching hospital, it is important to us that the DRG classification system reflect those cases that involved the sickest and most complex Medicare patients and that the correct assignment is made so that the DRGs adequately reflect the resources needed to treat these patients. Hospitals must be given appropriate information on the method and impact of any new severity adjustment system and given appropriate time to evaluate and comment on them.

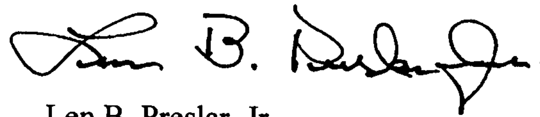
The impact of adopting cost-based methods and severity adjustment at different times should be addressed. NCBH believes that these changes should be implemented simultaneously to ensure equity and minimize payment volatility for our institution. Otherwise, we may be "whipsawed" by shifting dollars in opposite directions in succeeding years.

Finally, because the potential impact of these changes is monumental, there should be a significant transition period to implement these changes. There is historical precedence in the Medicare program on which we base this comment. Changes that were accompanied by transitions include: move to a PPS for capital (10 years); implementation of the operating IPPS (four years); eliminating day outliers (four years). The proposed changes will result in a redistribution of over one billion dollars and therefore requires a significant transition period.

NCBH remains committed to working with CMS and other health care organizations, such as the AHA and the AAMC to ensure that Medicare beneficiaries have continued access to high quality, efficient and effective health care. We look forward to a continuing dialog as it relates to this proposed rule.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, Vice President Government Relations at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,



Len B. Preslar, Jr.

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