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Advancing Health in America

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Brenda Aguilar
Office of Management and Budget
Human Resources and Housing Branch
New Executive Office Building, Room 10235
Washington, DC 20503

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W. Room 443-G
Washington, DC 20201

Ref: CMS-10079 — Agency Information Collection Activities: Submission for OMB Review; Comment Request; Hospital Wage Index Occupational Mix Survey, (68 *Federal Register* 54905), September 19, 2003.

Dear Ms. Aguilar and Administrator Scully:

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of care, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) revised hospital wage index occupational mix survey as announced in the *Federal Register* on September 19, 2003.

Section 304(c) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires the Secretary to collect data every three years on the occupational mix of hospital employees for each short-term, acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index beginning October 1, 2004 (federal fiscal year 2005).

The agency issued a proposed occupational mix survey in the May 4, 2001 inpatient prospective payment system (PPS) proposed rule (66 *Federal Register* 22674), but rejected adoption of the tool in its final rule, saying "it would be beneficial to work with the industry to develop a workable data collection tool," (p. 39862). Additionally, in the May 9, 2002 inpatient PPS proposed rule (67 *Federal Register* 31432), CMS indicated that it would issue instructions as to the type of data to be collected, in advance of actually requiring hospitals to provide the data, and only after the agency could develop an occupational mix method that "appropriately balances the need to collect accurate and reliable data with the need to collect data that hospitals can reasonably be expected to have available," (p. 31432).

On April 4, 2003, CMS published a Hospital Wage Index Occupational Mix Survey instrument (68 *Federal Register* 16516) for public comment. The survey would collect retrospectively for 2002 total wages and paid hours across four wage ranges for 12 occupational categories. Hospitals were to include staff that were full-time, part-time, and directly hired and acquired under contract, and from all areas of the hospital, regardless of whether the unit was paid under the inpatient PPS. The AHA submitted lengthy comments on the proposed tool on June 2, 2003. These comments can be located on our Web site at: http://www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/comment/2003/cl030602occmix.html

On September 19, 2003, the agency released a revised Hospital Wage Index Occupational Mix Survey calling for a prospective 30-day survey of hospital employees across nine broad occupational categories and 19 sub-categories. This revised survey has addressed many of the questions and concerns we raised in our June 2 comment letter. Specifically, we are pleased that the revised survey tool eliminates the burdensome collection of data across hourly wage intervals, includes all hospital employees through use of an "all other" category, and more closely mirrors data hospitals provide on the Medicare cost report, including the exclusion of PPS-exempt units. While we believe that CMS has developed a more rational survey, we continue to have questions and concerns about its completion, implementation and utilization.

Most importantly, it is still unclear how the occupational mix survey data will be used to adjust the hospital wage index, and what the projected impact of this adjustment will be on hospital payment. We are extremely disappointed that CMS has ignored our numerous requests – begun over two years ago – to provide a detailed methodology on how the information collected will be utilized to determine the occupational mix index and how it will be used to adjust the overall wage index. We continue to be uncertain whether the mix adjustment would truly result in a more equitable or efficient payment methodology. It is equally unknown whether the benefit of such an adjustment would outweigh the cost of collecting the data. Moreover, we remain deeply concerned that the data CMS will collect may not be what is ultimately required to perform a sound adjustment to the wage index. The result will be complicated and confusing revisions to an already implemented data collection tool and, potentially, the implementation of an erroneous adjustment that results in distorted and inaccurate wage indices. **The AHA urges that a detailed proposed methodology be released for comment, and an impact analysis of such an adjustment be performed by type of provider. This information is still critical to provide meaningful comments on the now-revised proposed data collection tool. Until this information is available, the AHA cannot support use of this tool. Hospitals should not be required to divert additional resources from patient care to complete a potentially unusable occupational mix survey.**

Occupational Categories

The revised occupational mix survey instrument proposes to use the occupational categories and definitions from the 2001 BLS Occupational Employment Statistics Survey based on its standard

occupational categories (SOCs), as recommended and supported by the AHA. The survey would collect data on the following 19 occupation sub-categories and an all other category:

- registered nurses
- licensed practical nurses
- nursing aides, orderlies & attendants
- medical assistants
- physical therapists
- physical therapists assistants
- physical therapists aides
- occupational therapists
- occupational therapist assistants
- occupational therapist aides
- respiratory therapists
- respiratory therapy technicians
- pharmacists
- pharmacy technicians
- pharmacy aides
- dieticians and nutritionists
- dietetic technicians
- medical and clinical lab technologists
- medical and clinical laboratory technicians
- all other occupations

Hospitals would be required to identify total full-time equivalents (FTEs) for each category, which includes employees that are full-time, part-time, directly hired and acquired under contract.

While it appears that CMS' intent is to collect data on direct patient care areas, it does not include <u>all</u> direct patient care employees. For example, it excludes critical radiology technologists and technicians that, according to BLS employment estimates, represent more hospital employees than the therapists, technicians and assistants delineated above. We question why CMS chose to include some direct care areas yet exclude others. It is also unclear whether the "all other" category is just for employees also involved in direct patient care areas, or whether it would include management occupations, facility, transportation, materials management, et cetera. **The AHA recommends that the "all other" category include <u>all</u> hospital employees not included in the delineated categories. This would help ensure that the data collected is accurate, and that it can be reconciled to total employees on a hospital's general ledger, W-2, and other externally reported data.**

It is also unclear whether it is CMS' intent to create an occupational mix adjustment based on the 19 defined occupational categories of clinical employees (representing approximately half of all hospital employees) or whether "all other occupations" would be included. **If the agency chooses to use only a subset of employees, then the AHA recommends that only a corresponding percent of the wage index undergo an occupational mix adjustment.**

The revised proposed survey would require hospitals to submit data on the number of FTEs in each category. **We question why this extra calculation is necessary, and recommend that hospitals submit total paid hours for each category, as this information can be pulled directly from hospital payroll systems.**

The new survey is imprecise about how hospitals should report employees who have clinical degrees but who are not involved in direct patient care. For example, some registered nurses (RNs) may work in an "overhead" department such as utilization review, quality improvement, or medical records. Are hospitals to report these individuals as RNs due to their educational background, or as "all other occupations" due to their function at the facility? **The AHA recommends that hospitals report employees based on their function rather than their education.**

Additionally, we are unclear about how to report clinicians who spend only a portion of their time performing direct patient care. For example, the director of physical therapy may take care of patients *and* perform administrative duties. This issue is especially common at smaller urban and rural hospitals. Is it CMS' intent to require hospitals to delineate the portion of time these individuals spend performing each function? For example, would that director of physical therapy who provides patient care 20 percent of the time be reported under physical therapists as 0.2 FTE, and under all other occupations as 0.8 FTE? This methodology could quickly become very complicated and could produce erroneous data.

Too much ambiguity would at best result in an inaccurate calculation of the occupational mix adjustment. At worst, CMS or the Office of the Inspector General might view these errors as intentional and fraudulent. **CMS must clearly define the occupational categories and the categorization of employees with multiple job roles to ensure that hospitals are as consistent as possible in their responses.**

U.S. Bureau of Labor Statistics (BLS) Data

The AHA is concerned about use of the BLS Occupational Employment Statistic (OES) survey as a national standard to determine average hourly wage rates by occupation, because it is unclear whether the survey is an adequate reflection of hospitals that will undergo an occupational mix adjustment. First, the BLS data only represent results from a sample of hospitals. While BLS has indicated that the overall response rate to its surveys is 76 percent, it is completely unclear what the response rate is for the OES survey. Second, it is unclear whether the OES survey includes PPS-exempt hospitals and units, such as rehabilitation, skilled nursing, and long-term care facilities. The case mix, and thus the employee mix, of these hospitals may be significantly different than that of short-term acute care facilities. Third, the OES survey includes critical access hospitals, yet these very small facilities are excluded from an occupational mix adjustment to the wage index because they are paid based on reasonable costs. Fourth, the OES collects data on full and part time employees, but excludes contracted labor. This may result in significantly different average hourly wages. Additionally, it is unclear whether the collection of employees versus FTEs would skew the analysis. Finally, the OES

collects information for one pay period in November. This timeframe will not match the same proposed "30-day snapshot" of hospital employee data, potentially resulting in distorted information.

Moreover, the OES average hourly wage data will be from 2001, yet the hospital occupational mix survey data would be from 2003 or 2004 and the wage index data from 2002 cost reports. This would result in an "apples-to-oranges-to-pears" comparison. Given that we are still unclear exactly how the information will be used, it is difficult to recommend one data source over another. **The AHA strongly suggests, however, that the impact of these data inconsistencies be more fully understood, addressed, and shared with the public for comment, before they are used in an occupational mix adjustment.**

Data Collection Timeframe

The revised survey proposes collecting occupational mix data from hospitals for a 30-day period, to be determined after approval of a final survey. The AHA is concerned that a 30-day time period may provide biased data. For example, the winter months bring on seasonality issues related to a hospitals' census. The flu season may hit some areas, increasing their need for a different mix of hospital employees. Moreover, November and December begin vacation periods for many workers. Finally, hospital turnover, construction projects, or strikes can greatly impact data from a one-month period. If CMS proceeds with a prospective 30-day survey, we encourage the agency to consider using a more flexible timeframe, such as two 14-day pay periods (or 28 days), or if the hospital has a monthly payroll, the entire month (which may be 31 days), and to allow the hospital to pro-rate the data to CMS' chosen number of days.

Collecting data retrospectively for 2002 would be less burdensome for hospitals because it could be easily extracted from hospitals' W-2 forms. But we are concerned that providers may not be able to obtain accurate retrospective information on contracted labor – potentially critical in the development of an occupational mix adjustment. In addition, the current Medicare cost report excludes some contract labor (i.e., food service, housekeeping) in calculation of the wage index, but includes other, traditionally professional contract labor (i.e., nursing, pharmacy, laboratory, teaching physicians). Differences between the proposed occupational mix survey and the cost report will lead to inconsistencies between the data collected to calculate the wage index and the data collected to calculate an occupational mix adjustment to the wage index. We continue to encourage CMS to exclude contract labor for certain support services, which would fall into the "all other employee" category and which may or may not be used to calculate an occupational mix adjustment.

Hospitals are being placed in a lose-lose situation in which neither alternative is adequate. A prospective survey covering a longer period of time would yield a more appropriate and reliable collection instrument. While collecting information over the 2004 calendar year would give hospitals the opportunity to capture both seasonality and contract labor, we acknowledge that CMS is under a congressionally mandated deadline. Thus we recommend that CMS consider collecting occupational mix data over the six-month time period of January 1, 2004 – June 30, 2004. This would allow hospitals to work with external agencies to receive contract labor

information, as well as to collect data over a longer time period to help even out some of the inconsistencies from one pay period to the next.

Opportunity for Review

The AHA would like to reiterate that it is crucial that hospitals be afforded an opportunity to review the finalized occupational mix data they submit to ensure its accuracy, and to appeal incorrect information. Even though the current wage data has been collected for many years, more than 30 percent of hospitals had corrections in 2002. Given that this will be the first instance of new data collection, CMS must develop a detailed process to allow both hospitals and fiscal intermediaries to make corrections to submitted data, understanding that this process will require a sufficient amount of time to complete.

Summary

The AHA continues to have broad concerns about the validity of the data collected, the reliability of the occupational mix adjustment developed based on this data, and the financial impact it will have on hospitals' payment. Moving forward with an occupational mix adjustment must be done thoughtfully, meticulously and cautiously. We are very concerned that the timeframe for data collection and the subsequent adjustment to the hospital wage index is too compressed – leading to poor data collection, insufficient analysis of financial impact, lack of time to make corrections, and an inability for hospitals to prepare for and respond to potentially large swings in Medicare payment. Given the significance of this change, and the continued uncertainties around the data and the adjustment, a phase-in or transition period must be adopted. For example, the exclusion of resident and nurse anesthetists' costs from the wage index calculation was phased in from 1999 through 2002. Additionally, CMS may wish to consider a voluntary pilot study to better determine appropriate job categories that provide the agency with the data it needs, yet is the least burdensome for hospitals and brings tangible results about how the adjustment would impact types of hospitals.

The AHA appreciates the opportunity to submit our comments on the proposed rule. If you have any questions about these comments, please feel free to contact me or Ashley Thompson, senior associate director for policy, at (202) 626-2340.

Sincerely,

Rick Pollack
Executive Vice President