American Hospital Association

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December 8, 2005

Melissa Musotto
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Form Number: CMS-10079; Hospital Wage Index — Occupational Mix Survey and Supporting Regulations

Dear Ms. Musotto:

On behalf of the American Hospital Association's (AHA) 4,800 member hospitals, health care systems, and other health care organizations, and our 33,000 individual members, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) revised occupational mix survey, proposed on October 14 in the *Federal Register*.

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 inpatient area wage index. This adjustment controls for the effect of hospitals' employment choices – such as the use of registered nurses versus licensed practical nurses, or the employment of physicians – rather than geographic differences in the costs of labor. The next adjustment is proposed for fiscal year (FY) 2008.

While we appreciate CMS' efforts to streamline the survey, we have some concerns about the revisions. **The AHA is supportive of the reduced number of occupational categories that must be collected and the addition of wages to the collection. However, we do not support the new occupational functional subcategories and do not believe that the timing of the collection is appropriate.** We provide more detailed comments below.

Collection Period

CMS proposes that hospitals collect occupational mix data for a six-month period from January 1, 2006 through June 30, 2006. **The AHA is concerned about the proposed collection timeframe, as the final survey likely will not be published until after the collection period**

begins. The delayed publication of the revised survey will again preclude hospitals from making advanced preparations based on the final notice and force a retrospective collection for a portion of the period. The AHA has repeatedly requested advance notice of the collection period and survey requirements in order to educate hospitals and improve the results of the collection. In the FY 2005 inpatient prospective payment system (PPS) final rule, CMS stated, "We also plan in future years to provide the next survey to hospitals prior to the period that the data collection begins." CMS further stated that a "60-day preparation period appears reasonable." Yet, CMS has again released this survey without allowing for an appropriate preparation phase.

Understanding that this cannot be rectified at this point, the AHA nevertheless recommends that CMS begin the collection January 1, 2006 as proposed. **However, we suggest that the collection continue until December 31, 2006 instead of June 30, 2006 as proposed.** We agree with CMS' statement in the FY 2005 inpatient PPS final rule that the "optimum data" would reflect wages and hours from a one-year period for all hospitals. This would ensure that seasonal and other variations do not skew the results and that the data collected would easily tie back to the payroll system. From speaking with many of our members, we understand that the collection of one year's worth of data is not significantly more burdensome than six months'. In addition, we believe a one-year timeframe will improve the accuracy of the data, as it can be compared with W-2 and other Internal Revenue Service (IRS) filings.

Collection of Wages and Hours

The proposed survey would require hospitals to include both the paid hours associated with the employees in question and the wages paid. **The AHA supports the addition of wages to the survey.** We believe there is value in calculating the national average hourly wage rates based on wage data collected at the same time as the hours paid, and that this data will improve the soundness of the occupational mix adjustment to the inpatient area wage index.

However, the AHA continues to have concerns, as expressed in the past, about using the U.S. Bureau of Labor Statistics (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 represent results from only a sample of hospitals. While BLS has in the past indicated an overall response rate of 76 percent for its surveys, the response rate is for the OES survey for hospitals in particular is unclear. 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 and units may differ significantly from that of short-term acute care facilities. Third, the OES survey includes critical access hospitals, but 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 survey collects data on full- and part-time employees, but excludes contracted labor. This may result in significantly different average hourly wages. Additionally, the OES survey collects information for one pay period in November (we would expect CMS to use the 2004 survey results). As a result, the BLS timeframe would not match the CMS-proposed, six-month period of January 1, 2006 through

June 30, 2006 or the AHA-recommended one-year period, potentially resulting in distorted information.

A comparison of the hours in the last collection to the BLS hours shows some discrepancies, calling into question the appropriateness of using that data source as a national standard. Attached to this letter is a table showing the variance between the hours reported by hospitals during the 2003/2004 collection and the 2001 BLS data. For instance, there was a 46 percent variance between the two data sets on medical assistants and a 25 percent variance on LPNs. This comparison does not tell us which collection was more accurate; however, using the wages from the same collection will at least increase the likelihood that we are comparing apples to apples.

Occupational Categories
The 2003/2004 occupational mix survey used occupational categories and definitions from the 2001 BLS OES survey, based on its standard occupational categories (SOCs). The survey collected data in seven categories – nursing, physical therapy, occupational therapy, respiratory therapy, medical and clinical laboratory, dietary, and pharmacy – broken down into 19 subcategories, plus an "all other" category. For the upcoming collection, CMS is proposing to collect data on only the nursing category, plus an "all other" category.

Specifically, CMS is proposing to collect the following categories and associated definitions:

- ***Registered Nurses (RNs, SOC 29-1111)*** - Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required. RNs who have specialized formal, post-basic education and who function in highly autonomous and specialized roles, maybe assigned a variety of roles such as staff nurse, advanced practice nurse, case manager, nursing educator, infection control nurse, performance improvement nurse, and community health nurse. **Exclude from the survey advance practice nurses (nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists) that are paid under a Part B fee schedule and not the IPPS.**

  Functional Subcategories:

  - ***Nursing Administrator/Director*** – Provide leadership for nursing practice, policy, and programs. Participate in strategic planning, resource allocation and evaluation processes that impact the delivery of services to patients. Assist in the coordination of medical and nursing services. Assign duties to professional and ancillary nursing personnel based on resident needs, available staff and unit needs. Supervise the maintenance of patient nursing records and reports. Requisitions and distributes clinic supplies and equipment.
  - ***Nurse Supervisor/Head Nurse*** – Direct nursing activities. Plan work schedules and

assign duties to nurses and aides, provide or arrange for training, and visit patients to observe nurses and to ensure that the patients receive proper care. May ensure that records are maintained and equipment and supplies are ordered.

- ***Staff Nurse/Clinician*** – Provide direct patient care based on scientific knowledge and standardized care plans. At the intermediate level, may become more skilled in developing individual care plans to meet patient needs. At the advanced level, may provide care for patients with more complex and unpredictable medical conditions.

- ***Licensed Practical Nurses*** **(LPNs, SOC 29-2061) –** Care for ill, injured, convalescent, or disabled persons in hospitals, nursing homes, clinics, private homes, group homes, and similar institutions. Most LPNs provide basic bedside care, such as vital signs as temperature, blood pressure, pulse, and respiration. May work under the supervision of a registered nurse. Some more experienced LPNs supervise nursing assistants and aides. Licensing is required after the completion of a state-approved practical nursing program.

  Functional Subcategories:

  - ***Nursing Administrator/Director***
  - ***Nurse Supervisor/Head Nurse***
  - ***Staff Nurse/Clinician***
    (See definitions above under RNs)

- ***Nursing Aides, Orderlies, & Attendants*** **(SOC 31-1012) -** Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.

  Examples: Certified Nursing Assistant; Hospital Aide; Infirmary Attendant.

- ***Medical Assistants*** **(SOC 31-9092) -** Performs administrative and certain clinical duties under the direction of physician. Administrative duties may include scheduling appointments, maintaining medical records, billing, and coding for insurance purposes. Clinical duties may include taking and recording vital signs and medical histories, preparing patients for examination, drawing blood, and administering medications as directed by physician. Exclude "Physician Assistants" (29-1071).

  Example: Morgue Attendant; Ophthalmic Aide; Physicians Aide.

<u>Reduction of Categories</u>
As we understand from discussions with CMS and our own analyses of the 2003/2004 occupational mix data, the additional occupational categories collected under the 2003/2004 survey have only a minimal affect on the adjustment. **Given the percentages for each of the former categories laid out in the FY 2006 inpatient PPS final rule, we agree that continuing to collect these categories is unnecessary and that they should be subsumed into the "all**

other" category. In addition, we caution CMS not to entertain additional categories, as hospitals will have no warning and will not have made preparations in their contracts or payroll systems to accommodate such changes.

Nursing

We do not support CMS' addition of the functional subcategories to the RN and LPN categories and suggest that CMS remove them. It is our understanding that it would be beyond the scope of practice for an LPN to function in the Nurse Administrator or Nurse Supervisor role in most states. In addition, such subcategories would be difficult for providers to distinguish between, decreasing the reliability of the data. For instance, it is unclear in which subcategory charge nurses should be included. This is a very common title and illustrates the lack of clarity in the functional subcategory definitions. We further question the functional subcategories chosen. The management positions that are specified represent a small portion of the nursing staff, with the bulk of nurses falling into the staff nurse/clinician subcategory. We do not believe that this level of specificity will greatly alter the adjustment. Moreover, it will add uncertainty and additional burden to the collection.

Medical Assistants

We find the definition of medical assistants problematic. If hospitals consider only this definition, we would expect wide variation across hospitals as to who would be considered a medical assistant and fear hospitals may inappropriately include too many employees in this category. For example, the definition mentions drawing blood, but we do not believe that phlebotomists should be included in this category. The definition also mentions that administrative duties may include scheduling appointments, maintaining medical records, billing and coding for insurance purposes. Hospitals may conclude from this that their Health Information Management staff should be included in this category. Others have expressed confusion over the description of personnel dispensing drugs. Thus, we recommend that CMS add clarifying language to this definition.

All Other

The AHA continues to support the "all other" category, which includes all hospital employees not otherwise delineated. This helps ensure that the data collected is accurate, and that it can be reconciled to the total number of employees on a hospital's general ledger, W-2 and other externally reported data.

Covered Employees

Nurses in Non-Traditional Areas

Nurses are prevalent throughout hospitals, from direct patient care roles to senior management positions. For example, some RNs may work in "overhead" departments or act as executives. As proposed, the new survey is imprecise about how hospitals should report employees who have clinical degrees but are not involved in direct patient care. **The AHA recommends that hospitals report employees based on their function rather than their education.** A specialized degree may be required for some positions, but we believe that the collection should focus on traditional nursing areas of the hospitals. Nurses whose responsibilities are solely

administrative and do not directly supervise those who provide direct patient care should be included in the "all other" category.

To clearly delineate which employees should be captured in the collection, regardless of what subcategory they fall into, we suggest that CMS designate which cost centers, as defined for cost reporting purposes, should be included in the nursing category. Employees subject to this collection would fall into the "all other" category. The cost centers we recommend are included in Table 1 below. Following this recommendation causes no additional administrative burden on hospitals. Cost center information is readily available and is already used to identify excluded and general services areas. This will minimize the uncertainty of where to place nurses who work in the medical records, information systems and technology, quality or revenue integrity departments or as case managers, compliance officers, clinical resource managers or internal research board nurses.

Table 1

COST CENTER DESCRIPTIONS	
GENERAL SERVICE COST CENTERS	
14	Nursing Administration
25	Adults and Pediatrics (General Routine Care)
26	Intensive Care Unit
27	Coronary Care Unit
28	Burn Intensive Care Unit
29	Surgical Intensive Care Unit
30	Other Special Care (specify)
33	Nursery
37	Operating Room
38	Recovery Room
39	Delivery Room and Labor Room
61	Emergency
62	Observation Beds

At best, too much ambiguity in where to place employees would result in an inaccurate calculation of the occupational mix adjustment. At worst, CMS or the Office of Inspector General might view these errors as intentional and fraudulent. Thus, it is imperative that CMS clearly define not only the occupational categories, but the categorization of employees within

non-traditional areas of the hospital as well to ensure that hospitals are as consistent as possible in their responses.

General Services Allocation

CMS has indicated that hospitals may apply an allocation methodology that is similar to the methodology used in the wage index calculation for allocating general service salaries and hours to excluded areas. **We recommend that CMS set a definitive policy to ensure that the data submitted by different providers is comparable.** If CMS uses the cost center approach we have recommended, the only general services area remaining that would need to be allocated between the inpatient PPS areas and the excluded units would be Nursing Administration. We recommend that CMS use either a proxy proportion based on the last submitted cost report or total man hours.

Survey Due Date

CMS proposes that surveys be submitted to intermediaries by July 31, 2006, 31 days after the close of the collection period. **The AHA recommends a 90-day period to complete the survey, check it for accuracy and submit it to the fiscal intermediary.** Given that contract labor is included in the collection, providers need time to receive invoices from their contractors and integrate that information into their systems and thus, the collection. In addition, if CMS agrees to extend the collection period to December 31, 2006, providers that end their fiscal year on September 30 likely would not want to complete the occupational mix survey while also trying to complete their cost reports.

Data Audit Process

The AHA reiterates that it is crucial that hospitals be afforded an opportunity to review the finalized occupational mix data they submit to ensure its accuracy and 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. Furthermore, we encourage CMS to review the data initially submitted by hospitals for potential errors such as blank fields, values that are outside a normal range, inconsistencies with the prior collections, etc. Given that this is only the second collection of occupational mix data, we believe it is worth CMS' time to review the data and notify hospitals of potential problems. Hospitals should then be given the opportunity to correct the data in time for inclusion in an October public use file and fiscal intermediary desk audits. Such a process will not only improve the data quality, but the eventual adjustment as well.

Calculation
CMS has not disclosed what changes, if any, it would make to the adjustment calculation. Nonetheless, we would like to offer for CMS' consideration comments related to the calculation that may affect the structure of the form.

CMS states that home office wages and hours are not to be included in the survey. Currently, part of the occupational mix adjustment calculation involves taking the general service categories' wages and dividing that by total wages. If total wages comes from the survey, it would not include home office wages. Computing the calculation in this way overstates the general service categories' percentage of total, and therefore overstates the entire occupational mix adjustment for providers. If CMS does not change the current calculation, home office wages and hours will be improperly excluded from the occupational mix adjustment. Thus, the AHA believes that home office wages and hours should be included in the collection and the calculation.

Adjustment Timeline
The AHA strongly encourages CMS to refrain from using the newly collected data to update the wage index until the FY 2009 inpatient PPS update. We do not believe there is sufficient time to collect a robust data sample and thoroughly review it in time for the FY 2008 adjustment. We believe that this is within CMS' authority, as the statute states that the data must be *collected* every three years, which our proposed time frame would satisfy.

Contact Information
If you have any questions about this comment letter, please contact me or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Attachment

ATTACHMENT

Comparison of Occupational Mix Survey and BLS Survey Information

General Service Categories	Occupational Mix Survey (% Total Employee Hours)	BLS (% Total Employee Hours)	% Variance	Avg. Hr. Rate per BLS	%Variance to Overall Avg. Hr. Rate
Nursing Services and Medical Assistant Services					
Registered Nurses	26.23%	25.88%	1.35%	$ 23.62	18%
Licensed Practical Nurses	2.89%	3.86%	-25.13%	14.65	-27%
Nursing Aides, Orderlies, & Attendants	6.79%	6.96%	-2.44%	10.01	-50%
Medical Assistants	1.36%	0.93%	46.24%	11.79	-41%
Total	**37.27%**	**37.63%**	**-0.96%**		
Physical Therapy Services					
Physical Therapists	0.83%	0.92%	-9.78%	27.80	39%
Physical Therapist Assistants	0.32%	0.35%	-8.57%	17.11	-14%
Physical Therapist Aides	0.22%	0.24%	-8.33%	10.40	-48%
Total	**1.36%**	**1.50%**	**-9.33%**		
Occupational Therapy Services					
Occupation Therapists	0.35%	0.48%	-27.08%	25.62	28%
Occupation Therapist Assistants	0.08%	0.11%	-27.27%	16.81	-16%
Occupation Therapist Aides	0.03%	0.04%	-25.00%	11.60	-42%
Total	**0.46%**	**0.63%**	**-26.98%**		
Respiratory Therapy Services					
Respiratory Therapists	1.55%	1.36%	13.97%	19.26	-3%
Respiratory Therapy Technicians	0.39%	0.51%	-23.53%	16.96	-15%
Total	**1.94%**	**1.87%**	**3.74%**		

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Pharmacy Services					
Pharmacists	1.02%	0.96%	6.25%	34.58	73%
Pharmacy Technicians	1.01%	0.88%	14.77%	12.30	-38%
Pharmacy Assistants/Aides	0.08%	0.13%	-38.46%	11.52	-42%
Total	**2.11%**	**1.97%**	**7.11%**		
Dietary Services					
Dieticians	0.35%	0.33%	6.06%	20.02	0%
Dietetic Technicians	0.48%	0.26%	84.62%	11.64	-42%
Total	**0.84%**	**0.59%**	**42.37%**		
Medical & Clinical Lab Services					
Medical & Clinical Lab Technologists	2.14%	1.73%	23.70%	20.74	4%
Medical & Clinical Lab Technicians	1.97%	1.26%	56.35%	14.90	-25%
Total	**4.10%**	**2.99%**	**37.12%**		
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	**48.08%**	**47.19%**	**1.89%**		
All Other Occupations	**51.92%**	**52.81%**	**-1.69%**		
Total Hospital Employees	**100.00%**	**100.00%**	**0.00%**		