MEDPAC Medicare Payment Advisory Commission

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December 13, 2005

Melissa Musotto
Center 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 occupational mix survey

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to comment on your proposed changes to the occupational mix survey that will be used to adjust hospital wage index computations (as published in the October 14 *Federal Register*). We appreciate your staff's ongoing efforts to administer and improve the hospital wage index, particularly considering the agency's competing demands.

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 workers for all hospitals paid under the acute inpatient prospective payment system. This adjustment is intended to control for the effects of differences in the mix of workers among labor markets so as to ensure that the wage index solely reflects geographic differences in wage levels.

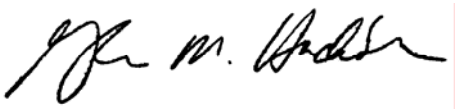
We are concerned about a mismatch between the type of hours and wages that hospitals report on their Medicare cost reports (which are used to compute the average hourly wage for each labor market area) and the type of hours and wages that hospitals will report on your proposed occupational mix survey (which will be used to adjust each area's average hourly wage for the mix of workers in the area). Under CMS policy, hospitals are permitted to exclude the hours and wages of non-patient-care contract labor from the data they report on their cost reports. Therefore, if a hospital contracts for its cleaning, maintenance, food service, or laundry workers (all low-wage workers), its reported average wage will be biased upward. The occupational mix survey cannot be used to correct for this distortion because it requires hospitals to include all contract labor in reporting hours and wages by occupation category. In other words, the survey will not reveal the occupational mix that lies behind the total wages and total number of hours reported in the cost report.

To fix this problem, the survey should be adjusted to exclude non-patient-care *contract* worker hours (so that it will match the cost report) and amended to add a new category on the survey for reporting *employee* hours in the categories most frequently contracted out—cleaning, maintenance, food service and laundry workers (BLS codes 37-0000 and 35-0000). These data would then be used to adjust upward the hospital-wide average wage for hospitals reporting a large share of these service workers (which would include hospitals that make little or no use of contract workers), and adjust downward the hospital-wide average wage for hospitals employing a small share of service workers (including hospitals that make extensive use of contract workers).

However, even with this one additional category, we are still concerned that the "other" category will remain large—consisting of roughly half of all employees. This remaining "other" category would include categories of personnel with widely divergent average wage levels, such as senior management, non-nursing professionals (pharmacists, therapists, laboratory technologists, etc.), technical, clerical, and other low-wage workers. We examined data from your first occupational survey and saw a moderate variation in the share of non-nursing professionals among labor market areas. Due to potential variation in the shares of various types of workers in the current "other" category, it would be preferable to have additional categories of employees (such as senior management, non-nursing professionals, technical, clerical, and other low-wage workers). These additional categories would reduce the risk of the wage index being distorted by differences in the occupational mix of workers within this large "other" category.

We appreciate the opportunity to comment on this issue. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman