

Comments to the Proposed 2006 Hospital Wage Index Occupational Mix Survey

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1. MedPAC Comments

Comment: MedPAC and another commenter expressed concern regarding the mismatch of data between Worksheet S-3 of the cost report and the occupational mix survey. The Committee noted that, under current CMS policy, hospitals exclude from the cost report the hours and wages for non patient care contract labor, while the occupational mix survey includes all contract labor. The Committee recommended that CMS revise the survey to exclude data for non patient care contract labor, so that the occupational mix data would match the cost report wage data. Additionally, the Committee recommended CMS to include on the survey a new category that would allow hospitals to report occupational mix data for directly hired employees in occupations that are most frequently contracted by hospitals (for example, cleaning, maintenance, food service, and laundry services). The Committee suggested that CMS could use this data to adjust for the disparity in average hourly wages between hospitals that contract and hospitals that hire employees for these lower paid services, adjusting the average hourly wage upward for hospitals reporting a large share of employees and downward for hospitals reporting a small share of employees.

Response: We recognize the current disparity between the occupational mix survey and the cost report wage data for non patient care contract labor. However, with

cost reporting periods beginning on or after October 1, 2003 (that is, beginning with the FY 2008 wage index), CMS is collecting cost report wage data on contract dietary, housekeeping, and administrative and general services (see 67 FR 50022 for a complete discussion of this policy). As a result, by the time we apply the 2006 occupational mix survey data to the FY 2008 wage index, there would be a match between the cost report wage data and the occupational mix survey data for a large portion of hospitals' non patient care contract labor costs. Additionally, the inclusion of non patient care contract labor costs in the cost report wage data will eliminate the disparity in average hourly wages between hospitals that contract and hospitals that hire employees for these lower paid general service occupations. Therefore, we disagree with MedPAC's recommendation to exclude non patient care contract labor data from the 2006 occupational mix survey, as the cost report has been revised, and is expected to undergo further modifications, to incrementally provide for the collection of non patient care contract labor data.

Comment: MedPAC recommended that CMS split the "all other occupations" category into smaller categories, such as senior management, non-nursing professionals, technical, clerical, and other low wage workers. The Committee suggested that a breakout of the "all other" category into smaller specified categories could reduce the risk of the wage index being distorted by regional differences in the occupational mix of hospital workers, as the Committee's analysis of BLS data demonstrates there is a moderate variation across labor market areas in the occupational mix of non-nursing personnel. The Committee expressed concern that the overall large size of the "all other"

category (approximately 60 percent nationally), relative to the smaller size of the nursing category (approximately 40 percent nationally), significantly impacts the occupational mix adjustment, so data accuracy and consistency in the “all other” category is crucial.

Response: We agree with MedPAC that the “all other occupations” category includes a large number of employees and, therefore, could have a significant impact on the wage index, making accurate and consistent reporting in this field critical to the accuracy of the occupational mix adjustment. However, we do not believe that a further breakout of this category, and the associated increased reporting burden for hospitals, is warranted. Consistent with the application of the 2003 survey results, we intend to use the 2006 data in the “all other” category for the sole purpose of determining a hospital’s ratio of workers in its nursing categories to its total workforce that are included in the wage index. We would then apply the occupational mix adjustment to only the portion of the hospital’s wage data that represents nursing occupations (approximately 40 percent of total staff hours). Rather than expand the survey as MedPAC recommends, and consequently increase hospitals’ reporting burden, we are revising the final 2006 survey to more clearly define the collective occupations that are to be included in “all other”. This clarification is based largely on suggestions we received from other commenters, including several national and state hospital associations. We believe that a clearer definition for “all other occupations” should achieve the same goal as MedPAC’s suggestion, that is, to produce more accurate and consistent reporting in the “all other occupations” category.

2. Survey Reporting Period, Due Date, and Implementation

Comment: Several commenters noted that in the FY 2005 hospital inpatient prospective payment system (IPPS) final rule [69 FR 49036, August 11, 2004], we assured hospitals that they would have at least 60 days' notice before the effective date of a new survey. The commenters argued that the proposed begin date of January 1, 2006 for the new survey is not at least 60 days from the date of publication of this final survey. As a result, hospitals would be precluded from making advanced preparations based on the final survey and would have to collect data retrospectively for a portion of the period.

Response: In the FY 2005 final rule [69 FR 49036, August 11, 2004], we stated that a "60-day preparation period appears reasonable" for hospitals to prepare for the new survey, and that "we will consider such a schedule for future occupational mix data collections." However, given the limited amount of time available to fulfill the statutory requirement to collect occupational mix data at least every 3 years, we were not able to publish the proposed survey prior to October 2005. We published the proposed survey on October 14, 2005, and the survey period began on January 1, 2006. Hospitals have had more 60 days to prepare for this occupational mix data collection. We believe the time period between the proposed paperwork collection and the begin date of survey period constitutes adequate notice for hospitals to prepare for the new survey.

Comment: Most commenters expressed concern that the proposed 6-month prospective reporting period for the 2006 survey may not accurately reflect a hospital's employment due to seasonal variations in staffing levels. The commenters urged CMS to extend the reporting period to 12 months, through December 31, 2006. The commenters

also stated that a 12-month reporting period would allow hospitals to report more accurate survey data and provide more time for hospitals to work with their contractors to collect the necessary data from invoices. Additionally, commenters recommended that CMS extend the proposed deadline for hospitals to submit their completed surveys to their intermediaries from 30 days to 60 or 90 days. The commenters were concerned that 30 days would not be sufficient time for providers to compile, review, and ensure the accuracy of their survey data. One commenter added that a 30-day submission period is particularly unreasonable for many teaching hospitals that have a fiscal year that ends on June 30th. The commenters recommended that CMS extend the data collection period from 6 to 12 months and apply the 2006 survey results beginning with the FY 2009 wage index rather than with FY 2008. The commenters indicated that the statute allows for a 12-month data collection period and application of the next occupational mix adjustment in FY 2009. They stated that Section 304 (c) of Public Law 106-554 requires CMS to *collect* data every three years on the occupational mix of employees, but does not indicate when the updated adjustment must be *applied* other than for the FY 2005 wage index.

Response: We proposed a 6-month prospective reporting period and a 30-day submission period in order to allow the 2006 survey to be administered and completed in time for application to the FY 2008 wage index. We understand the commenters concerns and appreciate hospitals' willingness to collect a complete year's worth of data in order to achieve what they believe would be more accurate survey results. Section 304(c) of BIPA 2000 requires CMS to collect occupational mix data at least once every 3 years. We believe that, in addition to collecting occupational mix data, it also is appropriate to update the occupational mix adjustment at least once every three years.

Therefore, we plan to apply the new 2006 survey beginning with the FY 2008 wage index, as the original measure of occupational mix (based on the 2003 survey) was applied beginning with the FY 2005 wage index.

We note that we are allowing some flexibility for the reporting period begin and end dates to accommodate some hospitals' bi-weekly payroll and reporting systems. That is, the 6-month reporting period must begin on or after January 1, 2006 and before January 9, 2006, and must end on or after June 30, 2006 and before July 9, 2006.

Comment: Several commenters were concerned that the reporting period for the occupational mix survey (in this case, the first 6 months of calendar year 2006) does not match the cost reporting years used to compute the wage index. The commenters urged CMS to consider using the cost report to collect occupational mix data, so that the cost report wage data and the occupational mix data would be aligned.

Response: We stated in the FY 2005 final rule (69 FR 49048), that "we will assess whether future occupational mix surveys should be based on the calendar year or if the data should be collected on the fiscal year basis as part of the Medicare cost report." We agree that, ideally, the cost report should be modified to accommodate the collection of occupational mix data. However, considering that the occupational mix adjustment is still relatively new, and we are still working on refining what types of data should be reported on the survey, we believe it is premature to modify the cost report at this point. Therefore, we believe a separate occupational mix survey form and process for the 2006 collection is still appropriate.

3. Survey Data

Comment: Most commenters, including two national hospital associations, supported CMS's proposal to collect both paid wages and hours data to compute hospital-specific weighted average hourly rates for the occupational mix adjustment. The commenters believe that collecting actual wage data from hospitals would be a sounder approach than using the BLS national average hourly rates that may be more or less than a specific hospital's wages. The commenters also stated that the collection of both paid wages and hours data makes the occupational mix survey data more comparable to the cost report data that are collected for the unadjusted wage index. However, one state hospital association strongly opposed CMS' proposal to collect data on paid wages for the occupational mix adjustment, requesting instead that CMS continue to use the BLS national average hourly rates to estimate hospitals' weighted average hourly rates. The commenter was concerned that the collection of wage data would be an additional burden to hospitals and that, with the collection period beginning January 1, 2006, hospitals would not have enough time to evaluate and implement systems that would report accurate wage information.

Response: We are pleased that most commenters support our proposal to collect both paid wages and hours data on the 2006 occupational mix survey, as we believe that the ability to compute a hospital's actual weighted average hourly rate will improve the accuracy of the occupational mix adjustment. In the FY 2005 final rule (69 FR 49048), we acknowledged the shortcomings of using the BLS survey data (for example, hospitals may pay wages above or below the national average hourly rates reflected in the BLS

data; the data for the BLS survey and the CMS wage index are not perfectly matched). We also noted our intent to collect both wages and hours in computing the weighted average hourly rates for the occupational mix adjustment for the 2003 survey. However, due to time constraints for collecting the data for the 2003 survey, and to reduce hospitals' reporting burden associated with the initial collection of the data, we instead used the BLS survey as a national standard for average hourly rates by occupation. We stated explicitly in the FY 2005 final rule (August 11, 2004) that, for future occupational mix surveys, we would collect both wages and hours data. Therefore, we disagree with the commenter that hospitals would not have adequate time to develop and implement systems for collecting wage information for the 2006 survey because hospitals have been aware of our intent to collect wages and hours for the occupational mix survey as early as August, 2004. We also do not believe that the collection of wage data on the occupational mix survey should significantly increase hospitals' reporting burden, as we have concurrently reduced the occupational categories on the survey. Accordingly, we are finalizing our proposal to collect both hours and salaries data on the 2006 occupational mix survey.

Comment: Overall, commenters agreed with our proposal to eliminate the categories of health care personnel that have a minimal effect on the occupational mix adjustment. One commenter cautioned CMS not to add additional categories in the final notice, as there would be insufficient time between publication of the final occupational mix survey and the data collection period for hospitals to be able to modify their data systems to collect additional occupational data. . Most commenters did not support our

proposed addition of functional subcategories to the RN and LPN categories, and requested that we remove them. The commenters believe that the additional subcategories add uncertainty and burden to the data collection process. The commenters advised that the new subcategories would not have enough hours to materially affect the occupational mix adjustment. In particular, RN managers represent only a small portion of nursing staff. Most RNs are staff nurses or clinicians. Further, the commenters stated it is generally beyond the scope of practice for an LPN to function in the role of a Nurse Administrator or Supervisor. For these reasons, the commenters suggested that we remove the subcategories from the RN and LPN categories.

Another group of commenters suggested that the sub-categorization of RNs should be simplified into two categories instead of three: Management Personnel and Staff Nurse/Clinician. This option would help account for RNs that provide both management and patient care services.

Response: We appreciate the commenters' support for our proposal to remove those categories that have minimal effect on the occupational mix adjustment. We agree with the commenters' that there are too few hours in the RN and LPN subcategories to have a material effect on the occupational mix adjustment. In order to streamline the survey and eliminate unnecessary or overlapping functional subcategories, we are reducing the number of functional sub-categories under RNs from three in the proposed survey to two in the final survey, as suggested by one group of commenters. Specifically, the final survey will have only two functional RN subcategories: Management Personnel and Staff/Nurse Clinician. On the survey, we are blending the existing definitions of Nursing Administrator/Director and Nurse Supervisor/Head Nurse to make the new RN

sub-category of Management Personnel. Accordingly, the wages and hours of nurses that function in an administrative, leadership, or supervisory role, *and that also provide supervision to staff nurses that are involved in direct patient care and/or provide direct patient care themselves*, are to be reported by hospitals under the RN sub-category of Management Personnel. However, the wages and hours of nurses that function in *solely* administrative or leadership roles (that is, they *do not directly supervise staff nurses that provide direct patient care and do not provide any direct patient care themselves*) are to be reported in the “All Other Occupations” category. (Note that if a nurse provides services in both the areas of the hospital included in the wage index and in excluded areas, only the portion of the nurse’s salaries and hours attributable to the areas of the hospital included in the wage index should be reported on the occupational mix survey). We also note that we are deleting the phrase, “Requisitions and distributes clinic supplies and equipment” from the definition of *Nursing Administrator/Director* because we have since learned that this task is not typically done by Nursing Administrators or Directors. Additionally, we are changing our definition of Staff Nurse/Clinician to specify that Charge Nurses are to be included in this category. Further, we agree that LPNs are unlikely to act in an administrative or supervisory role, and therefore, we are removing the proposed functional sub-categories under LPN. The final survey includes only the single general category for LPNs.

Comment: We received several comments stating that, to avoid confusion as to whether nurses acting in nontraditional roles should be classified as RNs or as “All Other” on the survey, we should limit the nursing categories to include only nurses

providing traditional nursing activities. The commenters suggested that wage and hour data for nurses working in the following areas should be excluded from the nursing category on the survey: Health Information Management (in many cases the HIM director), Information Systems, Risk Management, Compliance Officers, Internal Research Board, Quality Department, Revenue Integrity, Admitting Department, and Case Management. The commenters also strongly recommended that CMS apply existing Medicare cost report definitions to the occupational mix survey. The Medicare cost report definitions are readily available to use for determining whether nurses are working in general service areas that are included in the occupational mix survey or IPPS exempt areas that are excluded. Specifically, the commenters recommended that only nurses working in the following cost centers should be included in the nursing category of the survey:

COST CENTER DESCRIPTIONS

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

Note: Subscripted cost centers that would normally fall into one of these cost centers would be included in the survey.

The commenters do not believe that Cost Center 60 – Clinics, should be on the list, because the “majority of hospitals do not have clinic activity,” and excluding nurses in

this cost center would “make the nursing wage and hour data more consistent.” In general, the commenters stressed using Medicare cost report instructions will obviate the need for CMS to provide explicit instructions for the proper reporting of nursing personnel and allocation of wages and hours of personnel who work in both acute care and excluded areas.

Response: As we discussed in a previous comment, we are not limiting the nursing category to include only nurses that act in traditional nursing roles because we believe that nurses that function in both administrative and clinical capacities should also be included in the nursing category. If a nurse provides both administrative and clinical services, the nurse would be included in the RN Management Personnel subcategory. If a nurse functions only in an administrative capacity and does not supervise nurses who provide patient care services, the nurse’s wages and hours would be included in the “All Other Occupations” category. We agree with the commenters that suggested we use Medicare cost reporting instructions for determining how the RN and LPN categories should be reported on the occupational mix survey.. Therefore, only RNs and LPNs working in the following cost centers would be included in the nursing categories of the survey:

COST CENTER DESCRIPTIONS

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
60	Clinics
61	Emergency
62	Observation Beds

Note: Subscripted cost centers that would normally fall into one of these cost centers would be included in the survey.

Accordingly, the wages and hours of RNs, Nursing Aides, Orderlies, and Attendants, MAs, and LPNs working in any of these cost centers would be included in the appropriate category or subcategory of the revised occupational mix survey. If these employees work both in the cost centers listed above, and in IPPS-excluded areas of the hospital, only the wages and hours of these employees that are attributable to time spent in the above cost centers would be included in the appropriate subcategory. Wages and hours attributable to excluded areas of the hospital must not be included anywhere in the occupational mix survey. RNs whose roles are solely administrative, as well as other non-nursing employees who work in the above cost centers (unless excluded from the wage index; for example, Cranes, interns and residents) are to be reported in the “All Other Occupations” category.

We disagree with the commenters’ that suggested Cost Center 60 – Clinics, should not be on the list. Line 60 is reserved for certain provider-based clinics, which are treated as part of the hospital’s outpatient department and are commonly found in many hospitals. Since the wages and hours of employees working in the outpatient departments of hospitals are included in the wage index, we believe it is appropriate to include nursing personnel working in provider-based clinics in their appropriate subcategory on the occupational mix survey.

Comment: Several commenters were concerned that the instructions on the proposed survey related to the wages and hours of employees in general services overhead cost centers are too imprecise and can introduce inconsistencies in the reporting of the data. One commenter recommended that, rather than saying hospitals “*may* apply an allocation method similar to the methodology used in the wage index calculation,” we should require one consistent method. Other commenters noted that Nursing Administration will be the only general service category that will have to be allocated between IPPS acute care and excluded areas if CMS were to require that cost center definitions for staff allocations in the occupational mix survey. In this case, the commenters suggested that CMS specify that the wages and hours attributable to Nursing Administration be allocated either based on the method from the latest filed cost report or based on total hours. The commenters added that hospitals should be able to document the details of their allocation to their fiscal intermediaries if necessary.

Response: We agree with the commenters and are revising the instructions for allocating general service costs as recommended. As we have stated in our response to the previous comment, we are adopting the Medicare cost report center definitions to determine which nursing personnel should be included in the RN category. We are also specifying in the final 2006 survey that hospitals must use the same methodology for allocating the wages and hours of employees who work in both allowable and excluded areas on the occupational mix survey that they use to complete Worksheet S-3 Parts II and III on the Medicare cost report.

Comment: Some commenters believed that, although CMS is using only a handful of BLS classifications to define the occupational mix categories, the more than 300 definitions available for use under the BLS may still cause confusion among hospitals, particularly in the proposed categories of Medical Assistants (MAs). The commenters noted that the definition of MAs is fairly broad, and mentions activities such as drawing blood, scheduling appointments, and billing and coding for insurance purposes. The commenters were concerned that MAs are intended to be a subcategory of nurses but the BLS' definition could be interpreted to include *non-nursing* personnel, such as phlebotomists, health information management ("HIM") and information technology ("IT) personnel, and business office personnel. The commenters requested that CMS clarify the definition of MAs.

Response: In the proposed definition of MAs, which is based on the BLS' definition, we stated clearly that an MA is an employee that "performs administrative and certain clinical duties *under the direction of a physician*" (emphasis added). Phlebotomists and most business office IT/HIM or clerical personnel may interact with physicians but, unlike nurses, they do not perform their duties "under the direction of a physician." We will note on the revised survey that these employees would *not* be categorized as MAs. Rather, only those employees that perform administrative and certain clinical functions under the direction of a physician (i.e., the activities are medical in nature and ordered by a physician) in the IPPS acute care and outpatient areas of the hospital would be reported as MAs on the occupational mix survey. [We note that, the salaries and hours for phlebotomists, HIM/IT personnel, and business office personnel

who work in IPPS and outpatient areas of the hospital would be reported in the “All Other Occupations” category.]

Comment: One commenter said the new survey is not clear regarding how hospitals should report employees who have clinical degrees but are not involved in direct patient care, such as RNs who work in “overhead” departments or act as executives. The commenter recommended that hospitals report employees based on their function, not on their education, so that nurses whose responsibilities are solely administrative and do not involve supervision of staff nurses who provide patient care would be included in the “all other” category.

Response: We agree with the commenter’s recommendation, and added the functional subcategories in the proposed survey so that hospitals would focus on the type of work a nurse actually performs, rather than the nurse’s level of education. Consistent with our response to previous comments the wages and hours for a nurse that performs solely administrative duties should be reported in the “All Other Occupations” category. Nurses providing direct patient care, supervising staff nurses who provide direct patient and also serving in an administrative role should be reported under RN Management Personnel. In addition, we are modifying our definition of “All Other Occupations” to include nurses whose responsibilities are solely administrative and do not directly supervise those who provide direct patient care, or do not furnish patient care themselves.

Comment: A commenter opposes the addition of functional subcategories to the RN and LPN categories because there are mandatory nurse-staffing ratios for inpatient

facilities in some states. The commenter explained that hospitals in states with mandatory nurse-staffing ratios will be adversely affected by the additional subcategories because they have more nursing employees.. Another commenter stated that generally, the survey fails to reflect individual state requirements, such as mandated nurse staffing ratios. Another commenter expressed concern that data generated by hospitals in these states could skew national averages and affect hospitals in other states, and urged CMS to “devote special attention” to this matter and “explore its impact” on the occupational mix adjustment.

Response: We understand that the first commenter might be concerned that hospitals in a state that has mandatory nurse-staffing ratios could be negatively affected by the occupational mix adjustment due to a relatively higher number of RNs. However, we do not believe that the addition of the functional subcategories would exaggerate the effect of occupational mix adjustment on these hospitals. Nevertheless, we hope the commenter’s concerns will be ameliorated by our decision to streamline the functional RN subcategories to RN Management Personnel, and Staff Nurse/Clinician. Further, since there are relatively fewer Nurse Administrators compared to staff nurses, we do not believe that the subcategory of RN Management Personnel will significantly affect the overall occupational mix adjustment for hospitals in states with mandated nurse staffing ratios. Finally, to address the commenter’s concern about taking individual state requirements into account in applying the occupational mix adjustment, the statute requires us to construct an occupational mix adjustment in the hospital wage index to better reflect differences in average hourly wages once we control for the effect of employment decisions (regardless of the reason) on a hospital’s average hourly wage.

For this reason, we do not believe that the occupational mix adjustment should take into account state laws that mandate nurse staffing ratios.

Comment: One commenter was concerned that hospitals may be confused as to where to categorize “charge nurses”, and that CMS should give specific directions for classifying these staff. The commenter believes that these nurses receive a differential for supervising a shift but still provide direct patient care and should be categorized as staff nurses. The commenter also suggested that an “all other nursing” sub-category be made within the overall category of RNs to account for personnel in the allowable cost centers, but that are not classified into the other categories or sub-categories. Although the commenter does not believe the wages and hours of these “all other” nurses should be included in the occupational mix calculation, they believe that their data should be collected for informational purposes to possibly refine the survey in the future, and to assist the fiscal intermediaries when performing reasonableness testing on the nursing hours.

Response: We agree that charge nurses should be categorized as Staff Nurse/Clinician. Even though charge nurses have some supervisory responsibilities, their supervisory roles are more limited in scope and duration than other RNs who would be included in the Personnel Management subcategory. Accordingly, we are clarifying that our definition of Staff Nurse/Clinician includes “charge nurses” in the final 2006 survey.

We disagree with the commenter’s request to add an “all other nursing” subcategory within the RN category. The commenter did not specify the types of nurses would go into this “all other nursing” subcategory, and we believe the addition of this

category would only generate more confusion as to the types of nurses that should be reported there. Furthermore, we do not believe an “all other nursing” subcategory is necessary, as the RN Management Personnel and the Staff Nurse/Clinician subcategories should be all-inclusive for hospitals.

Comment: One commenter stated that it “continues to support the ‘all other’ category, which includes all hospital employees not otherwise delineated,” to allow the data to be reconciled to the total number of employees on the hospital’s general ledger, W-2, and other externally reported data.

Response: While we acknowledge the commenter’s support for our proposal to continue use of the “All Other Occupations” category, we would like to rectify a slight (and likely inadvertent) inaccuracy in the commenter’s statement. The commenter stated that the “all other” category includes all hospital employees not otherwise delineated, which seems to imply that the “all other” category includes all hospital employees that are not either nursing or a sub-category of nursing. In fact, consistent with the employees we include in the wage index, the “all other” category does not include all other non-nursing employees; rather, it only includes non-nursing employees in IPPS reimbursable cost centers and the outpatient department of the hospital.

Comment: Some commenters stated that home office wages and hours should be included in the survey, because otherwise, when dividing the general service categories’ wages by total wages, the general service categories’ percentage of the total is overstated. Thus, the overall occupational mix adjustment for providers is overstated as well. To

resolve this issue, the commenters recommended that CMS require submission of home office wage and hour data on a separate line of the survey, to assure that the home office data covers the same time period as the other wage data on the survey. Alternatively, hospitals could add their home office data from Worksheet S-3 Part II of the latest available Medicare cost report to the total wages and hours data on the survey before determining the nursing general service category's percent of the total. In either case, the commenters asserted that it is "critical" that home office wage and hour data be added to the total wages and hours on the survey to account for the fact that many hospitals conduct many support functions at the home office and not in-house. Another commenter asked that we include instructions on how to report the wages and hours of personnel from related parties.

Response: We agree that inclusion of wages and hours from the home office in a hospital's total wages and hours on the occupational mix survey will improve the accuracy of the survey results. However, we do not think it is necessary to require submission of home office data on a separate line of the survey, particularly since the majority of home office functions are administrative in nature would be reported in the "All Other Occupations" category. Furthermore, since home office data can apply across occupational categories, we do not believe that it should be reported separately on a single line. We also do not agree that hospitals should use the home office data reported on the latest available Medicare cost report. Rather, in order to maintain consistency and ensure that the home office data is from the same time period as the rest of the data on the survey, hospitals should collect wage and hour information for their home office and related party employees as part of the new occupational mix survey, and report the data in

the appropriate categories on the survey. That is, as stated above, while most of the home office personnel perform solely administrative functions, and will be reported in the “All Other Occupations” category, to the extent that there are home office personnel that are engaged in patient care activities, they would be reported in the appropriate nursing subcategory. Similarly, related party personnel should be reported in either the nursing category or the “All Other Occupations” category, depending on whether they provide patient care or function in a solely administrative capacity. We are revising the instructions on the final occupational mix survey regarding reporting of home office and related party data accordingly.

Comment: We received a few comments urging us to include separate survey pages for directly hired and contract employees, since it may be difficult for hospitals to accurately report data for contract labor. The commenters argued that, by requiring separate reporting, CMS will be able to analyze the reasonableness of such data for contract employees and make any appropriate adjustments. Another commenter asserted that requiring hospitals to report contract labor by the proposed subcategories will be problematic, as hospitals will have to rely on vendors, over whom they have no control, to properly identify the employee subcategories on their invoices.

Response: We do not agree that it is necessary for hospitals to report the costs separately on the occupational mix survey. Contract labor was included in the 2003 occupational mix survey, and has historically been included in the cost report wage data. Therefore, we believe that hospitals and their vendors have experience reporting this information and should have minimal difficulty providing contract data for the 2006

occupational mix survey. In fact, over the years, we expanded our definition of contract labor for the wage index, because hospitals and their associations convinced CMS that hospitals can more accurately report contract labor costs than in the past. Also, we note that we are revising the final 2006 survey to include only 2 subcategories for RNs, so it should be less problematic for hospitals to collect contract labor data at the subcategory level. Accordingly, we are requiring hospitals to report on the 2006 occupational mix survey the *combined* wage and hour data for their directly hired and contract employees.

Comment: One commenter stated that they did not oppose the addition of wages to the occupational mix survey. However, the commenter noted that the data for the occupational mix survey will be from a time period that is 4 years more recent than the data reported for the wage index. The commenter asked CMS to address how the data will be used in calculating the occupational mix adjustment and the wage index.

Response: The addition of hospital-specific wage data to the occupational mix survey replaces the BLS AHWs that were used to calculate the current occupational mix adjustment. Thus, in the new occupational mix survey, hospital-specific wage and hour data will be used to compute AHWs for each occupational category. We anticipate that using hospital-specific wage data will result in a more accurate and equitable occupational mix adjustment than the current one calculated using BLS data. We also note that the occupational mix data will not be four years ahead of the area wage data, as the commenter stated. The occupational mix survey data from 2006 will be used to adjust the FY 2008, FY 2009 and FY 2010 wage index that will be based on cost report data FY 2004, FY 2005 and FY 2006 respectively.

Comment: Some commenters said that the occupational mix form does not adequately address whether the wages and hours of the following employees are to be included in the “All Other Occupations” category, if at all: physicians services relative to Part A administrative functions, physician Part B services, interns and residents, and employees who work in non-reimbursable cost centers such as physician private offices.

Response: In the instructions for the occupational mix survey, we state that employees that are excluded from the wage index calculation must similarly be excluded from the occupational mix survey. Thus, wages and hours associated with administrative Part A physicians would be included in the “All Other Occupations” category, while physician Part B, interns and residents, and employees working in non-reimbursable cost centers must not be included anywhere in the occupational mix survey.

Comment: One commenter believed that, because the occupational mix survey only captures salaries and wages of employees, but excludes fringe benefits and other wage-related costs, there may be “significant distortions” in the wage index. The commenter argued that wage-related costs are an important part of the AHW, and there may be as much variation in benefit levels between providers as there is in wage levels. The commenter also argued that because fringe benefits (such as health insurance) are fixed amounts per employee, the benefits comprise a larger percentage of total compensation for lower-paid employees than for highly paid employees, resulting in an understatement on the survey of the average compensation of certain lower-paid occupational categories. The commenter recommended that the survey be revised to

incorporate wage-related costs, and that this would require estimates at the category level, since not all wage-related costs are employee-specific.

Response: We understand the commenter's concern that the occupational mix survey excludes wage-related costs, although the survey results are used to adjust salaries and wage-related costs in the wage index. However, we are not convinced that including wage-related costs in the occupational mix survey would result in a more accurate occupational mix adjustment to the wage index. As the commenter acknowledged, wage-related costs at the category level would have to be estimated, because hospitals' reporting systems typically do not provide actual data on wage-related costs by occupation. Also, including wage-related costs on the survey would significantly increase the reporting and documentation burden for hospitals and the review burden for intermediaries. However, we are uncertain as to whether the benefits of collecting the additional data would outweigh the associated burdens. An alternative approach would be to apply the occupational mix adjustment to the portion of the wage index that represents *only salaries* associated with the survey categories. Although we received no other comments on the exclusion of wage-related costs from the occupational mix survey, we will give further consideration to this matter after we collect and analyze the data from the 2006 survey.

Comment: A few commenters stated that some hospitals may not have data readily available in a format that would map hospital-specific job categories to the categories requested by CMS. The commenters noted that they will require the assistance

of their information system staff or payroll processing vendors to match data used for payroll and IRS purposes to the categories in the occupational mix survey.

Response: We understand the additional administrative responsibility that completing the occupational mix survey entails. We have attempted to minimize that burden for the 2006 survey by reducing the number of subcategories on the survey, and by extending the data collection period to 6 months, plus one additional month for hospitals to finalize their data, before submitting the completed surveys to their intermediaries. Hopefully, hospitals' can use their experience with the 2003 survey to help facilitate their preparation for the 2006 data collection.

Comment: A commenter representing rural hospitals argued that because the survey does not recognize ancillary services provided within rural hospitals, the survey does not collect data on the areas of the hospital where rural hospitals employ a less expensive labor mix through the use of technical assistants, such as in radiology, therapy, and laboratory departments. The commenters emphasized that they support a survey with expanded employment categories to recognize different staffing patterns in rural areas.

Response: We understand the rural hospitals' interest in including the less expensive labor mix typically employed in ancillary departments in the occupational mix survey, because generally, the lower a hospital's AHW, the higher the occupational mix adjustment. However, since these lower paid employees are a relatively small percentage of a hospital's labor mix, we do not believe that inclusion of these lower paid workers will have the desired effect of inflating the occupational mix adjustment of these rural hospitals. Furthermore, as we explained above, the purpose of the occupational mix

survey is not to emphasize the salaries of lower paid employees. Rather, the purpose of the occupational mix adjustment is to “standardize” each hospital’s AHW by controlling for the number of employees in a particular category a hospital employs, and ultimately reflect the relative salaries paid to those employees by each hospital. Accordingly, the occupational mix survey focuses on a group of employees (i.e., nursing occupations) where, because of some amount of overlap in skills between the various occupational levels (e.g., RNs and LPNs), management does have a certain amount of flexibility to decide on the number of employees at each skill level it will employ. Therefore, consistent with our decision in this final notice to streamline the survey and eliminate the functional subcategories, we are not implementing the commenter’s suggestion to include expanded employment categories.

Comment: Two commenters noted that on the proposed survey, ten categories are related to nurses. The commenters were skeptical as to how ten categories of nurse personnel are representative of the other hospital employees, and asked CMS to carefully consider the amount of an occupational mix adjustment that should be applied. Another commenter stated that if “the occupational mix survey is to accomplish its intended goal, it should not focus exclusively on nursing,” since there are other hospital personnel where there are “degrees” of professionals among staff (i.e., physical therapy, occupational therapy, laboratories, chemotherapy, pharmacy, imaging, and others). Yet another commenter was concerned that non-nursing staff, which comprise about 60 percent of hospital employees, “are not considered in this important adjustment factor.” The commenter stated that a growing number of non-nursing staff are “vital in impacting

quality of care particularly related to clinical management.” The commenter observed that the proposed BLS definition of “Registered Nurses” could also apply to pharmacists, dietitians, and nutritionists who currently advise patients on health maintenance and disease prevention, and provide case management for drug regimens or nutritional therapies. The commenter requested that we consider reinstating the pharmacy and dietary services occupational categories to the survey, and only include staff wage and hour information for those positions that provide services similar to those listed under the definitions for the proposed nursing category. Finally, a commenter posited that with the addition of collecting salaries data, the new occupational mix adjustment calculation will likely differ somewhat from the current occupational mix adjustment calculation. Since the impact of removing the smaller subcategories that were on the first survey “has yet to be quantified by CMS,” the commenter recommended that we continue to include those categories and subcategories that were on the original survey.

Response: As we mentioned previously, we are reducing the number of functional subcategories under RNs from three in the proposed survey to two in the final survey. Therefore, the final survey will consist of 5 categories in total: RN (which consists of 2 subcategories), LPN, Nursing Aides, Orderlies, & Attendants, Medical Assistants, and All Other Occupations. However, although the number of categories in the final survey is less than the number of categories in the proposed survey, the final survey still focuses on nurse personnel. This is because, as we indicated in the background information accompanying the proposed survey, nurse personnel comprise the single largest component of hospital employees that affect the wage index. Since most of the occupational mix adjustment is correlated with nurses, and because most

commenters in fact support the deletion of these smaller categories, we have decided to proceed with our proposal, and combine the general service categories of those employees that account for only a small percentage of a hospital's total hours with the "All Other Occupations" category. The fact that, as one of the commenters pointed out, the BLS definition of "Registered Nurses" can be interpreted to include tasks that are also performed by pharmacists, dieticians, or nutritionists does not mean that these employee categories should be reinstated in the survey. Typically an RN's job duties are distinct from other health care professionals, and while a hospital administrator might consider whether to hire an RN or an LPN to perform nursing duties, the hospital administrator would not normally consider hiring an RN or a pharmacist, for example, for the same position. Finally, as the last commenter noted, although we have not yet quantified the impact of deleting these non-nursing categories based on data from the new survey, we examined the impact of maintaining only the nursing categories on the average hourly wages of providers based on the data we currently have available from the 2003 survey, and we determined that almost all hospitals experienced less than a one percent change in their wage index values. Thus, we expect that the occupational mix adjustment will "accomplish its intended goal" despite the exclusion of the individual categories for non-nursing health care personnel. We will perform extensive analyses on the results of the 2006 survey.

Comment: One commenter noted that in contrast to the first occupational mix survey, CMS has specified that APNs should be excluded from the proposed new survey. The commenter understood CMS' rationale for excluding APNs as long as the services of

APNs are not billed for under Part B. However, the commenter stated that his hospitals employ hundreds of APNs, and they do not bill under Part B for their Medicare patients since the vast majority of their services are for non-Medicare managed care plans which do not recognize services provided by APNs, and it is not cost efficient for his hospitals to bill for, monitor, and collect payment on such a small portion of Medicare claims. The commenter argued that the APNs represent a true cost to the IPPS and should be included in the new occupational mix survey.

Response: We understand that there are a variety of often unique billing arrangements that hospitals have, not only with their APNs, but with physicians, and other personnel who are authorized to bill for their services under the Medicare Part B fee schedule. Consequently, we have chosen not to allow individual hospitals to include or exclude certain categories of employees from the occupational mix survey, depending upon how those employees would impact a hospital's occupational mix adjustment. We believe that it is prudent to apply consistent reporting rules to all hospitals. Therefore, in accordance with our longstanding policy to exclude the wages and hours of employees attributable to services payable under Part B from the wage index, we are requiring that APNs be excluded from the occupational mix survey.

4. Verification of the Survey Data

Comment: Several commenters urged CMS to provide a review and correction process for the occupational mix survey data that is similar to the process established for the cost report wage data. Commenters also recommended that CMS review hospitals'

survey data for potential errors, such as blank fields, values that are outside a normal range, and inconsistencies with the prior occupational mix survey collection. However, some commenters were concerned that CMS's estimate of 5 hours is insufficient for the amount of time intermediaries should spend reviewing each hospital's occupational mix data.

Response: We agree with the commenters that there should be a review and correction process for the occupational mix survey data. In fact, we plan to provide for a process that parallels the annual wage index development process and timetable. For example, CMS would publish both the preliminary cost report wage data and occupational mix data files on the Internet by early October. Hospitals would have until early December to request revisions to both their cost report wage data and occupational mix survey data. Intermediaries would have until mid-February to review and submit any revised cost report wage data and occupational mix survey data to CMS. We anticipate developing a review program for the occupational mix survey data that will be less extensive than the cost report wage data review program because it has far fewer data elements. Our best estimate is that it will take 5 hours for intermediaries to perform edits that would check for potential problems, such as, blank fields, values that exceed a normal range, and inconsistencies: within the survey data, with the prior survey collection, and with the cost report wage data totals. However, if necessary, we will revise the estimate, for future survey data collections if experience suggests that it will take the fiscal intermediaries longer than 5 hours to complete this process.

5. Calculation

Comment: Commenters “strongly encouraged” us to only apply the occupational mix adjustment to that percentage of employees that were actually placed in a specific nursing category, and not to employees in a miscellaneous or “All Other” category.

Response: Following the methodology of the existing occupational mix adjustment (70 FR 47367), we would apply the occupational mix adjustment derived from the 2006 survey only to the portion of a hospital’s wage costs that represents employees in the RN, LPN, Nursing Aides, Orderlies, and Attendants, and Medical Assistants categories. For example, if Hospital X’s nursing employees comprise 40 percent of its total employment on the 2006 survey, then we would adjust only 40 percent of Hospital X’s Worksheet S-3 salaries and wage-related costs for occupational mix. We are not adjusting the wage index for the occupational mix of employees reported in the “All Other Occupations” category.

Comment: Commenters requested that CMS provide a clear explanation of the calculation of the occupational mix adjustment, and give hospitals an opportunity to comment on it in the next IPPS proposed rule in the Spring of 2006. Commenters stated generally that because of the problems and unexpected results associated with the first occupational mix survey and adjustment, the preliminary survey results and methodology for computing the new occupational mix adjustment should be released for review and public comment. Another commenter was concerned that the proposed survey could have a “drastic” effect on hospitals, and recommended that CMS propose the occupational mix adjustment methodology in advance of the proposed IPPS rule and

provide hospitals with adequate time to provide comments. Other commenters were “opposed to the implementation of the revised survey without clear policy direction on the objective of the occupational mix adjustment, the specific methodology that will be utilized to determine the occupational mix adjustment and how it will be utilized by CMS to adjust the overall wage index.” Another commenter stated that CMS has not provided detail on how it intends to apply the occupational mix adjustment, making it impossible to analyze the impact of collecting data only for the nursing categories. One hospital commented, “Frankly, we will engage in this exercise because it is being mandated by the CMS. As a provider, we do not know the objective or the benefit to us as we expend valuable time required to gather this information.”

Response: We anticipate that the calculation of the new occupational mix adjustment will be very similar to the existing one which is explained in detail in the IPPS rules for FY 2005 and FY 2006 (see 69 FR 49042-3, August 11, 2004 and 70 FR 47367-8, August 12, 2005 respectively). However, we cannot be certain if and how the occupational mix adjustment calculation will change before we have the data. As we stated in response to other comments, we plan to provide for a process that parallels the annual wage index development process and timetable. For example, CMS would publish both the preliminary cost report wage data and occupational mix data files on the Internet by early October. Hospitals would have until early December to request revisions to both their cost report wage data and occupational mix survey data. Intermediaries would have until mid-February to review and submit any revised cost report wage data and occupational mix survey data to CMS. Therefore, there will be one schedule for calculating the wage index and occupational mix adjustment for FY 2008

and the earliest date that we will be able to provide an opportunity for public comment will be in the proposed FY 2008 IPPS rule scheduled for publication in April, 2007. Of course, there will be a 60-day public comment period on the FY 2008 IPPS proposed rule and we will give every public comment careful consideration before we announce our final policies and the occupational mix adjustment for FY 2008. Regarding the commenters who are opposed to implementation of the revised survey without clear direction as to the objective of the occupational mix adjustment, we have explained the purpose of the occupational mix adjustment in the initial survey (68 FR 54905, September 19, 2003) and January 23, 2004 (Pub. 100-20, R47OTN), and the IPPS final rules for FY 2005 and FY 2006 (, 69 FR 49034, and 70 FR 47365, respectively), and the second proposed survey (70 FR 60092, October 14, 2005). In response to the commenter's assertion that it will "engage in this exercise because it is being mandated by the CMS," we note that Section 304(c) of BIPA requires CMS to collect data on the occupational mix of employees for each IPPS hospital to construct an occupational mix adjustment in the hospital area wage index. As we explained in the various notices listed above, although there may be multiple factors which influence hospitals' hiring decisions, the primary purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. To a certain extent, the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

Comment: A number of commenters suggested that, if there are any data quality concerns, or if the changes to the new occupational mix adjustment are significant enough to warrant a transition period, then we should implement only a percentage of the occupational mix adjustment.

Response: When we first implemented the occupational mix adjustment for the FY 2005 wage index, we explained in the FY 2005 IPPS final rule (69 FR 49052, August 11, 2004) that we decided to implement only 10 percent of the occupational mix adjustment in order to minimize its redistributive effects. For the initial occupational mix adjustment, we were concerned that the data had not been previously and collected and we had no baseline information to use as a basis for auditing the data. We were also concerned that hospitals had a short timeframe to prepare and collect the survey data. For these reasons, we believed it was appropriate to implement only a portion of the occupational mix adjustment. However, given the improvements that we made to the 2006 survey and the timeframe for completing the collection, we anticipate that these problems will be mitigated, if not entirely eliminated. We also plan to implement a review program for the occupational mix data. Nevertheless, we expect to perform extensive analysis on the results of the new survey, and will consider phasing in, or implementing a portion of, the new occupational mix adjustment, only if warranted.

6. Miscellaneous

Comment: Several commenters, including a national hospital association, indicated that they oppose the occupational mix adjustment. The commenters believe

that the adjustment has resulted in positive results for certain large metropolitan areas and negative results for a significant number of rural areas inconsistent with its intended purpose. The commenters are concerned that the occupational mix adjustment does not achieve Congress' goal of assisting rural hospitals. Some commenters also believe that there is no need for an occupational mix adjustment because the unadjusted wage index sufficiently accounts for regional salary differences and employment decisions reflect the types and levels of services each facility provides and are accounted for in the hospital's DRG payments. According to these commenters, hospitals should not be penalized for employing higher cost labor needed to treat patients that, on average, have a higher case mix. The commenters concluded that hospitals are responsible for managing their employment mix, and that CMS should not make an additional payment adjustment for management practices. The commenters recommended that CMS seek legislation to repeal Section 304(c) of BIPA 2000 that requires the occupational mix adjustment, because the adjustment is not having the anticipated impact. Other commenters expressed continued support for the intent of the occupational mix adjustment and commended CMS's efforts to administer and improve the overall hospital wage index.

Response: We understand the commenters' concerns regarding the results of the 2003 occupational mix survey. As we discussed in the FY 2005 final rule (69 FR 49052), the unexpected outcomes may have been due to a combination of factors including the newness of the survey and changing trends in hospital employment. We have added several improvements to the 2006 survey that should reduce the risk of reporting and measurement errors. These improvements are based largely on suggestions we received

from MedPAC and the hospital community. Given statutory requirement to collect data on occupational mix every 3 years, we are obligated to proceed with the data collection.

Comment: Several commenters asked CMS to explicitly state that there are consequences if a hospital does not complete the survey fully and accurately. The consequences should be stated clearly on the survey itself or on the survey transmittal. In addition, the commenters urged that “under no circumstances should there be a negative impact on other hospitals in the CBSA wherein a hospital has failed to submit the survey.”

Response: As we stated in response to a similar comment in the August 11, 2004 Federal Register (69 FR 29035), we agree that other hospitals should not be harmed by a hospital’s failure to respond to the occupational mix survey. At this point, particularly before we know the results of the new survey, we believe it is still appropriate to continue to apply the national average adjustment of 1.0000 to a hospital that does not complete the survey, as this adjustment will have no effect on the overall wage index of the CBSA in which the hospital is located. Accordingly, the other hospitals in the CBSA will not be harmed by another hospital’s failure to complete the survey. We might reconsider applying the national average in the future if warranted.

Comment: Some commenters suggested that is inappropriate for CMS to apply an occupational mix adjustment to payments made under the Outpatient PPS, because the survey captures information mainly for employees that render inpatient care, and “does

not capture any data on the direct mix of employees providing services to hospital outpatients.”

Response: If commenters have concerns related to payments made under the Outpatient PPS, they should submit their comments for consideration as part of the Outpatient PPS proposed and final rulemaking process. However, we would like to point out that the commenters are incorrect that the survey “does not capture any data on the direct mix of employees providing services to hospital outpatients.” It has been our longstanding policy to include in the wage index the wages and hours of employees working not only in the IPPS acute care areas of the hospital, but also in the outpatient departments (for example, emergency room, outpatient clinic), because some employees (such as nurses) may work in both areas. Consistent with the wage and hours data that are collected on Worksheet S-3 of the cost report, the occupational mix survey also includes the wages and hours for employees in outpatient departments.

Comment: Two commenters, one writing on behalf of urban hospitals, and one writing on behalf of rural hospitals, took issue with CMS’ and MedPAC’s assertion that the occupational mix adjustment serves to control for “management decisions” on the types of health care personnel that hospitals employ. Both commenters argued that there are a number of factors that go into a hospital’s employment decisions. The commenter representing the urban hospitals noted that hospitals can employ higher-skilled employees because they care for patients with a higher degree of medical acuity and provide more complex forms of care. The commenter noted that urban hospitals with higher-skilled workforces serve as “a vital resource for other hospitals – and especially, for rural

hospitals” who refer or transfer their patients to urban hospitals that provide specialized care. The commenter representing the rural hospitals mentioned that “due to supervision rules required by CMS for inpatient and outpatient services, hospitals must have a registered nurse (RN) on each unit to oversee licensed practical nurses (LPNs). Therefore, the ratio of higher employed nurses in rural areas will necessarily be greater than that of urban and teaching hospitals who can meet the supervisory requirements using less RNs to supervise a greater number of LPNs.” Both commenters stated that the variation in labor pools in different areas of the country and the nursing shortage are two critical factors affecting a hospital’s workforce, but over which a hospital has no control.

Response: We appreciate the challenges facing all hospitals in maintaining adequate RN coverage, and we acknowledge the commenters’ point that there are a number of different factors that influence hiring practices at hospitals, not simply arbitrary “management decisions.” Nevertheless, the goal of the survey remains the same—to control for the effect that the *quantity* of employees hired in an occupational category has on a hospital’s average hourly wage (AHW). With all other factors equal, a hospital that employs a relatively higher number of RNs, will have a relatively higher AHW. The purpose of the occupational mix adjustment is to “standardize” each hospital’s AHW by controlling for the number of RNs a hospital employs, and ultimately reflect the relative salaries paid to RNs by each hospital.

Comment: One commenter believed that, implicit in the proposed changes to the occupational mix survey is a belief on CMS’ part that the effects of difference in skill level among hospital employees are currently being captured twice, in both the wage

index and in hospitals' case mix index. The commenter asserted that case mix does not actually account for the varying skill levels among hospitals' employees, since the diagnosis-related groups (DRG) system that CMS currently uses "fails to reflect adequately the potentially considerable variations in the severity of patient illness or injury that are possible." Another commenter stated that, as part of the process to implement an occupational mix adjustment that controls for the effects of hospital employment choices on the wage index, CMS should consider that the DRG system does not adequately adjust hospital reimbursement for the treatment of the most severely ill patients. Both commenters urged CMS to implement a refined DRG system concurrent with the occupational mix adjustment.

Response: As we stated in the August 11, 2004 Federal Register (69 FR 49036), we believe that Medicare's DRG assignment already reflects the higher costs of providing services in hospitals that hire more highly skilled workers because they treat more complex cases. Nevertheless, we acknowledge the commenters' point that the occupational mix adjustment should be developed in the context of refinements to the DRG system. We note that, consistent with MedPAC's [insert date] report, we will be considering the adoption of severity-adjusted DRGs. However, since we have been required by Congress to apply the occupational mix adjustment to the wage index since October 1, 2004, we believe we have no choice but to implement the occupational mix adjustment at this time in the absence of severity-adjusted DRGs.

Comment: One commenter said that there are too many discrepancies and inconsistencies between the BLS definitions for the nursing functional categories and

advanced practice nurses and hospital-specific job descriptions and duty assignments. The commenter added that a cursory review of their hospitals' wage data found that compensation levels do not necessarily reflect the levels of advancement described and, as a result, should not be applied to reimbursement calculations that are intended to adjust for trends in cost. Trends are difficult to notice and are not representative of hospitals' payroll cost structures.

Response: We do not clearly understand the commenter's concerns, but we note that we are including functional categories because they do reflect ranges of salaries which could have an impact on the occupational mix adjustment. In addition, as we stated in the proposed survey, advanced practice nurses (APNs) are excluded from the occupational mix adjustment because the services they provide are not paid under the IPPS.