MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

(2)

April 2, 2007

Ms. Bonnie L. Harkless
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development—C
7500 Security Boulevard, Room C4-26-05
Baltimore, MD 21244 - 1850

RE: *CMS–10079 (OMB#: 0938–0907); Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR 412.64, February 2, 2007*

Dear Ms. Harkless:

On behalf of its 145 member hospitals, the Michigan Health & Hospital Association (MHA) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed revision of the occupational mix survey, published in the February 2 *Federal Register*.

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 (RNs) versus licensed practical nurses (LPNs) – rather than geographic variances in labor costs.

While the MHA appreciates efforts by the CMS to further streamline and refine the survey and its instructions, we continue to have concerns which are highlighted below.

NEW 2007 COLLECTION PERIOD

The CMS proposal would extend the data collection period from six months to a full twelve months covering pay periods *ending* between July 1, 2007 and June 30, 2008. Hospitals would be required to submit the completed survey to fiscal intermediaries due 60 days later on September 1, 2008.

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The MHA appreciates the change to include pay periods *ending* within a date range rather than pay periods beginning and ending within a date range, since this will be less confusing for hospitals. Although the MHA is supportive of a one-year collection period to ensure that the data is not skewed due to seasonal fluctuations in patient volume and employment, **we believe a calendar year collection period would be preferred for matching data reported on payroll forms, such as W-2 reporting for IRS purposes.**

The MHA believes that 90 days would be a more appropriate time frame for hospitals to compile the data. While we recognize that a 60-day time frame is necessary to accommodate the data for this collection into the wage index review process, we urge the CMS to undertake the next data collection early enough to allow hospitals 90 days to submit the completed survey.

CATEGORIES FOR 2007 COLLECTION

The CMS proposes eliminating the collection of the management personnel and staff nurse/clinician subcategories from the RN category. The MHA believes that this change is appropriate because the subcategories had a minor affect on the adjustment and added additional work for hospitals.

The CMS would also add surgical technologists to the LPN category, as they perform similar functions and sometimes substitute for nurses. We believe that this addition is warranted since there was substantial confusion regarding the placement of surgical technologists during the last data collection. Surgical technologists represent 1.21 percent of hospital employees, per the Bureau of Labor Statistics (BLS) data for General Medical and Surgical Hospitals as of May 2005. In addition, the BLS data show that the mean hourly wage rate for surgical technologists is $16.96 versus $16.65 for LPNs. As a result, we believe that combining the two categories is reasonable given their prevalence, similar functions and wages.

Finally, the CMS would clarify that paramedics who are employed by the hospital and work in the emergency department, and unit secretaries, or "ward clerks," should be included in the "all other" category since they do not appropriately fit under the other existing definitions associated with this collection. While the MHA agrees that paramedics should be included in the "all other" category, we believe that it is more appropriate to include unit secretaries in the nursing category. Even though unit secretaries do not provide direct clinical care, they serve a function that frees up the nursing staff to do other duties, just as medical assistants (MAs) do in clinics.

Unit secretaries are not simply office staff; they work on the floor with nurses and complete tasks such as charting, transporting patients, completing laboratory/dietary slips, stocking patient supplies, census taking, etc.

Based on a sample by the American Hospital Association, findings indicate that unit secretaries represent 5.1 percent of nursing staff, and all hospitals had hours in this category. The AHA also reviewed the summary information from the BLS, which shows that the "Healthcare Support Workers, All Other" category – which we believe likely captures unit secretaries – has one-and-a-half times as many hours as MAs. See the table below.

SOC Code Number	Category	Hours	% of Entire Hospital	% of Nursing
29-1111	RN	1,354,020	28 %	65%
29-2061	LPN	171,270	4%	9%
31-1012	Nursing Aides, Orderlies, and Attendants	377,080	8%	18%
31-9092	Medical Assistants	47,540	1%	2 %
29-2055	Surgical Technologists	58,170	1 %	3%
31-9099	Healthcare Support Workers, All Other	70,780	1%	3%
	Total Nursing with New Categories	2,078,860	43 %	100%
	Total All Employees	4,826,410		

MAs are more common in physician offices and clinics, where they are more likely to be cross-trained in other areas like phlebotomy. Unit secretaries do less clinical work than MAs because of their location. However, their function is generally the same: to relieve the nursing staff of simpler and more administrative tasks. We believe that unit secretaries should be included in the same category as MAs, as they are more prevalent, paid similarly and serve a similar function in the hospital setting.

Using unit secretaries to free up RNs and other staff lowers the overall hospital average hourly rate, in the same manner as using more nursing aides.

EMPLOYEES TO INCLUDE IN THE COLLECTION

The CMS would further clarify which nursing personnel to include in the "all other" category. We appreciate the clarification in the survey instructions clearly restricts the collection to "only" these cost centers. The MHA is supportive of the inclusion of the following cost centers: 53 (Electrocardiology), 58 (Ambulatory Surgical Center (Non-Distinct Part)) and 59 (Other Ancillary). However, we have some additional suggestions.

An AHA survey of 20 hospitals measured how well the existing cost center definitions captured traditional nursing personnel. An internal skill mix indicator for "Registered Nurses-Direct Patient Care" served as a proxy for this review. For the 20 combined hospitals, the existing categories accounted for 93 percent of traditional nursing personnel.

If the four cost centers mentioned above are added to the survey, the categories would then account for at least 97 percent of traditional nursing personnel in the sample hospitals. This validates that the cost centers chosen by the CMS for the previous survey captured the vast majority of nursing personnel. Any additions should be restricted to areas of the hospital with a high percentage of nursing personnel, whose exclusion may unfairly advantage some hospitals.

Line 53 Electrocardiology – Based on a review of a sample of hospitals, the largest single concentration of direct patient care RNs that were not included in the survey was in cardiac catheterization laboratories. These laboratories can be subscripted under Line 53 or 59. Because of the typically high percentage of traditional nursing staff working in these laboratories, we believe that this cost center should be captured in the survey.

Line 58 ASC (Non-Distinct Part) – This cost center includes the cost and staffing information for outpatient surgeries paid under the outpatient prospective payment system and is included in Worksheet S-3 on the cost report that is utilized to calculate the wage index. These are not the ambulatory surgical centers, which are paid under their own fee schedule *(please note: cost center 92, Ambulatory Surgery Center (Distinct Part), should not be included since it is excluded from the S-3 wage index information utilized to calculate the wage index)*. Since the operating room and recovery room cost centers are already included in the cost center listing, it would be inconsistent to exclude this cost center.

Line 59 Other Ancillary – This cost center should be included since many areas within it are subscripted cost centers with high use of nursing staff, such as cardiac catheterization laboratories, cardiac rehabilitation and endoscopy. However, the CMS should consider specifying only these two subscripted lines within this cost center to avoid collection of other scattered outpatient ancillary services that are not necessarily provided broadly across hospitals and do not necessarily have high nursing usage.

Line 57 Renal Dialysis – While this cost center was not recommended by the CMS, we believe it should be considered given the high utilization of traditional nursing staff in this area.

Other lines considered – The MHA does not support the inclusion of X-Ray line 41 because imaging has a fairly low percentage of RNs compared to the overall cost centers, and because adding line 41 would likely require lines 42 and 43 as well. Nor, do we recommend that Social Services be added to the survey unless a new Social Worker category is added. Much of the staffing in this area can be accomplished with either RNs or Social Workers. Therefore, reporting only RN staffing would overstate hospitals' RN percentages, which could result in adverse occupational mix adjustments in areas where Social Services are staffed by a higher percentage of RNs.

If you have any questions or require further information, please contact me at (517)703-8603 or via email at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Policy

Federation of American Hospitals®

Charles N. Kahn III
President

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3
1 of 10

March 30, 2007

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development—C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244 - 1850

RE: *CMS–10079 (OMB#: 0938–0907); Hospital Wage Index Occupational Mix Survey and Supporting Regulations*

Dear Ms. Harkless:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") Occupational Mix Survey.

The FAH wishes to express its appreciation to CMS for working with the various stakeholders to gather and incorporate suggestions on how the survey and process could be improved in order to develop a more accurate occupational mix adjustment. FAH is very pleased to note that CMS's efforts developing the proposed changes have significantly improved the survey.

Some of the key points that we support in the proposed survey include:

- Full year collection period, eliminating concerns about seasonal fluctuations
- Survey timing, which will allow for sufficient review during the normal wage index review process

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Also enclosed, is a description of the types of training a unit secretary, or medical office specialist as they are sometimes called, typically undertakes to earn a degree in this field. You will notice that a significant component falls far outside the realm of administrative tasks and is directed to building a core body of medical and clinical knowledge that clearly distinguishes this class of personnel from routine administrative support staff, and that enables them to perform the most important part of their job– facilitating the efficient delivery of direct patient quality care. In addition, the cost center limitations on the survey will limit inclusion of these positions to clerical support in the actual nursing departments and not general administrative staff.

This type of personnel is common in hospitals nationwide. An examination of the listings on the job website found at http://www.indeed.com/q-Unit-Secretary-jobs.html indicates the prevalence of unit secretaries.

Currently, Medical Assistants are included in the "nursing" categories on the survey, while Unit Secretaries are not. Medical Assistants are more common in physician offices and clinics, where they are more likely to be cross-trained in something like phlebotomy. In a hospital, phlebotomists usually come from the lab, so it is not necessary to do the same sort of cross-training. Thus, the Unit Secretaries generally do less clinical work than Medical Assistants because of their location on hospital inpatient floors, rather than in clinics or physician offices. However, their function is otherwise generally the same: to relieve the other nursing staff of simpler and more administrative tasks. It should also be noted that over 56% of the hospitals reported no Medical Assistant hours on the 1st and 2nd quarter 2006 occupational mix survey. **As Unit Secretaries are more prevalent, are paid similarly and serve a similar function as Medical Assistants, we believe Unit Secretaries should be included in the category with medical assistants.**

Should CMS decide not to include Unit Secretaries among the nursing categories, we would strongly encourage the elimination of the Medical Assistant category. As stated above, many of their job functions are very similar to Unit Secretaries. In addition, the Unit Secretary position is far more common in hospitals as reflected in the BLS data and by the fact that the majority of hospitals reported no Medical Assistant hours in their 1st and 2nd quarters 2006 occupational mix data.

We believe the inclusion of both Medical Assistants and Unit Secretaries will address the apparent inconsistencies in reporting. We believe the alternative of excluding both Medical Assistants and Unit Secretaries would also reduce this inconsistency.

We understand that CMS may have concerns about including Unit Secretaries, since they do not, for the most part, provide hands-on patient care or clinical care. The decision to limit the survey to positions that provide direct clinical care was a decision that CMS made with the initial occupational mix survey. The FAH supported this decision because we believed the survey process should begin with traditional nursing areas. The FAH believes that CMS's decision to limit personnel in the nursing categories

to specific cost centers resolves this concern. As shown above, we believe that inclusion of Unit Secretaries in the nursing categories (i.e., within the Medical Assistant category) will significantly improve the accuracy of the Occupational Mix Adjustment. Should CMS determine that Unit Secretaries do not meet the current criteria of providing clinical care the FAH would encourage CMS to amend its decision in this limited instance in order to include Unit Secretaries within the Medical Assistant category in light of their substantially similar contributions to increasing efficiency in the direct delivery of patient care.

Below are some of our detailed comments and suggestions on the other issues regarding the survey.

Collection Period

The FAH strongly supports CMS decisions related to the collection period and pay periods to be included in the specifications. The collection period from July 1, 2007 and June 30, 2008 will eliminate our concerns related to seasonality. In addition, this timing will allow the occupational mix data to go through the same review and developmental process as normal wage index data prior to being implemented. In addition, the specification that the survey will include pay periods ending from July 1, 2007 to June 30, 2008 will greatly simplify hospital efforts to accumulate the data.

Home Office and Related Party

The FAH strongly supports the CMS position that Home Office and Related Organization hours and salaries should be reported on the survey. Failure to consider Home Office and Related Organization hours and salaries would overstate the general service categories' percentage of the total and therefore overstate the entire occupational mix adjustment for providers. Over 50% of the hospitals have reported 292,923,211 home office hours in the latest PUF for 2008.

Use of Cost Centers to Determine Personnel to Be Included in Nursing Categories

The FAH strongly supports the CMS decision to require that only nursing personnel working in specific cost center be reported in the various nursing categories. This allows hospitals to focus their review efforts on nursing departments and increases the consistency between hospitals. Further, the FAH supports the addition of the 3 specified cost centers –53, 58 and 59 -- that CMS has proposed on the occupational mix survey. We would suggest one addition and some additional parameters be added to one cost center.

We reviewed detailed information for 20 hospitals in four states to measure how well the existing cost center definitions were capturing traditional nursing personnel. An internal skill mix indicator for Registered Nurses-Direct Patient Care served as a proxy for this review. For the 20 combined hospitals, we noted that the existing cost centers managed to account for 93.6 percent of traditional nursing personnel, ranging from 83.7

percent to 98.9 percent from hospital to hospital. Only one hospital's percentage was below 89.1 percent.

If the three cost centers mentioned above are added to the survey, the categories would then account for at least 96.9 percent of traditional nursing personnel in the sample hospitals. The percentages by hospital range from 93.9 percent to 99.6 percent. This demonstrates that the cost centers chosen by CMS for the previous survey captured the vast majority of nursing personnel. Any additions should be restricted to areas of the hospital with a high percentage of nursing personnel whose exclusion may unfairly advantage or disadvantage some hospitals.

Line 53 Electrocardiology – Based on a review of a sample of hospitals, the largest single concentration of direct patient care RNs that were not included in the survey was in cardiac catheter labs. These labs can be subscripted under Line 53 or 59. Because of the typically high percentage of traditional nursing staff working in these labs, we believe this cost center should be captured in the survey.

Line 58 ASC (Non-Distinct Part) – This cost center includes the cost and staffing information for outpatient surgeries paid under the outpatient PPS and is included in Worksheet S-3 on the cost report that is utilized to calculate the wage index. These are not Ambulatory Surgical Centers that are paid under their own fee schedule *(Please note: cost center 92 Ambulatory Surgery Center (Distinct Part) should not be included since it is excluded from the S-3 wage index information utilized to calculate the wage index).* Since the operating room and recovery room cost centers are already included in the cost center listing, it would be inconsistent to exclude this cost center.

Line 59 Other Ancillary – This cost center should be included since many areas within it are subscripted cost centers with high usage of nursing staff such as cardiac catheter labs, cardiac rehabilitation and endoscopy. However, a review of HCRIS data indicates that many and various types of services can be subscripted under this cost report center. We recommend that CMS specify the services that should be included under this cost center to ensure consistency between hospitals. Inclusion or exclusion of all cost centers subscripted under this cost center will lead to inconsistency. We would recommend that the following areas be included:

- Operating Room
- Endoscopy
- Recovery Room
- ASC
- Delivery Room & Labor Room
- Birthing Center
- Electrocardiology
- EKG and EEG
- Electromyography
- Cardiopulmonary
- Stress Test

- Cardiology
- Holter Monitor
- Cardiac Catheterization Laboratory
- Inpatient Routine Areas
- Clinics

We believe that Cardiac Catheterization Laboratories and Endoscopy are the two biggest areas of concern. All of these areas would generally fall under the existing Cost Center lines if they were not subscripted.

Line 57 Renal Dialysis – While this cost center was not recommended by CMS, we believe it should be considered given the high utilization of traditional nursing staff in this area.

Other lines considered — The FAH does not support the inclusion of X-Ray, line 41, because imaging has a fairly low percentage of RNs to the overall cost centers (6 percent in our sample) and because adding line 41 would likely require lines 42 and 43 as well. Nor do we recommend that Social Services be added to the survey, unless a new Social Worker category is added. Much of the staffing in this area can be accomplished with either RNs or Social Workers. Therefore, reporting only RN staffing would overstate hospitals' RN percentages and could result in adverse occupational mix adjustments in areas where Social Services are staffed by a higher percentage of RNs. Our overall sample indicated that greater than 51 percent of staffing in these areas is not RNs. Seven of the sample hospitals showed no RN staffing, while five hospitals showed 100 percent RN staffing.

We also have a concern about the wording on the first sentence on page 3 of the occupational mix survey document. The sentence states the following: "Only nursing personnel working in the following cost centers as used for Medicare cost reporting purposes may be included in the appropriate nursing subcategory". We are concerned that the word "may" could be interpreted by providers that this requirement is optional. We feel that all nursing personnel that fall within the nursing subcategories on the survey should be reported. The FAH recommends the sentence be changed to *"Nursing personnel working in the following cost centers as used for Medicare cost reporting purposes must be included in the appropriate nursing subcategory".*

Survey Categories

- Surgical Technologist

The FAH strongly supports the CMS decision to add Surgical Technologist to the LPN category of the survey. This position represents 1.21% of total hospital employees per the May 2005 summary information from the Bureau of Labor Statistics (BLS) for General Medical and Surgical Hospitals. This is significantly higher that the .99% for Medical Assistants. In addition, combining LPN and Surgical Technologist makes sense since their pay level is very similar. The May 2005 BLS information indicated the mean

hourly rate for Surgical Technologists (SOC Code Number 29-2055) is $16.96 versus $16.65 for LPNs (SOC Code Number 29-2061).

- Unit Secretaries

The FAH has significant concerns related to not including Unit Secretaries in the occupational mix survey that we have covered previously in this comment letter.

- RN Category Consolidation

The FAH supports CMS's decision to consolidate the two RN categories into a single category. However, we feel there will be confusion on where RNs with some management responsibility should go. We would recommend that CMS clarify the RN definition to include RN managers in the consolidated RN category.

- All Other

The FAH supports CMS in its decision to include paramedics, phlebotomists, information technology personnel and general business office personnel in a all other category on the survey

- Advance Practice Nurses

The FAH has concerns about how Advanced Practice Nurses (APNs) are to be treated on the survey. Some hospitals may utilize APNs in nursing areas where their job function will not support billing Part B. It is our understanding in this situation that they would be included in the S-3 data utilized in wage index development. We feel they should be excluded from the survey if they are excluded from the S-3 data due to billing for their services to the Part B carrier, but they should be included if they are in a nursing cost center and are included in the S-3 data. We recommend that CMS specifically state this on the survey form.

* * * * *

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

Respectfully submitted,

cc: Valerie A. Miller, CMS
Job Description Enclosure

7 J 10

Source: Dictionary of Occupational Titles

http://www.occupationalinfo.org/24/245362014.html

CODE: **245.362-014** **Buy the DOT:Download/CD-ROM**

TITLE(s): **UNIT CLERK (medical ser.) alternate titles: health unit clerk; ward clerk**

Prepares and compiles records in nursing unit of hospital or medical facility: Records name of patient, address, and name of attending physician to prepare medical records on new patients. **Copies information, such as patient's temperature, pulse rate, and blood pressure from nurses' records onto patient's medical records. Records information, such as physicians' orders and instructions, dietary requirements, and medication information, on patient charts and medical record**s. Keeps file of medical records on patients in unit. Prepares notice of patient's discharge to inform business office. Requisitions supplies designated by nursing staff. **Answers telephone and intercom calls** and provides information or relays messages to patients and medical staff. Directs visitors to patients' rooms. Distributes mail, newspapers, and flowers to patients. Compiles census of patients. May keep record of absences and hours worked by unit personnel. **May transport patients in wheelchair or conveyance to locations within facility**. May key patient information into computer.
GOE: 07.05.03 STRENGTH: L GED: R3 M3 L3 SVP: 3 DLU: 87
ONET CROSSWALK: 55347 General Office Clerks

8 of 10

Enclsoure - description of the types of training the unit secretaries go through

MT. Hood

Medical Office Specialist - Unit Secretary

(Associate of Applied Science Degree Program)

Catalog Year 2006-07

MHCC Faculty Advisor:

Carole Wickham: 503-491-7195 - Room AC 2772 Carol.Wickham@mhcc.edu

A Medical Office Specialist as a Unit Secretary functions as the center of the communications hub found in a hospital unit. S/he works in a dynamic medical setting with physicians, nurses, and other healthcare professionals. Desirable traits of a Unit Secretary include strong communication skills, flexibility, professionalism, and responsibility. Students should have typing competency and basic formatting knowledge before enrolling in classes in this program.

Upon graduation, students may be hired to work in physicians' offices, public and private hospitals, teaching hospitals, clinics, laboratories, insurance companies, and governmental facilities.

Please check the MHCC website for any curricular changes that have occurred since the catalog was published.

First Quarter (Fall)		**Cr**
MO10	Powerful Strategies for the Office Team	4
MO14	Medical Terminology I	3
BI100	Survey of Body Systems	4
BT116	Business Tools and Techniques	3
MTH65	Beginning Algebra II (or higher)[2]‡	3
		17
Second Quarter (Winter)		
MO15	Medical Terminology II	3
MO24	Introduction to Medical Transcription	3
MO25	Medical Office Procedures	4
BA131	Introduction to Business Computing	4
WR121	English Composition1	3

		17
Third Quarter (Spring)		
MO12	Diversity and Healthcare	3
MO27	Hospital Administrative Procedures	4
MO34	Medical Transcription I	3
HPE295	Health and Fitness for Life	3
SP115	Introduction to Intercultural Communication or SP100 Basic Speech Communication	3
		16
Fourth Quarter (Fall)		
MO31	Medical Coding I - ICD-9-CM	3
MO36	Medical Transcription II	3
BA205	Business Communications	4
BI121	Essentials of Human Anatomy and Physiology I[1]	4
BT110	Business Editing	3
		17
Fifth Quarter (Winter)		
MA24	Medical Law and Ethics	3
MO35	Medical Coding II - Procedural Coding	4
BI122	Essentials of Human Anatomy and Physiology II	4
BT218	Records Management with Microsoft Access	3
BT220	Electronic Calculator and 10-Key Operations	1
		15
Sixth Quarter (Spring)		
MA23	Pharmacology for Medical Office Occupations	3
MA25	Disease Processes	3

MO39	Building a Professional Portfolio	1
PSY201	General Psychology or PSY101 Psychology of Human Relations	3
WE280MOB	Cooperative Education Internship	4
		14

1 Prerequisite. See course description in back of catalog.
2 Students may not use demonstrated proficiency on the College Placement Test (CPT) to satisfy this requirement.

‡ See pages 7-10 of the printed catalog.

The student must document initiation of the three dose Hepatitis B vaccine series, the second dose of measles immunization, and current Tuberculin skin test (PPD) by the first week of classes.

Note: A minimum grade of "C" grade is required in all courses.

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(4) 1 of 2

March 27, 2007

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development - - C
Attention: Bonnie L Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments to Proposed 2007-2008 Occupational Mix Survey

Dear Ms. Harkless:

This letter is written in response to the proposed 2007-2008 Occupational Mix Survey. Our comments are based upon frequent questions we have received from the provider community during recent reviews.

1. More specific occupation descriptions should be included in the survey instructions. This will assist the providers and FIs in determining if the correct occupations are included and/or reported on the survey.

2. Perhaps the survey instructions should state that the data should include all hospital occupations in the data, not just nursing occupations. A few providers have thought the survey was only for the nursing personnel. Additional instruction should clarify this.

3. Instructions should also state that the survey does not have to be completed for no/low utilization providers.

4. One of the biggest problems or concerns was the reporting of bonus information. The instructions were not at all clear regarding how providers should determine bonus pay information that should be included in the data. I think this was mostly a problem for providers that paid bonuses after the period that we were reviewing. Initially the provider would accrue the cost for the period. However, it was difficult to determine if the data submitted was accurate because the bonus information may not have been actual expense. Also, there was great inconsistency between the providers in determining actually what to report. Perhaps bonus pay information should be excluded from the survey data because the bonus is not paid per hour, and is also at the discretion of the provider if a bonus will be paid. Reporting the bonus without associated hours inflates the average hourly wage. This inflated rate does not accurately reflect the normal/average rate for the particular occupation.

We feel our suggestions will help add clarity for the providers. We appreciate your time and consideration of this information. If you have any questions you may reach me at (423) 535-3805 or cindy.hauke@rgbagov.com.

Sincerely,

Cindy S. Hauke

CINDY S. HAUKE
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PROVIDENCE
Health & Services

March 30, 2007

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Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development - C
Attention: Bonnie L. Harkless
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7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR 412.64, Form CMS-10079 (OMB# 0938-0907)

Dear Ms. Harkless:

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide our comments on the revision of the currently approved information collection request entitled "Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR 412.64." CMS published the proposed collection and comment request in the *Federal Register* on February 2, 2007.

Providence Health & Services is a faith-based, non-profit health system that operates acute care hospitals, physician groups, skilled nursing facilities, home health agencies, assisted living, senior housing, PACE programs, and a health plan in Washington, Oregon, California and Montana. As a Catholic health care system striving to meet the health needs of people as they journey through life, Providence Health & Services is pleased to submit the following comments on the above proposed collection and comment request, which was published in the *Federal Register* (Vol. 72, No. 22, page 5055) on February 2, 2007.

We agree with many of the changes and enhancements CMS has made to the Medicare wage index occupational mix survey and support the goal of obtaining accurate data with this tool. Providence Health & Services would like to offer two suggestions to increase the reliability of the information reported by providers while reducing the burden of survey completion.

1. Require the collection of hospital-specific wage and hour data for a one year reporting period to coincide either with the provider's cost report period or a calendar year.

CMS has proposed to extend the collection of wage and hour data from six months to one year with the revised occupational mix survey. While Providence Health & Services supports the extension of this data collection, we are strongly advocating for this data to be tied

directly to the provider's cost report period. Although the occupational mix survey is to be completed only on a three year cycle, while a provider's cost report is an annual requirement, the data is much more likely to be accurate when a facility is gathering similar information for cost report completion. The July to June collection period does not coincide with either many providers' cost report period or the payroll processing year. As a result, providers must accumulate data for the occupational mix survey period as well as the cost report period. Even if providers were required to complete the occupational mix survey on an annual basis, as opposed to every three years, the burden on providers would certainly not increase, and may in fact decrease, if the data on the survey covered the same time frame as the cost report. Additionally, the likelihood that the data would have increased reliability exists because it would eliminate the requirement for providers to piecemeal calculations to gather data reflecting the federal fiscal year timeframe as opposed to the cost report time frame.

In the alternative, if CMS requires providers to supply the data for the occupational mix survey for the exact same calendar days, Providence Health & Services urges that such a timeframe coincide with the calendar year from January 1–December 31. Providers naturally gather wage and hour data for this timeframe for payroll tax reporting purposes. Completing the survey using this same period of time would increase the likelihood that such information is accurate, as well as decreasing the burden to providers for the collection of the data.

2. Include the allocation methodology used for the wage index calculation for allocating general service salaries and hours to excluded areas in the instructions and/or survey form.

CMS requires that hospitals apply the allocation methodology that is used in the wage index calculation for allocating general service salaries and hours to excluded areas. The instructions and definitions provided by CMS for the Medicare wage index occupational mix survey cite to the *Federal Register* for this methodology. Providence Health & Services urges CMS to incorporate the allocation methodology directly into the instructions or the survey form rather than relying on providers to refer to a specific page of the August 12, 2005 *Federal Register*.

In closing, Providence Health & Services would like to thank you for the opportunity to review and comment on the proposed information collection regarding the Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR 412.64. Please contact Beth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about the material in this letter.

Sincerely,

John Koster MD

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services