American Hospital Association

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April 3, 2007

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 our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 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 differences in the costs of labor.

We appreciate CMS' efforts to further streamline and refine the survey and its instructions. Our detailed comments are provided below.

NEW 2007 COLLECTION PERIOD

The proposal would extend the collection period from six months to one year and would cover pay periods *ending* between July 1, 2007 and June 30, 2008. Data would be due 60 days later on September 1, 2008.

The AHA appreciates the change to include pay periods *ending* within a date range rather than pay periods beginning and ending within a date range, which will be less confusing for hospitals. We also are fully supportive of a one-year collection period to ensure that the data is not skewed as a result of seasonal fluctuations in patient volume and employment.

In addition, we support the chosen time frame. While we believe that 90 days would be a more appropriate time frame in which to compile the data, we understand that CMS only can afford 60 days in order to integrate the data for this collection into the wage index review process. However, we urge CMS to undertake the next data collection early enough to allow hospitals 90 days in the future.

CATEGORIES FOR 2007 COLLECTION

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

CMS also would add surgical technologists to the LPN category, as they perform similar functions and sometimes substitute for nurses. We believe that this addition is warranted because there was substantial confusion regarding the placement of surgical technologists during the last collection. Surgical technologists represent 1.21 percent of hospitals employees, per the Bureau of Labor Statistics (BLS) data for General Medical and Surgical Hospitals as of May 2005, and 4.25 percent according to data from 20 of our member hospitals.[1] In addition, the BLS data show that the mean hourly wage rate for surgical technologists is $16.96 versus $16.65 for LPNs. Thus, we believe combining the two categories is reasonable given their prevalence, similar functions and wages.

Finally, 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 AHA 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 directly provide 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. A job description can be found on the Dictionary of Occupational Titles (DOT) Web site at www.occupationalinfo.org/24/245362014.html. The DOT listings are

[1] This sample includes hospitals from four states and only includes staff from the cost centers specified by CMS in the 2006 collection instructions.

used by several federal agencies, large companies, universities and hospitals, as described on the DOT main Web page. Attachment I contains a description of the training that unit secretaries go through under the MT. Hood curriculum. Notice that it is not all administrative – they also must take classes on anatomy and physiology, psychology, medical terminology, disease processes, etc. In addition, the cost center limitations should limit these positions to clerical support in the actual nursing departments and not general administrative staff.

This type of personnel is common in hospitals nationwide. The listing on the job Web site http://www.indeed.com/q-Unit-Secretary-jobs.html shows the prevalence of unit secretaries.

In our sample of 20 hospitals, unit secretaries represent 5.1 percent of nursing staff, and all hospitals had hours in this category. We also looked at the summary information from 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	28.05%	65.13%
29-2061	LPN	171,270	3.55%	8.24%
31-1012	Nursing Aides, Orderlies, and Attendants	377,080	7.81%	18.14%
31-9092	Medical Assistants	47,540	0.98%	2.29%
29-2055	Surgical Technologists	58,170	1.21%	2.80%
31-9099	Healthcare Support Workers, All Other	70,780	1.47%	3.40%
	Total Nursing with New Categories	2,078,860	43.07%	100.00%
	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.

Ultimately, using unit secretaries to free up RNs and other staff lowers the overall hospital average hourly rate, just like using more nursing aides. We provide an example in Attachment

II, which demonstrates that the exclusion of even a relatively small number of unit secretaries would have a significant impact on a hospital's occupational mix adjustment. The example, based on our 20 hospital survey, shows that counting unit secretaries in the "all other" category would lower a hospital's occupational mix adjusted salaries by 1.1 percent. Hospitals that use this type of staff to lower costs and be more efficient will be penalized.

EMPLOYEES TO INCLUDE IN THE COLLECTION

CMS would further clarify which nursing personnel to include in the "all other" category. In particular, we appreciate the alteration of the wording on the survey instructions in the second paragraph that previously suggested that the cost centers were only a "general rule," but now clearly restricts the collection to "only" these cost centers. The AHA also 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.

We surveyed the 20 hospitals previously noted to measure 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 93.6 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 four 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 would 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 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, 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 CMS, we believe it should be considered given the high utilization of traditional nursing staff in this area.

Other lines considered – The AHA 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 (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, which could result in adverse occupational mix adjustments in areas where Social Services are staffed by a higher percentage of RNs. Our sample indicated that greater than 51 percent of staffing in these areas are not RNs. Seven of the sample hospitals showed no RN staffing, while five hospitals showed 100 percent RN staffing.

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

Sincerely,

Rick Pollack
Executive Vice President

Attachments

6 g 10

Attachment I

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

7 J 10

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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Attachment II

Impact of Unit Secretaries on the Occupational Mix Adjusted Average Hourly Rate

Average Hourly Rate 5% Unit Secretaries included in the Medical Assistant Category	$32.20
Average Hourly Rate Unit Secretaries included in the All Other Category	$31.85
Impact	$0.35
% Impact	1.1%

Spreadsheet for Proposed FY 2007 Calculation of Provider Occupational Mix AHW

Fields in are filled in by the provider from the provider's occupational mix spreadsheet

Fields in BLUE are filled in from IPPS wage index Web Site or Federal Registers (these are the same in the proposed and final rules)

Fields in **BOLD** are calculated fields--DO NOT ENTER any information here

Example with 5% Unit Secretaries included under the All Other Category

Provider Number
FI #
Occ Mix Begin Date
Occ Mix End Date

Name
% Change -0.10%

	Hours	Salaries		step 1	step 2	step 3	step 5	step 6	in step 7
RN Mngt	3,087	121,241		**2.17%**	$38.59080	**$0.84**			
RN Staff	104,005	3,925,333		**73.26%**	$33.37390	**$24.45**			
LPNs	862	20,457		**0.61%**	$19.27210	**$0.12**			
Nurse Aides	25,304	371,866		**17.82%**	$13.69060	**$2.44**			
Medical Assistants	8,714	128,652		**6.14%**	$15.63040	**$0.96**			
Total Nurse Hours	141,972	4,567,549		**100.00%**		**$28.80**	**$28.7431**	**0.99787**	**47.83%**
						step 4			
ALLOTHER (Including Unit Secretaries)	193,825	4,982,818							**52.17%**
TOTAL	335,797	9,550,367							

Wages (From S-3, Parts II and III)	**$39,998,143**	**Based on final 2007 wage data**
Hours (From S-3, Parts II and III)	**1,254,547**	
Unadjusted AHW	**$31.88**	
Nurse Occ Mix Wages	**$19,088,730**	step 7
All Other unadjusted Occ Mix Wages	**$20,868,671**	step 7
Total Occ Mix Wages	**$39,957,401**	step 8
Final Occ Mix Adjusted AHW	**$31.85**	step 8

0.998981402

(1) Per page 59887 of the October 11,2006 Federal Register

Example with 5% Unit Secretaries included under the Medical Assistant Category

Provider Number
FI #
Occ Mix Begin Date
Occ Mix End Date

Name	
% Change	0.98%

	Hours	Salaries	step 1	step 2	step 3	step 5	step 6	in step 7
RN Mngt	3,087	121,241	2.07%	$38.59080	$0.80			
RN Staff	104,005	3,925,333	69.77%	$33.37390	$23.28			
LPNs	862	20,457	0.58%	$19.27210	$0.11			
Nurse Aides	25,304	371,866	16.97%	$13.69060	$2.32			
Medical Assistants (+ Unit Secretaries)	15,813	233,455	10.61%	$15.63040	$1.66			
Total Nurse Hours	149,071	4,672,352	100.00%		$28.18	$28.7431	1.0201	48.92%
					step 4			
ALLOTHER	186,726	4,878,015						51.08%
TOTAL	335,797	9,550,367						

Wages (From S-3, Parts II and III)	**$39,998,143**	**Based on initial 2008 PUF dated 10/6/06**
Hours (From S-3, Parts II and III)	**1,254,547**	
Unadjusted AHW	**$31.88**	
Nurse Occ Mix Wages	**$19,961,465**	step 7
All Other unadjusted Occ Mix Wages	**$20,429,745**	step 7
Total Occ Mix Wages	**$40,391,210**	step 8
Final Occ Mix Adjusted AHW	**$32.20**	step 8

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1966 - 2006

April 2, 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:

Enclosed is an amended version of the comments on the occupational mix survey that we sent to you on Friday, March 30th. This amended version includes an attachment that is referenced on page 2 of the comments, but which was inadvertently omitted from the comment letter filed on March 30th.

Thank you for your consideration. If you have any question, I can be reached at 202-624-1529 or sspeil@fah.org.

Sincerely,

Steven Speil
Senior Vice President, Health, Finance and Policy

Enclosure

801 Pennsylvania Ave., NW, Suite 245 • Washington, DC 20004-2604 • 202-624-1500 • Fax: 202-737-6832

Impact of Unit Secretaries on the Occupational Mix Adjusted Average Hourly Rate

Average Hourly Rate 5% Unit Secretaries included in the Medical Assistant Category	$32.20
Average Hourly Rate Unit Secretaries included in the All Other Category	$31.85
Impact	$0.35
% Impact	1.1%

Spreadsheet for Proposed FY 2007 Calculation of Provider Occupational Mix AHW

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Fields in **BOLD** are calculated fields--DO NOT ENTER any information here

Example with 5% Unit Secretaries included under the All Other Category

Provider Information

Provider Number
FI #
Occ Mix Begin Date
Occ Mix End Date

Name	
% Change	-0.10%

			step 1	step 2	step 3	step 5	step 6	in step 7
Provider Occ Mix Hours	**Hours**	Salaries	**Provider % by Subcategory**	**National AHWs by Subcategory (1)**	**Provider Adjusted AHW**	**National Nurse AHW (1)**	**Nurse Occ Mix Adjustment Factor**	**Provider % by Total**
RN Mngt	[illegible]	[illegible]	**2.17%**	$38.59080	**$0.84**			
RN Staff	[illegible]	[illegible]	**73.26%**	$33.37390	**$24.45**			
LPNs	[illegible]	[illegible]	**0.61%**	$19.27210	**$0.12**			
Nurse Aides	[illegible]	[illegible]	**17.82%**	$13.69060	**$2.44**			
Medical Assistants	[illegible]	[illegible]	**6.14%**	$15.63040	**$0.96**			
Total Nurse Hours	141,972	4,567,549	**100.00%**		**$28.80**	**$28.7431**	**0.99787**	**47.83%**
					step 4			
ALLOTHER (Including Unit Secretaries)	[illegible]	[illegible]						**52.17%**
TOTAL	[illegible]	[illegible]						

Wage Data from Cost Report

Wages (From S-3, Parts II and III)	[illegible]	**Based on final 2007 wage data**
Hours (From S-3, Parts II and III)	[illegible]	
Unadjusted AHW	**$31.88**	

Nurse Occ Mix Wages	**$19,088,730**	step 7	
All Other unadjusted Occ Mix Wages	**$20,868,671**	step 7	
Total Occ Mix Wages	**$39,957,401**	step 8	
Final Occ Mix Adjusted AHW	**$31.85**	step 8	0.998981402

(1) Per page 59887 of the October 11,2006 Federal Register

Spreadsheet for Proposed FY 2007 Calculation of Provider Occupational Mix AHW

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Fields in **BOLD** are calculated fields--DO NOT ENTER any information here

Example with 5% Unit Secretaries included under the Medical Assistant Category

Provider Number
FI #
Occ Mix Begin Date
Occ Mix End Date

Name	
% Change	0.98%

	step 1	step 2	step 3	step 5	step 6	in step 7
Provider Occ Mix Hours	**Hours**	Salaries	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Nurse AHW**	**Nurse Occ Mix Adjustment Factor**	**Provider % by Total**
RN Mngt	3,087	121,241	**2.07%**	$38.59080	**$0.80**			
RN Staff	104,005	3,925,333	**69.77%**	$33.37390	**$23.28**			
LPNs	882	20,457	**0.58%**	$19.27210	**$0.11**			
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Medical Assistants (+ Unit Secretaries)	15,813	353,465	**10.61%**	$15.63040	**$1.66**			
Total Nurse Hours	149,071	4,672,352	**100.00%**		**$28.18**	**$28.7431**	**1.0201**	**48.92%**
					step 4			
ALLOTHER	185,726	4,878,016						**51.08%**
TOTAL	334,797	9,550,367						

Wage Data from Cost Report

Wages (From S-3, Parts II and III)	$39,999,143	**Based on initial 2008 PUF dated 10/6/06**
Hours (From S-3, Parts II and III)	1,254,647	
Unadjusted AHW	$31.88	
Nurse Occ Mix Wages	$19,961,465	step 7
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Total Occ Mix Wages	$40,391,210	step 8
Final Occ Mix Adjusted AHW	$32.20	step 8

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5 of 14

Charles N. Kahn III
President

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

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

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- 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

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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

11 J 14

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

12 y 14

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.

(9) 1 of 3

MERCY Rec'd 4/9/07

SISTERS OF MERCY
HEALTH SYSTEM pst mrkd 4/2/07

March 30, 2007

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

Attention: **CMS-10079**

Dear Ms. Harkless:

Sisters of Mercy Health System (Mercy) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed revision to the survey instrument for the occupational mix adjustment entitled *"Agency Information Collection Activities: Proposed Collection; Comment Request"*, 72 Fed. Reg. No. 22 (February 2, 2007). Mercy is a 19-hospital system operating in Missouri, Kansas, Oklahoma and Arkansas.

Mercy appreciates CMS's consideration of provider comments and suggestions on the 2008 Occupational Mix Survey (OMS) and their willingness to incorporate into the 2010 Occupational Mix adjustment.

I. Impact of Registered Nurses (RNs) in the Occupational Mix Adjustment

The financial effect of the Occupational Mix adjustment is in our belief a contradiction to the effort to promote a higher level of quality care. CMS, Congress and President Bush are advocating for an increase in quality of care for patients at all levels. It is reasonable to expect that the quality of care provided by an RN is superior to the level of care provided by an LPN, CNA, or any other health care worker with a lower level of expertise, training, and education. However, the construction of the Occupational Mix adjustment is such that a facility with a high percentage of RN's receives a negative financial adjustment. We ask that you take quality initiatives into consideration and consider a higher percentage of RNs to be a positive

adjustment to the Occupational Mix adjustment as opposed to the current impact,

II. Wage Data Reporting Period

Mercy has contended that a full year of retrospective wage data would reduce or average out peak and slow utilization seasons. Mercy commends CMS for extending the OMS period to one year.

III. Advance Practice Nurses (APN)

CMS has not changed the position from the 2006 survey to exclude APNs from the 2006 OMS. The rationale has been that the services provided by these employees are billed and paid under a Part B fee schedule and not IPPS. Mercy agrees with this rationale as long as their services are billed under Part B. We employ hundreds of APNs throughout our System. The vast majority of their services are for non-Medicare patients. A significant portion of managed care plans do **not** recognize this level of service and therefore we do not bill. It is not cost efficient for our hospitals to bill, monitor, and collect for such a small portion of claims. These employees represent a true cost to IPPS. Mercy believes CMS should reconsider excluding APN wages and hours from the 2008 OMS.

IV. Reporting Deadline

CMS proposes that completed 2008 OMS be submitted to fiscal intermediaries by September 1, 2008. Mercy would suggest this deadline be moved to allow for additional analyses and validation of the data. Compilation and review of the required data will take the coordination of several departments such as Human Resources, Payroll, Finance, and Reimbursement. Mercy's fiscal year end is June 30 – as is many providers - therefore Human Resources and Finance are working through year-end activity through August. We believe a more realistic and manageable timetable would be the month ending 90 days following June 30, 2008. Mercy urges CMS to revise the deadline to be September 30, 2008.

V. Common Review of Wage Index data

Mercy contends that the propriety of all Wage Index data, including the Occupational Mix adjustment, is of great value to all providers. However, this data is subject to varying levels of review and interpretation by multiple Fiscal Intermediaries. As in a previously submitted comment, Mercy suggests that a

single Fiscal Intermediary be appointed to audit all Wage Index related data to better adhere to common review practices and reporting of valid and comparable data.

VI. Conclusion

Thank you for this opportunity to present our views. We welcome further discussion with CMS on any of the issues discussed above.

If you have questions concerning these comments, please feel free to contact Kyle Lee at (417) 820-8640.

Sincerely,

James R. Jaacks
Senior Vice President and Chief Financial Officer
Sisters of Mercy Health System

c: Ron Ashworth
Randy Combs
Ron Trulove