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

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

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.

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 PINK 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 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	**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 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%**
ALLOTHER (Including Unit Secretaries) 193,825	4,982,818			step 4			**52.17%**
TOTAL 335,797	9,550,367						

Wage Data from Cost Report

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%

Provider Occ Mix Hours	Hours	Salaries	step 1 Provider % by Subcategory	step 2 National AHWs by Subcategory	step 3 Provider Adjusted AHW	step 5 National Nurse AHW	step 6 Nurse Occ Mix Adjustment Factor	in step 7 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	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						

Wage Data from Cost Report		
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