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Comments on Notice of Proposed Rule Making: Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities

This letter is submitted on behalf of the American Health Care Association (AHCA). The American Health Care Association represents nearly 11,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities. We are pleased to have the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed regulation **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities** published in the June 29, 2007 edition of the *Federal Register*.

AHCA members and AHCA staff reviewed the proposed rule and the preamble text. This letter reflects their collective responses and recommendations.

General Comments

AHCA strongly disagrees with the underlying policy rationale of imposing user fees on Medicare providers. Although the proposed fee system is intended to recoup costs incurred by the government in the survey and certification process, its net effect is a reduction in the resources available to care for Medicare beneficiaries. The user fee created by the proposed rule indirectly results in a reduction in payment for services provided by Medicare providers and suppliers. The proposed rule fails to consider that any reduction in payment will necessarily impact the operations of Medicare providers and suppliers, regardless of whether the reduction results from a direct decrease in payment rates or an indirect fee.

In the current nursing facility survey, certification, and enforcement process, there is little surveyor accountability. The imposition of a user fee creates an incentive for otherwise unaccountable surveyors to produce more revenue for the government, without producing

THE AMERICAN HEALTH CARE ASSOCIATION IS COMMITTED TO PERFORMANCE EXCELLENCE AND QUALITY FIRST, A COVENANT FOR HEALTHY, AFFORDABLE AND ETHICAL LONG TERM CARE. AHCA REPRESENTS MORE THAN 10,000 NON-PROFIT AND FOR-PROFIT PROVIDERS DEDICATED TO CONTINUOUS IMPROVEMENT IN THE DELIVERY OF PROFESSIONAL AND COMPASSIONATE CARE FOR OUR NATION'S FRAIL, ELDERLY AND DISABLED CITIZENS WHO LIVE IN NURSING FACILITIES, ASSISTED LIVING RESIDENCES, SUBACUTE CENTERS AND HOMES FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES.

a concomitant increase in quality. Furthermore, imposed user fees will potentially increase and extend the number of current revisit surveys, and monies the government collects in fees may or may not be used to improve the quality of care in nursing facilities. Better results would emerge if the government and healthcare providers worked together to improve quality rather than impose a punitive fee that may or may not be tied to quality.

A possible solution to the possibility of increased revisit surveys without cause may be to consider a proposal where the user fee is imposed only when CMS identifies cases of actual harm or substandard quality of care that has led to the imposition of a remedy. In this situation, there is better justification for imposing a fee on a healthcare provider.

The proposed rule is silent on the process for repaying providers assessed user fees in instances where a nursing facility challenges, either through the informal dispute resolution or the administrative review process at the Departmental Appeals Board, a deficiency and CMS ultimately sustains that appeal. Additionally, the facility should be reimbursed by CMS for whatever time and expenses they incurred to recoup the fees. Why should the nursing facility provider be charged the revisit user fee when a revisit is not necessary in the first place? In this regard, AHCA believes that there should be an appeal mechanism that allows nursing facilities, with a good faith argument that the fee should never have been imposed or that it is too high. After all, the user fee is a fine or assessment and CMS must comply with due process requirements. Put simply, the fee should not be paid until a facility exhausts its appeals.

The proposed rule does not acknowledge that the implementation of the Quality Indicator Survey demonstration, the survey of record for many facilities, is resulting (according to the formative evaluation published in June 2006) in overall increased number of deficiencies. Therefore, in addition to a facility being part of a pilot project which CMS acknowledges is still in the process of revision and development, the facility will now be penalized with increased revisits and user fees.

The use of revisit fees following a complaint survey is particularly problematic and inherently flawed on at least two levels. First, the prospect of justifying a fee assessment on the identification of deficiencies has the practical effect of giving surveyors an incentive to substantiate a complaint when it might not otherwise be substantiated without such an incentive. Second, the definition of "substantiated complaints" appears overly broad in that it "includes any deficiency that is cited during a complaint survey, whether or not the deficiency was the original subject of the [complaint]." Obviously such a system lends itself to a scenario where, when the original complaint is not substantiated, surveyors have the incentive to identify other deficiencies in order to validate assessment of a revisit fee. Nothing in the proposed rule limits surveyors from acting in their own self interest in soliciting any reason to impose a user fee. The incentive to find some reason to assess a revisit fee does nothing to promote quality care and is unfair to providers seeking an impartial review by the surveyors.

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CMS estimates that this program will generate $37 million. However, if the surveyors continues to generate more fees by alleging more deficiencies, does CMS have a method to calculate how the figure might grow exponentially, and how it may adversely impact nursing facilities and patient care?

Some facilities may face both revisit user fees coupled with civil money penalties. Has CMS calculated the cumulative negative effect on skilled nursing facilities and the ability of small independent facilities in particular to pay, given the small operating margin?

If Congress does not reinstate user fees, what is the potential effect in September, 2007? Does CMS agree that the program otherwise expires at the conclusion of this fiscal year?

I. Background
B. Authority to Assess Revisit User Fees

AHCA has significant doubts about the legal authority for the Secretary of the Department of Health and Human Services to impose a fee on health care providers to recover the cost associated with a resurvey during fiscal year 2007, given the clear provisions in the Social Security Act prohibiting such fees. Additionally, we must point out that the Continuing Resolution does not require, or permit the Secretary to require, a state to impose fees associated with resurvey costs. The prohibition against state governments collecting fees for a survey relating to determining a facility's compliance remains in effect. Under Section 1864(e) of the Social Security Act the Secretary may not "require a State to impose" a user fee for survey activities. Accordingly, the Continuing Resolution only authorizes the Secretary to charge user fees. We believe this may raise practical problems as to what entity is responsible for charging and actually collecting the fees.

Section 488.30(a) DEFINITIONS
AHCA agrees that Medicaid-only "providers of services" or "providers" should not be assessed a user fee.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE
AHCA agrees with the proposal that there be no revisit fee assessed if the visit is due to a revisit for Life Safety Code requirements. We also agree that visits associated with a Federal Monitoring Survey, such as a Federal look-behind survey, will not be assessed a revisit fee.

The proposed rule states that CMS may make adjustments of revisit user fees to account for the provider or supplier's size, the number of follow-up revisits resulting from uncorrected deficiencies, and/or the seriousness and number of deficiencies. There is no specific information about how these adjustments may be made nor guidelines that will be in place to determine such adjustments. It is impossible for AHCA to comment on this aspect of the proposed rule without specific information on how these adjustments

will be made. Please provide additional information about the guidelines that CMS will use to determine such adjustments.

Section 488.30(e) RECONSIDERATION PROCESS FOR REVISIT USER FEES
AHCA agrees that there must be a reconsideration process available to providers or suppliers that have been assessed a revisit user fee if the provider or supplier believes an error of fact, such as a clerical error, has been made. The requirement that a reconsideration request be received by CMS within seven calendar days seems to be a reasonable time frame.

IV. Regulatory Impact Analysis
Proposed Fee Schedule for Onsite Revisit Surveys

The formula for determining the amount of the fee to be imposed needs to have some reasonable relationship to the actual cost of that particular revisit. CMS' extrapolated methodology seems to reflect a revenue raising devices as opposed to a fairly assessed cost.

AHCA is very concerned that the revisit fee for onsite revisit surveys will be based on an average length of onsite revisit surveys, which, according to the proposed rule is 18.5 hours. This is extremely unfair to those facilities that have just a few deficiencies that may require an onsite revisit – they are being penalized for the costs associated with facilities whose revisit surveys may require review dozens of deficiencies. A fee based on the average length of onsite revisit surveys does not provide an incentive for quality care.

As mentioned earlier, we agree that there be no revisit fee assessed for Medicaid-only providers. The proposed rule, however, does not address how CMS will account for facilities that, although they are certified for both Medicare and Medicaid patients, have a predominance of Medicaid patients. Please explain how the proposed rule will be applied to these facilities. Also, how will CMS account for those individuals who are dually eligible? We request an explanation for how this will be accomplished for those Medicaid patients that are primarily the responsibility of the state, particularly in light of the fact that there is no independent authority for the state to impose these fees.

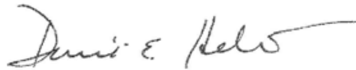
In order to fully understand the proposed CMS methodology and its impact, and in the interest of openness and transparency, it is imperative that the public have access to all necessary data sources used to develop the proposed rule. In particular, AHCA cannot independently conduct analysis to replicate the CMS findings, or to fully understand the impact of the proposed rule on its members. While aggregate CMS-670 data needed to replicate the CMS findings seems to be available, CMS-435 data are not publicly available. During the comment period, AHCA requested additional information about the CMS-435 form data and how to gain access to the data. AHCA was told by CMS staff that the data is not available to the public. The result is that AHCA cannot fully

respond to the proposed fee schedule, without having the relevant information at hand. The value of the rule-making process is severely curtailed by the lack of access to relevant data. Accordingly, we urge CMS to delay implementation of the proposed rule until the relevant data is made available to the public for comment (and on an ongoing basis).

AHCA requests that CMS provide more information and greater clarity on the source of data and specific data elements used in the onsite revisit survey fee calculation. As noted by CMS Secretary Michael Leavitt in the CMS vision statement in the booklet *Better Care, Lower Costs: You deserve to know…Health Care Transparency*: "I believe that bringing transparency to quality and cost information will reform health care in America." AHCA requests that CMS enhance transparency with respect to the proposed rule and make available the requested and relevant data.

Again, AHCA appreciates the opportunity to provide comment on the proposed rule to establish revisit user fees for Medicare survey and certification activities.

Sincerely,



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