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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Hand-delivered

Re: CMS-2268-P
Establishment of Revisit User Fee Program
for Medicare Survey and Certification
Activities

Dear CMS Colleagues:

The Center for Medicare Advocacy, on behalf of itself and the undersigned groups, submits these comments on the proposed rule to establish a revisit user fee program for Medicare survey and certification activities, CMS-2268-P. We generally limit our comments to the effect of the proposed rules on nursing facilities, although some of our comments are applicable to other health care providers and suppliers.

We have serious reservations about the imposition of revisit user fees on nursing facilities. The first concern is that revisit user fees appear to *replace* federal appropriations for survey and certification activities. We are concerned that if CMS and the states do not collect user fees in the amounts projected, state survey and certification agencies will not have sufficient money to conduct all the survey and certification activities that they are required to conduct. The survey and certification budget is already inadequate to perform all the necessary survey and certification activities.

The second concern is that state survey agencies will be pressured to limit the number of their revisits or to conduct only the less costly offsite (i.e., desk) revisits or to forego revisits entirely. Since the enforcement system for nursing facilities gives most facilities, under most circumstances, an opportunity to correct before imposing remedies and since remedies, in general, are imposed only if deficiencies continue to be identified at a revisit, the limited enforcement we have now will decline even further. The end result will be limited or no enforcement consequence to facilities for their noncompliance. Residents will inevitably suffer poorer care.

A third concern is that nursing facilities will use the fact of user fees to argue for deemed status. They will attempt to replace annual public surveys with privately-conducted surveys for which they could get deemed status. Opposition to the proposal to provide deemed status for nursing facilities in 1981 led to two Congressional moratoria and, eventually, enactment of the Nursing Home Reform Law. We believe strongly in the need for, and importance of, the public regulatory system and oppose actions that would lead to its weakening. We believe that revisit user fees weaken and undermine the public regulatory system.

We understand that revisit user fees could be viewed as a quasi-enforcement method; requiring facilities to pay for revisits that are made necessary by their noncompliance with federal Requirements of Care is a quasi-civil money penalty. The mandatory nature of revisit user fees would be useful, since most enforcement at present is discretionary. However, in order to have a significant effect on providers, the amount of the revisit user fees would need to be substantial and would need to reflect the extent and severity of deficiencies. As discussed below in the discussion of Fee Schedule, the proposed rules, while allowing for varying amounts for revisit user fees, in fact establish a fee schedule that imposes uniform, and only the most minimal of, fees for nursing facility revisits.

If the Centers for Medicare & Medicaid Services issues final rules to implement the revisit user fee policy, we submit the following specific recommendations about the proposed rules.

CRITERIA FOR DETERMINING THE FEE

The proposed rules create several exceptions to the assessment of a revisit user fee. The exception we disagree with is Life Safety Code requirements. CMS has not set out any rationale for exempting Life Safety Code revisits from revisit user fees and we know of none. We urge you to delete the Life Safety Code exemption.

FEE SCHEDULE

Although the proposed rules authorize CMS to adjust the amount of the user fee to account for various factors (size of facility; number or severity of deficiencies, or both), §483.30(b)(1)(iii), the fee schedule proposed for fiscal year 2007 includes none of these

factors. Instead, the FY 2007 fee schedule proposes uniform rates, based solely on the provider type and whether the revisit is onsite or offsite (desk).

The use of a uniform fee schedule for revisit user fees undermines the potential deterrent effect of revisit user fees. A \$168 offsite revisit fee for a skilled nursing facility is too negligible to have any effect on facilities, whose per day Medicare reimbursement ranges from a low of \$161.79 to a high of \$628.90 (72 Fed. Reg. 43,411, at 43,419 (Table 5, rural rates) (Aug. 3, 2007); \$162.68 to \$601.90 (72 Fed. Reg., at 43,418 (Table 4, urban rates). Since 80% of Medicare SNF stays are for rehabilitation, the most common Medicare reimbursement rates for rehabilitation categories actually range from \$250.04 to \$628.90 (Table 5, rural rates); \$246.95 to \$601.90 (Table 4, urban rates).

COLLECTION OF FEES

The proposed rule says that revisit user fees are not allowable items on costs reports, but adds that this prohibition does not apply to providers and suppliers that are reimbursed through prospective payment systems. The distinction that CMS makes does not reflect good public policy. No providers, regardless of how they are reimbursed, should be able to use Medicare reimbursement that they receive to provide care to beneficiaries to pay for revisit user fees.

The prohibition should be applied to nursing facilities, even though they are reimbursed through a prospective payment system. The Nursing Home Reform Law explicitly prohibits nursing facilities from claiming the costs of civil money penalties on Medicaid cost reports. 42 U.S.C. §1396b(i)(8) prohibits payment “with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h).” Facilities should not be able to shift the costs of CMPs or revisit user fees to Medicare.

To the extent that revisit user fees are intended to promote high quality of care and reduce the federal deficit, it makes little sense to allow facilities to divert Medicare reimbursement to revisit user fees, which are caused by the poor care they are providing.

We suggest that CMS amend §488.30(d)(2) as follows:

(2) Fees for revisit surveys under this section are not allowable items on a cost report, as identified in part 413, subpart B of this chapter, under title XVIII of the Act. Fees for revisit surveys under this section may not be paid from Medicare reimbursement under any circumstances, whether Medicare reimbursement occurs on a fee-for-service, prospective payment, or any other basis. [underlined language is added]

In addition, providers and suppliers that have revisit user fees imposed must be subject to a financial audit, to assure that they have not used Medicare reimbursement to pay the fees. CMS should conduct audits each fiscal year in at least 10% of providers and

suppliers that are required to pay revisit user fees. Audits serve an important function of assuring that providers spend public reimbursement as Congress intended. GAO, *State Audits to Identify Medicaid Overpayments to Nursing Homes*, HRD-77-29 (Jan. 24, 1977), <http://archive.gao.gov/f0902b/100503.pdf>.

We suggest that CMS add a new subsection (3) to (d) as follows:

(d)(3) Audits. Providers and suppliers that are required to pay revisit user fees may be subject to audit by CMS to assure that they have not used Medicare reimbursement to pay the fees. CMS shall conduct audits each fiscal year in at least 10% of providers and suppliers that are required to pay revisit user fees.

RECONSIDERATION PROCESS FOR REVISIT USER FEES

CMS must assure that the sole issue available at the reconsideration process is whether a revisit occurred. Facilities should not be permitted to argue the merits of the deficiencies in any way.

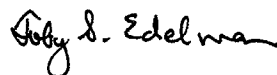
We suggest that CMS amend §488.30(d) as follows:

Reconsideration process for revisit user fees. CMS will review revisit user fees if a provider or supplier believes an error of fact has been made. The only error of fact that may be raised by a provider or supplier is that a revisit did not occur. A provider or supplier may not raise or argue the merits of the deficiencies in any way in the reconsideration process. A request for reconsideration must be received by CMS within seven calendar days from the date identified on the revisit user fee assessment notice. [underlined language added]

These comments are submitted by the Center for Medicare Advocacy, a private, non-profit organization founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and healthcare rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Thank you for the opportunity to comment on the proposed regulations.

Sincerely,



Toby S. Edelman
Senior Policy Attorney
Center for Medicare Advocacy

Additional Groups

Advocates Committed to Improving Our
Nursing Homes (ACTION), Florida

AFSCME

California Advocates for Nursing Home
Reform

Center for Advocacy for the Rights and
Interests of the Elderly (CARIE),
Pennsylvania

ElderCare Rights Alliance, Minnesota

Family Advocates for Nursing Home and
Home Care Improvement (FANHI), Florida

Indiana LTC Ombudsman Program

Long Term Care Community Coalition,
New York

NCCNHR

National Association of Local Long-Term
Care Ombudsmen

Nursing Home Monitors, Illinois

Office of the State Long-Term Care
Ombudsman, Tennessee Commission on
Aging and Disability

TLC4LTC, Virginia

Texas Advocates for Nursing Home
Residents

United Senior Action, Indiana

Voices for Quality Care (LTC), Maryland