Submitter : **Ms. Shelly Peterson** **Date: 08/14/2007**

Organization : **North Dakota Long Term Care Association**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

Thank you for the opportunity to comment on the Revisit fee's for nursing facilities. Quality assurance checks are an obligation of the government and the cost should be an expenditure of the Federal government, not the provider delivering care and services. The role of government is to assure compliance with the federal regulations and the eost of this function should be an obligation of our general tax system. On behalf of all the skilled nursing facilities in ND, which are all members of our association, we object to any revisit fees. We further object, if the fee continues that it must be considered an allowable cost on the cost report. ND is an equalized rate state, which means medicaid sets the same rate for all residents regardless of payor source. It is against the law to charge above the medicaid approved rate. If we are not allowed to include this proposed cost in our cost report, where will the funds come from to pay for the expenditure? Should you have any questions regarding my comments please don't hesitate to contact me at 701-222-0660. Shelly Peterson, ND Long Term Care Association

Submitter : **Valerie Smith** **Date: 08/14/2007**

Organization : **Lone Star Health Services**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

cms2268-p. I do not feel it would be fair to charge for re-surveys, or re-visits by the surveyors. The survey process is so broken as it is. It is very unfair to the smaller agencies already. It will be the smaller agencies that are re-visited or re-surveyed. The big agencies in my area keep Medicare patients, who drive, for 3 to 5 years. This should be a point that surveyors look at, but so far they have looked the other way. A survey is not objective. It is very subjective. Until the survey process is fixed, adding fines for re-visiting will do nothing but penalize the small guy even more.

Submitter : **Date: 08/14/2007**

Organization :

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

On behalf of a skilled nursing facility in central ND:

Myself, along with the staff of this facility, do not want to go forward with any revisit fees. If this fee has to continue, you must strongly consider it to be an allowable cost on the annual cost report. There already is not enough funds associated to pay for some long term care expenditures, and adding this to it would be a step in the wrong direction.

Submitter : **Date: 08/14/2007**

Organization :

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

Thanks for the opportunity to comment on the revisit fee's. I feel that the government has the obligation to conduct these revisits at the cost of the Federal Government. If you do implement these fees then you should allow LTC to capture these as allowable costs. The LTC facilities in North Dakota are on rate equalization? If we have to pay for your resposibilities, where will the money from?

Submitter : **Ms. Kathleen Hoeft** **Date: 08/14/2007**

Organization : **Ashley Medical Center**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

I would oppose the establishment of revist user fees because most facilities are not in a financial situation that they can afford to have unreimbursed costs, particularly after a survey.

Submitter : Mrs. M. Shawn Smothers **Date:** 08/14/2007

Organization : Trinity Kenmare Community Hospital

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

I would like to thank you for the opportunity to share my opinion on the proposal to charging Revisit fees to nuring facilities. We are a small critical access hospital, clinic, 12 bed skilled nursing home and it is a pleasure to be able to provide our services to our community. However, adding additional charges for a possible surveryor revisit when we are only trying to provide quality care to our patients, residents and community would be an excessive fee in my opinion. We are always striving to provide all the care our residents need as well as continually working to meet all the rules and regulations which govern our industry. It is the goal of every one of our staff members to do their very best to always insure the patient care is excellent and exceeds the patient and family expectations. The survey process is already a stressful situation for all staff - not because we don't want to be regulated and held to the highest standards but if anyone makes a mistake it could then not only trigger a survey revisit but additional expenses - we only have 12 nursing home beds and the revenue flow is limited by the size of the facility. I feel the survey process should be an expense of the state health department or if it were a federal survey revist a shared expense with state and federal government - Again I must stress we all try to do our very best to provide care but we are human and errors do happen - please do not add this as yet another stressor to the facilities. Thanks you for allowing me to express my concerns. I would be willing to share my concerns or further explain if you contact me at 701-385-4296 Shawn Smothers, RN Hospital Administrator.

Submitter : Mr. Mitch Leupp **Date:** 08/15/2007

Organization : Mountrail Bethel Home

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

I appreciate the opportunity to be able to comment on the proposed establishment of a user fee for the Medicare Survey and Certification Activity.
I believe that the responsibility for the survey process is that of the federal goverment, and as such the cost should be covered by the federal government.

North Dakota is an equalized state - we cannot charge more than Medicaid will pay. If this does proceed it must be an allowed cost within our cost report. If this is not the case how will we be able to cover the cost?

If it is an allowed cost you are just passing the cost on to the residents and the state Medicaid system. That just doesn't make sense!

Mith Leupp, Administrator
Mountrail Bethel Home
Stanley, ND
701-628-2442

Submitter : Mr. GREGORY SALWEI **Date:** 08/15/2007

Organization : WISHEK HOME FOR THE AGED

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

I AM WRITING TO EXPRESS MY OPPOSITION TO THE PROPOSED REVISIT FEE. QUALITY ASSURANCE CHECKS/SURVEYS ARE GOVERNMENT OBLIGATIONS AND AS SUCH ALL COSTS SHOULD CONTINUE TO BE AN EXPENDITURE OF THE FEDERAL GOVERNMENT AND NOT THE PROVIDER WHO IS PROVIDING THE CARE AND SERVICES. SINCE ND IS AN EQUILIZATION OF RATES STATE, THIS REVISIT FEE WOULD HAVE TO BE AN ALLOWABLE COST AND THUS PASSED ON TO OUR RESIDENTS. I ALSO BELIEVE THAT THIS FEE WOULD INCREASE THE NUMBER OF REVISITS CURRENTLY BEING DONE, PUTTING AN EXTRA BURDEN ON MY STAFF AS WELL AS REQUIRING ADDITIONAL TIME FOR STATE SURVEYORS. LONG TERM CARE COSTS ENOUGH ALREADY, WE DO NOT NEED ADDITIONAL REGULATORY BURDENS TO DRIVE THE COSTS EVEN HIGHER.

Submitter : **Mrs. Veronnica Smith** **Date: 08/16/2007**

Organization : **Avera Brady Health and Rehab**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

I am opposed to the revist user fee program for Medicare Survey and Certification. Currently in South Dakota, only about 86% of facilities require re-visits. I believe that this would increase to 100% because of the financial incentive. Further, even for phone re-visits, a fee of $168 per hour is excessive when all deficiencies are treated alike. For example, my organization recieved a deficiency for resident dignity last year because closet doors were open and there was a large red garbage can in the room. AAHSA, our national organizations estimates the the annual cost per facility for revisit under this program will be $2100. The concept I don't have issue with for truly care related deficiencies, but these are not differentiated from little things as I have described above. Further, regulators should not have a financial incentive for finding things wrong. In addition, according to my reading, any costs would be considered non-allowables in cost reports, which means that it is an added expense on an industry already struggling to continue to provide services.

I would prefer that if fees are needed, to charge an up-front fee, that does count towards approved expenses of doing business/cost report based on bed size. I am probably in the minority of the industry that would dare say such a thing- but I understand that regulators have financial restraints just as providers do.

I have met with Senator Johnson about these views and plan to visit with the rest of the SD and Iowa Delegation. The revisit fee proposal is flawed and should not be enacted.

Respectfully,

Veronnica J. Smith
Adminstrator
Avera Brady Health and Rehab

CMS-2268-P-20 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Ms. Donna Colley **Date & Time:** 08/17/2007

Organization : MedWay HHC

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

In reference to File code CMS-2268-P: They are no constraints to prevent a surveyor from citing an already corrected problem to trigger a revisit survey. There are no specifics on how fees would be paid. Need a process for reconsiderations for unfounded citations before payment schedules are imposed.

CMS-2268-P-21 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Mr. Garth Rydland **Date & Time:** 08/17/2007

Organization : Valley Memorial Homes

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

Our organization opposes the use of fees associated with revisits to skilled nursing facilities. An off-site revisit is a standard part of the survey process because facilities are not expected to have zero deficiency surveys. For those surveys that require an on-site revisit, I understand this costs health departments resources they might not have. I don't believe that the revisit charge is an effective method to recoup the costs of the revisit for the health department, and it certainly is not enough of a charge to change provider behavior either if that was even an intended consequence of the regulation.

Medicare should look at the reasons that trigger an on-site revisit. For example, survey agencies are required to do an onsite revisit with isolated G level deficiencies. A survey agency should have the discretion to do an offsite revisit for a single G deficiency. Maybe if it is a second year in a row or there are multiple G deficiencies in the same year it should be mandated, but a single G deficiency can often be a large waste of time and resources for the health department to investigate onsite.

CMS-2268-P-22 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Mrs. Linda Panchot **Date & Time:** 08/17/2007

Organization : Bethany Homes

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

I have deep concerns regarding the revisit fees. By requiring the facilities to subsidize the cost of these visits, there is the potential to decrease the positive outcomes of the survey process, because valuable resources are being expended on this fee instead of on components of the solutions to any deficiencies. This fee could be a tremendous hardship on an organization and could be detrimental to the care of its residents.

In North Dakota, an equalized rate state, funds are already very limited because of the inability to charge a market rate for services provided. The funds needed for the proposed fees can better be utilized on purchasing equipment and supplies for residents or for general safety, for building upgrades necessary to provide a safe and comfortable environment for our residents, or for staffing related expenses to assist with recruiting and retaining quality staff to care for our vulnerable adults.

Please reconsider this proposed fee and consider the long term effects that it will have on our residents and our facilities.

CMS-2268-P-23 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Ms. Cathy Swenson **Date & Time:** 08/20/2007

Organization : Nelson County Health System-Care Center

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

Thank you for the opportunity to comment on the proposed Revisit fee's for nursing facilities. The government has mandated these survey procedures, and we feel it should be the governments responsibility to finance them, not the facilities. The federal government's role to raise funds has always been in the form of Federal taxes - not in the implementation of 'fees' for the very programs/processes they require. Please note - we are not advocating a tax increase, but utilizing the very same process that has been in place to pay for programs, improvements, etc. As evidenced by the regulatory process, as well as reviewing national publications on quality and satisfaction survey data, the care provided in LTC facilities in our state ranks very high among all providers. Consistency in the survey process itself though is a problem. This involves the actual survey process, and the subjective implementation and determination of citing and scoring deficiencies. Where do the inconsistencies lie? With the individual states interpretations of the process, the individual state surveyors, and the Federal surveyors themselves. This is not a new concern and it has been identified and reported in the Congressional Records, News Releases, various committee reports, comments from legislators such as Senator Grassley, Health Care Associations, and the individual states. To mandate a 'fee' for revisits when there is such inconsistency in the actual survey process seems inconsistent with the overall purpose of the survey itself - to assure quality care and compliance with the mandated regulatory process. Without consistency, the survey process is not equitable and/or fair for the residents we serve, much less the long term care providers. Before any discussion and/or decisions are made re: revisit fees for revisits required by the regulations cited during the LTC survey process, we request these concerns and inconsistencies in the survey process itself be corrected first, in order to ensure accuracy in the actual survey process. This will provide a consistent and objective determination of deficiencies in every facility, provide accurate and consistent data across state and regional areas, and enable a fair and equitable survey process which accurately verifies the quality of care and services provided for the people we serve. Please contact me if you have any questions. Thank you again for this opportunity. Cathy Swenson, RN-CEO, Nelson County Health System

Submitter : **Mrs. Nancy Farnham** **Date: 08/21/2007**

Organization : **Maryhill Manor**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to comment against the implementation of revisit user fees. The use of this type of fees will make our system more punitive. I believe we will achieve better care for our elders if we work together, rather than work in a punitive environment. Also, in North Dakota we have an equalization of rates system, which means the rates we charge our private pay residents are the same as what we are paid through Medicaid. In this system, we would have no place to get the funds to pay the fees if we were not allowed to include them as allowable costs. Thank you for the opportunity to comment.

Submitter : Mr. Louis Cottrell **Date:** 08/22/2007

Organization : Alabama Nursing Home Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-25-Attach-1.PDF

#25

ALABAMA NURSING HOME ASSOCIATION

Serving Alabama Since 1951

August 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2268-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Subject: CMS-2268-P

To Whom It May Concern:

On behalf of the Alabama Nursing Home Association (ANHA) members, I am sending comments that we believe will be useful to the staff at the Centers for Medicare & Medicaid Services (CMS) as they continue through rulemaking process regarding their ability to charge revisit user fees to health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys.

Our facilities are extremely concerned with the punitive method CMS is proposing regarding revisit user fees. Our issues are as follows:

- Our facilities strive to always remain in substantial compliance. We employ dedicated professionals and certified staff to care for our residents. We are humans taking care of humans and are prone to make an occasional error or mistake. At any given time a deficiency could be cited at a level that would cause a facility to be out of compliance and a revisit survey triggered to occur in the future. In most cases these errors do not affect resident care. According to OSCAR data as of June 2007, only 10.2% (1,610 out of 15,850 facilities) were in substantial compliance on a survey. In addition, only 3% of the surveys (482 out of 15,850 facilities) were cited for substandard quality of care. In Alabama, only 5.2% (12 out of 235 facilities) were in substantial compliance on a survey and 3.9% (9 out of 235 facilities) were citied for substandard quality of care. This proposal of a revisit user fee would affect literally every nursing facility across the nation/state.

- We feel that limited Medicare and Medicaid resources should be utilized to provide high quality care directed to our residents rather than fund the administrative constraints of that care. It is our understanding that Medicaid is already under funded by more than $4.5 billion annually according to research conducted by the national accounting firm, BDO Seidman. All resources should be directed in the most economical and logical manner – meeting the care needs of our residents.

4156 Carmichael Road, Montgomery, AL 36106 Phone (334) 271-6214 Fax (334) 244-6509 www.anha.org

- The enforcement process is already overly punitive in nature. The revisit user fee would only add to the financial burden facilities face regarding the current enforcement system. Nursing facilities are already penalized for deficiencies that are determined to constitute immediate jeopardy and substandard quality of care. This proposal will now additionally place a financial penalty on facilities that have deficiencies that do not constitute substandard quality of care or immediate jeopardy.

- The survey process is subjective in nature. Although procedures are designed to be in place to allow for consistency in the survey process, it is not consistent. The inconsistencies are from state to state, regional office to regional office and from surveyor to surveyor. More focus should be directed on restructuring the survey process to make it more consistent.

- According to data provided in the proposed regulation, 87.9% of skilled nursing facilities required a revisit survey during FY 2006. The next closest provider was ESRDs where 15.7% required a revisit survey. Our regulations and enforcement procedures are much more stringent than any of these other providers. It appears as if this proposal is directly aimed at the skilled nursing facility. This is further verified when the projections for the last quarter of FY2007 for onsite revisit surveys (if user fees were in effect) is $8,643,028 and $7,401,184 of that will come from nursing facilities.

The Association cannot in anyway support this proposal in any form or fashion. User fees should not be charged by CMS. The process of health care delivery is dynamic and must never remain static. Achieving progressively higher levels of care quality is an ongoing effort – as is the progressive effort to measure, assess and evaluate quality care itself. CMS should place more effort on restructuring the survey process including the enforcement policies and procedures than on penalizing all facilities by instituting revisit user fees. The revisit user fees are an attempt to make up for administrative budget shortfalls on the backs of the nursing facility provider community who takes care of the most vulnerable population – our nation's elderly.

Thank you very much for considering our comments. Please ask your staff to contact me if further discussion is needed.

Sincerely,

Louis E. Cottrell, Jr.

Louis E. Cottrell, Jr.
Executive Director

Submitter : **Ms. Paula Schutzmann** **Date: 08/22/2007**

Organization : **Lee Regional Visiting Nurse Assn., Inc.**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

I think the Revisit Fee is extremely punishing to a home health agency. If there are deficiencies that need to be corrected, some of this oversight could be done off-site. Sometimes, agencies are wrongfully cited in the first place and this is an additional burden. It is primarily a cost issue for agencies and would be very burdensome for most.

Submitter : James Enz **Date:** 08/23/2007

Organization : Asbury Park, Inc.

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

To establish this user fee will undoubtedly add financial strains to the already strained nursing home industry, especially to the stand alone, not-for-profits.

As Director of Finance at Asbury Park, we strive for exceptional care. Our nursing hours per resident days are far above the standard as set by CMS.

If the fees are imposed, then your agency must see to it that the survey process is not a witch-hunt, common sense is used, and that needless deficiencies are not sighted to a facility that gives good quality care. Otherwise, this becomes a waste of time and money for both sides. Needless to say any fees imposed will be considered as part of rate increases that are passed on to residents. The industry's rate structure is already at unaffordable rates for the average american in this country. You may thank the lawyers for this as well as the gouging insurance companies that have increased liability insurance premiums 200% or more over the last 6 years. As increased costs are imposed to our industry they are in turn passed on to the nursing residents. Who in turn use up their assets faster, thereby forcing them in to the Medicaid program faster. Which puts pressure on the tax payer. Does anyone consider the ramifications or long term effects of this endless cycy when considering manditory costs to the nursing industry?

Thank you.

Jim Enz

The user fee does not make sense.

Submitter : Mr. David Burd **Date:** 08/23/2007

Organization : Nebraska Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2268-P-28-Attach-1.DOC

#28

NHA Nebraska Hospital Association

August 23, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2268-P, Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities, Proposed Rule, (Vol.72, No. 125), June 29, 2007

Dear Mr. Kuhn:

On behalf of our 85 member hospitals and the 39,000 persons they employ, the Nebraska Hospital Association (NHA) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule for the establishment of a revisit user fee program for Medicare survey and certification activities.

CMS has proposed to establish a revisit user fee program for Medicare survey and certification activities that would allow CMS to charge revisit user fees to health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys.

The NHA is very concerned about the negative impact of this proposed rule on providers, which includes urban and rural hospitals, nursing facilities, and home health agencies. The impact of this proposed rule would ultimately result in shifting funds previously utilized for improving the quality of patient care to the payment of revisit user fees. Hospitals located in rural areas provide a valuable service to the people in their communities. Forcing providers to use scarce resources for revisit fees instead of patient care could impact their ability to continue to provide services at the current level.

The NHA is concerned that no criteria have been developed to clarify the need for an onsite revisit verses an offsite revisit. This issue has been discussed with the Nebraska Department of Health and Human Services (DHHS). Direction should be provided as to when an onsite revisit is necessary and when it is acceptable to conduct an offsite revisit. Additionally, requiring the assessed fees to be paid within 30 days would not allow a sufficient amount of time to appeal the onsite or offsite revisit outcome.

CMS estimates that $37.3 million would be collected in revisit fees annually to cover the costs associated with the revisit surveys. Based on recent revisit surveys conducted in Nebraska, the estimate impact on Nebraska providers is $450,000 annually. A large portion of this impact would be related to onsite surveys. This emphasizes the importance of establishing criteria to determine the necessity of conducting an onsite survey.

The NHA urges CMS not to finalize the proposed rule to establish a revisit user fee program. These fees would redirect funds needed to provide and improve patient care in all health care facilities, especially in rural areas.

If CMS moves forward and establishes a revisit user fee program, the NHA requests that criteria are developed to specify when onsite and offsite revisits are necessary and thereby eliminate the possibility of inappropriate fees being assessed. Finally, the requirement of payment within 30 days should be extended to within one year from the date of receipt of the assessed amount to provide adequate time for an appeal of the status of the revisit.

The NHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact David Burd, Senior Director of Finance, at (402) 742-8144 or dburd@nhanet.org.

Sincerely,

Laura J. Redoutey, FACHE
President

Submitter : **Ms. Valerie Edison** **Date: 08/23/2007**

Organization : **Iowa Health Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to comment on the proposed user fee for Medicare resurveys. Iowa Health Home Care is one of the largest home care agencies in Iowa. We are affiliated with 7 home care agencies in the State of Iowa and provide both home care and hospice services. Survey issues are a concern for us individually and as a group entity. The main issue is the high percent of survey deficiencies that are received for home care agencies in Iowa.

The Federal Register indicates agencies requiring a revisit survey is 6 percent. In Iowa, based on information secured from the Oscar Report 20 for 11/2006, Iowa s home care deficiency percentage in all areas was significantly higher than the region (VII) and the national average. For example, for G0337, assessment including review of medications, Iowa had 57% deficiencies compared to the region average of 26.7% and the national reference of 16.95%. G0227: Home health aide services provided reflects a 22% deficiency rate in Iowa compared to 7.4% regionally and 1.01% nationally.
I do not have data on hospice survey deficiency comparisons. The surveyors are the same individuals, so I would presume the scores are similar.
Based on this data, I feel charging a fee for this revisit survey is not appropriate or fair for those states with diligent surveyors. Some regional/ CMS oversight needs to be in place to assure consistency in survey practices between states prior to instituting any fees for re surveys.
The $1613 flat rate proposed is based on a revisit survey time average of 14 hours for home health. Based on a poll of our 7 Iowa affiliates and the history for our agency over the last 15 years, revisit surveys take less than 4 hours. Much of the time is spent in retrieving medical records (printing hard copies from the electronic record) for the surveyor review.
I would like the proposed rule to include some clarification on when an offsite versus and onsite survey is indicated. Our survey deficiencies have all been on documentation issues. I would think those issues could be handled via offsite review rather than an onsite visit. An offsite review has never been an option.
The time frame for the reconsideration process for revisit user fees is not long enough. The proposal indicates the request must be received by CMS within seven calendar days from the date identified on the revisit user fee assessment notice. Reconsideration processes take time to prepare and submit. Seven calendar days is not sufficient to prepare. Thirty days should be the recommended minimum time frame.
It is time to look at updating the Conditions of Participation to ease up on the training requirements and documentation demands placed on the clinicians providing home care and hospice. That step needs to take place before any user fees are assessed.

Submitter : **Ms. Kerry Pitcher** **Date: 08/23/2007**

Organization : **Ka Punawai Ola**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

I am in opposition to the proposed rule as it imposes a revist user fee which would result in a direct draw down on direct patient care funds thereby reducing funds that should be used to provide quality care for the Residents. There is already a State punitive system to impose civil money penalties when facilities are out of compliance. This rule seeks to create a program that results in no improvement to the quality of resident care. Therefore I am in opposition to this docket CMS-2268-P

Submitter : Doug Frihart **Date:** 08/24/2007

Organization : St. Joseph Village

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

The impostion of user fees for nursing facility inspections (other than the initial certification inspection) is worse than unfunded mandates that come from the government from time to time. In this case, visits that are not requested will result in fees of $2000 for an onsite inspection. Any individual with an axe to grand may create financial hardships for a facility simply by calling with unsubstantiated complaints, thereby generating a visit from an survey team. Nursing care providers should not be singled out to fund federal oversight programs: IF this is good policy, THEN apply to every industry which the government inspects (USDA charges when they inspect a packing plant, FDA charges when they review a new drug for which approval is sought, individuals under investigation pay the FBI/ATF/ETC when they raid and entity, etc., etc., etc.). The fees should also apply to federal validation/oversight surveys conducted with the fees charged to the State Agency who is being "monitored. The proposed fees take money out of a very tight financial balance. The money can be better spent improving the quality of life of elders, improving the quality of training provider to staff serving those elders, and improving the environments elders live in nationally. The fees will further erode the relationships between inpsection teams and providers, relationships many have spent years building so that everyone invloved in the process understands and accepts the others' role in improving the lives of elders living in nursing homes.

Submitter : Miss. **Date:** 08/24/2007

Organization : Miss.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my strong opposition to the proposed rule CMS 2268-P, 42 DFR Parts 424, 488, and 489. The reasons for my opposition are several. As I understand, State Agencies seemed to be almost forced to keep up with deficiencies cited by other states so they do not score off of the chart different than other states. It seems to me sometimes surveyors are looking for numbers and are tying to reach for deficiencies with higher scopes and severity to keep up the Jones . Some of the survey process is based on interpretation and is flawed due to the human element and interpretive guidelines . Surveys in general are disruptive to the facility, compliant surveys can be just as disruptive. The facility is not able to charge anyone for the time spent with surveyors to answer questions because surveyors have not taken the time to read the chart and they can not find what they are looking for. I am not able to charge for my time to come to the facility during a complaint survey that happens to be unsubstantiated. What about complaint surveys that are unsubstantiated, would it not be only just and fair charge the complainant a fee for the surveyors time and the facility time wasted?

Submitter : Ms. Heather Vasek **Date:** 08/24/2007

Organization : Texas Association for Home Care

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2268-P-33-Attach-1.DOC

CMS-2268-P-33-Attach-2.DOC

#33

Home Care: Keeping Texans Proud and Independent

Attach-1

DRAFT

August 24, 2007

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-2268-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

The Texas Association for Home Care is a nonprofit association representing more than 960 licensed home and community support services agencies throughout Texas that provide home health, hospice and personal assistance services. Nearly 700 of our members are Medicare-certified home health or hospice providers. We appreciate the opportunity to comment on the proposed rule published on June 29, 2007 regarding the imposition of revisit fees for Medicare providers.

First, we question the Center for Medicare & Medicaid Services (CMS) intentions regarding this proposed rule when the authority granted to levy the fees expires on September 30, 2007, and there does not appear to legislation pending that would extend CMS' authority to impose these fees beyond FY 2007. If Congress does not extend this authority, then it appears that this rule will be void.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE

If CMS will have the authority to adjust revisit user fees to account for the provider's size, number of follow up visits required, and/or the seriousness and number of deficiencies, these criteria must be made clear in the written notification given to the provider with an explanation of how much each of the above factors impacts the amount being assessed. Furthermore, it would seem that all of these factors would influence the length of time required to conduct the revisit survey, so it is unclear why the revisit fee amounts are initially based on averages but can then be adjusted for the factors listed above. Would it not be more clear and transparent for it to be a straight calculation for each provider/supplier based on the actual number of hours?

Section 488.30(d) COLLECTION OF FEES

We believe that CMS must allow more than one method of collection of fees under this section of the proposed rule. If the fees could only be deducted from amounts otherwise payable to the provider by CMS, a provider assessed a revisit fee on an initial certification survey may not have enough amounts payable to pay what they owe. Providers should have the option of different payment methods outlined in a certified letter with payment due within 60 days of the date of the letter.

We would also like to know if the fees deposited as an offset collection to be used exclusively for survey and certification activities are going to be allocated proportionally by provider type and by state.

3737 Executive Center Drive, Ste. 268, Austin, Texas 78731 ★ (512) 338-9293 ★ fax (512) 338-9496 ★ www.tahc.org

Section 488.30(e) RECONSIDERATION PROCESS FOR REVIST USER FEES

The state of Texas has an informal review of deficiencies (IRoD) process for home care agencies whereby agencies can appeal state licensure and Conditions of Participation (CoPs) deficiencies. Will the fees not be levied until all appeals are exhausted? Can a provider request reconsideration of the assessment of a revisit fee if they are appealing deficiencies?

Section 488.30(f) ENFORCEMENT

We believe that the proposed 30 calendar day provision for full payment of the revisit fee is too short and should be at least 60 days.

If the revisit fee that is assessed against a provider is greater than the amounts payable to the provider, how will the provider be able to comply without having their provider agreement terminated? This underscores the need for multiple methods of payment.

We appreciate the opportunity to comment on these proposed rules.

Sincerely,

Heather Vasek
Director of Public Policy

Home Care: Keeping Texans Proud and Independent

#33
attach #2

DRAFT

August 24, 2007

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-2268-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

The Texas Association for Home Care is a nonprofit association representing more than 960 licensed home and community support services agencies throughout Texas that provide home health, hospice and personal assistance services. Nearly 700 of our members are Medicare-certified home health or hospice providers. We appreciate the opportunity to comment on the proposed rule published on June 29, 2007 regarding the imposition of revisit fees for Medicare providers.

First, we question the Center for Medicare & Medicaid Services (CMS) intentions regarding this proposed rule when the authority granted to levy the fees expires on September 30, 2007, and there does not appear to legislation pending that would extend CMS' authority to impose these fees beyond FY 2007. If Congress does not extend this authority, then it appears that this rule will be void.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE

If CMS will have the authority to adjust revisit user fees to account for the provider's size, number of follow up visits required, and/or the seriousness and number of deficiencies, these criteria must be made clear in the written notification given to the provider with an explanation of how much each of the above factors impacts the amount being assessed. Furthermore, it would seem that all of these factors would influence the length of time required to conduct the revisit survey, so it is unclear why the revisit fee amounts are initially based on averages but can then be adjusted for the factors listed above. Would it not be more clear and transparent for it to be a straight calculation for each provider/supplier based on the actual number of hours?

Section 488.30(d) COLLECTION OF FEES

We believe that CMS must allow more than one method of collection of fees under this section of the proposed rule. If the fees could only be deducted from amounts otherwise payable to the provider by CMS, a provider assessed a revisit fee on an initial certification survey may not have enough amounts payable to pay what they owe. Providers should have the option of different payment methods outlined in a certified letter with payment due within 60 days of the date of the letter.

We would also like to know if the fees deposited as an offset collection to be used exclusively for survey and certification activities are going to be allocated proportionally by provider type and by state.

3737 Executive Center Drive, Ste. 268, Austin, Texas 78731 ★ (512) 338-9293 ★ fax (512) 338-9496 ★ www.tahc.org

Section 488.30(e) RECONSIDERATION PROCESS FOR REVIST USER FEES

The state of Texas has an informal review of deficiencies (IRoD) process for home care agencies whereby agencies can appeal state licensure and Conditions of Participation (CoPs) deficiencies. Will the fees not be levied until all appeals are exhausted? Can a provider request reconsideration of the assessment of a revisit fee if they are appealing deficiencies?

Section 488.30(f) ENFORCEMENT

We believe that the proposed 30 calendar day provision for full payment of the revisit fee is too short and should be at least 60 days.

If the revisit fee that is assessed against a provider is greater than the amounts payable to the provider, how will the provider be able to comply without having their provider agreement terminated? This underscores the need for multiple methods of payment.

We appreciate the opportunity to comment on these proposed rules.

Sincerely,

Heather Vasek
Director of Public Policy

Submitter : Mr. Mark Wheeler **Date:** 08/27/2007

Organization : Iowa Alliance in Home Care

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Position of the Iowa Allianee in Home Care on the
Proposed Medicare Survey and Certification Revisit User Fee

The Iowa Alliance in Home Care (IAHC) represents home health ageneies, and other providers of in-home services, throughout the state of Iowa. The majority of Alliance members are small to mid-sized organizations with modest operating budgets. The Iowa Alliance in Home Care emphatically opposes the establishment of a Medicare Survey Revisit User Fee for the following the following reasons at a minimum:

1. It would immediately create a significant financial hardship for most Iowa home care providers.

2. Home Health Agencies have been adversely impacted by stagnant and declining reimbursements from both Medicare and Medicaid the past several years.

3. The proposed revocation of enrollment and billing privileges provision would create additional and unrealistic financial obligations that extend far beyond the fees associated with the revisit alone.

4. Iowa home care providers would almost certainly be subjected to far more frequent revisit user fees since it is a widely known fact that Iowa surveyors are more stringent than surveyors in most every state, those in the surrounding Midwestern states at a minimum.

All other issues being equal this last point clearly makes it unconscionable to implement such a fee without at least assuring the provider community that surveys, and the resulting deficiency rates, would be consistently and equitably applied nationally. Since the assurance of a level playing field outcome is highly unlikely the implementation of this user fee is completely unacceptable to Iowa providers as it would severely over penalize them as the result of grossly skewed revisit levels.

CMS-2268-P-34-Attach-1.DOC

#34

Position of the Iowa Alliance in Home Care on the Proposed Medicare Survey and Certification Revisit User Fee

The Iowa Alliance in Home Care (IAHC) represents home health agencies, and other providers of in-home services, throughout the state of Iowa. The majority of Alliance members are small to mid-sized organizations with modest operating budgets. The Iowa Alliance in Home Care emphatically opposes the establishment of a Medicare Survey Revisit User Fee for the following the following reasons at a minimum:

1. It would immediately create a significant financial hardship for most Iowa home care providers.

2. Home Health Agencies have been adversely impacted by stagnant and declining reimbursements from both Medicare and Medicaid the past several years.

3. The proposed "revocation of enrollment and billing privileges" provision would create additional and unrealistic financial obligations that extend far beyond the fees associated with the revisit alone.

4. Iowa home care providers would almost certainly be subjected to far more frequent revisit user fees since it is a widely known fact that Iowa surveyors are more stringent than surveyors in most every state, those in the surrounding Midwestern states at a minimum.

All other issues being equal this last point clearly makes it unconscionable to implement such a fee without at least assuring the provider community that surveys, and the resulting deficiency rates, would be consistently and equitably applied nationally. Since the assurance of a "level playing field" outcome is highly unlikely the implementation of this user fee is completely unacceptable to Iowa providers as it would severely over penalize them as the result of grossly skewed revisit levels.

Submitter : Mrs. Theresa Edelstein **Date:** 08/27/2007

Organization : New Jersey Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-35-Attach-1.PDF

#35

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

August 24, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2268-P; RIN 0938-AO96 – Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities

Dear Acting Administrator Norwalk,

On behalf of its almost 300 member acute care hospitals, specialty hospitals, skilled nursing facilities, home health agencies and hospice providers, the New Jersey Hospital Association appreciates the opportunity to provide comments on the proposed establishment of revisit user fees for Medicare survey and certification activities.

NJHA respectfully opposes the imposition of these fees for several key reasons:

- State agencies will have a perverse incentive to cite deficiencies because fees will only be generated for CMS when revisits occur.
- These fees constitute a penalty that providers will have to pay regardless of whether cited deficiencies are overturned as the result of an appeal.
- User fees will remove resources from operations and programs that are directly related to services for patients and residents.
- Providers will have no way to plan in their budgets for the possible assessment of these fees.
- These fees would be onerous on top of fines and other expenses associated with deficiencies and plans of correction.
- Nursing facilities would bear an undue burden because of the frequency of inspections.
- Even minor deficiencies would lead to imposition of a user fee because State agencies would have to verify that the provider was back in substantial compliance with regulations.

Specific comments on sections of the proposed rule follow below

CRITERIA FOR DETERMINING THE FEE

NJHA appreciates the exclusion from this proposal of visits associated with Medicare provider or supplier compliance with Life Safety Code requirements, as well as the exclusion of State monitoring visits and visits associated with a federal monitoring survey.

It is unclear how CMS will use size, number of revisits, scope and severity and regional differences in cost to adjust revisit user fees. Therefore, NJHA cannot offer specific comments or suggestions on the criteria listed.

FEE SCHEDULE

If this proposal moves forward, NJHA strongly suggests that CMS consider a mechanism, such as a "cap," to limit the total amount of user fees associated with any one revisit and for all revisits experienced by a provider annually, so that providers' financial exposure can be better anticipated and managed.

COLLECTION OF FEES

If this proposal were to move forward, NJHA believes that, similar to skilled nursing facility civil monetary penalty funds, any user fees collected should be dedicated to quality improvement and available to State agencies to use to fund initiatives that would have an impact on quality of care. This would be consistent with CMS' focus on quality improvement in all settings. We respectfully disagree with the proposed plan to deposit these fees as an offset collection to be used exclusively for survey and certification activities conducted by State agencies pursuant to section 1864 of the Act.

RECONSIDERATION PROCESS FOR REVISIT USER FEES

NJHA respectfully disagrees with the seven calendar day timeframe proposed for requesting a reconsideration of a revisit user fee. If this proposal moves forward, NJHA would recommend that CMS consider changing the timeframe to business days (from calendar days) and increasing the number of days to at least 14. In this way, providers would have the same amount of time to request reconsideration for notices of a revisit user fee that arrive on a weekend or holiday.

NJHA also respectfully disagrees with CMS' plan to "credit" a revisit fee payment against future assessments when a reconsideration request is approved by CMS, even with the availability of a refund following its reconciliation period. For smaller providers, waiting for a refund at some future time following reconciliation could have a significant impact on cash flow. In the age of electronic payments, NJHA believes that

refunds should be made within 60 calendar days of the reconsideration request being approved by CMS.

ENFORCEMENT

NJHA believes the enforcement provision as proposed is quite heavy-handed, particularly since CMS has proposed that fees may be deducted from amounts otherwise payable to the provider or supplier. It is not clear to NJHA how a provider could be delinquent in paying the revisit fee if the fee is being deducted from payments. Having said that, NJHA does not believe that 30 calendar days is adequate, particularly if a reconsideration request is submitted and particularly when a provider's Medicare provider agreement and enrollment in the Medicare program is at stake.

Thank you for this opportunity to provide comments. Please contact me at 609-275-4102 or via email at tedelstein@njha.com if you have any questions about our comments.

Sincerely,

Theresa Edelstein, MPH, LNHA
Vice President
Continuing Care Services

Submitter : Ms. Kelly Priegnitz **Date:** 08/27/2007

Organization : Sun Healthcare Group, Inc.

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-36-Attach-1.DOC

#136

Sun Healthcare Group

Kelly A. Priegnitz
Assistant General Counsel
Regulatory Affairs
Direct Dial 949-255-7140
FAX 949-255-7057

August 26, 2007

Via Electronic Transmission & Overnight Delivery

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

To Whom it May Concern,

On behalf of Sun Healthcare Group, Inc. and its subsidiaries (collectively referred to herein as "Sun"), I hereby submit the following comments and opposition regarding the Centers for Medicare & Medicaid Services ("CMS") proposed regulation for the **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities** (hereinafter referred to as ("proposed User Fee")as published in the June 29, 2007 edition of the *Federal Register*.

The Proposed User Fee System has no Correlation to the Improvement of Quality of Care

The proposed regulation purports to be based upon the President's goal to promote quality of care and reduce the deficit. While the collection of user fees for survey revisits might facially appear to be a successful measure of reducing the deficit, it does not have any correlation to the improvement of quality of care to Medicare beneficiaries. In fact, the proposed regulation will reduce the amount of resources providers could otherwise utilize for enhancement of the services provided to their patients.

According to CMS, the proposed User Fee will encourage providers to maintain substantial compliance with regulatory requirements, thereby promoting and improving quality of care. This perception is without merit and fails to take into account the fact that the survey process already encompasses a mechanism to promote provider compliance through the imposition of both discretionary and mandatory remedies such as civil monetary penalties ("CMP"), denial of payment and termination of provider agreements. The proposed User Fee will be imposed in addition to the remedial measures already included in the survey process and will increase the drain of resources to an already under funded industry. Additionally, whereas the imposition of a CMP is based upon the scope and severity of the deficiencies cited, the proposed User Fee is a blanket assessment that will not take such nuances into account. The very nature of the built in funding source of proposed User Fee is likely to result in revisits becoming more common. A survey agency can use the proposed User Fee as a pretext to cite deficiencies so as to generate the need for a revisit and thereby generate revenue by way of the User Fee. As a result, the costs associated with the revisit process will actually increase as more visits will be required resulting in greater administrative costs that will either be born by increased fees, or an increase in budget needs. The proposed rule fails to address these potential abuses and does not provide a process to ensure such abuses do not occur.

The Proposed User Fee System does not Account for Survey Inconsistencies

It is widely known that survey outcomes vary greatly from state by state. Outcomes can vary as a result of surveyor bias, surveyor competency and training, state reimbursement rates, state politics and more. As an example of the variances seen from state to state, the Online Survey, Certification and Reporting System ("OSCAR) for June 2007 indicates that the median number of deficiencies for a standard survey in the State of California is 10.0, whereas the State of Rhode Island has only a median number of 2.0. Because of the subjectivity that is built into the survey process, one cannot properly do a cross comparison of California operators to Rhode Island operators on the basis of survey outcome alone. The proposed User Fee, however, will in essence draw such a comparison and will disproportionably impact operators by virtue of geography rather than quality of operations. The disproportionate impact of the imposition of the proposed User Fee fatally flaws the rule and as a result, it should not be imposed.

The Proposed User Fee System does not Account for Survey Errors

The proposed User fee fails to address what process will be utilized when a facility successfully challenges, either in Informal Dispute Resolution ("IDR") or via a Departmental Appeals Board ("DAB") appeal, a deficiency that is ultimately rescinded. Under the survey process currently in place, CMPs are stayed pending the outcome of a

DAB appeal, a process which takes on average 6 to 12 months. An IDR process can take anywhere from 30 days to 4 months depending on the state. The proposed User Fee does encompass a process for appealing errors, but as it contemplates resolution within a 30 day period, it is clear that the process contemplates purely administrative types of errors and not appeals associated with IDR and DAB appeals. The failure to have a process in place for operators to appeal the assessment of a User Fee in IDR and DAB appeal situations would constitute a violation of the due process rights constitutionally afforded to operators.

The Proposed User Fee System Unfairly Assesses a Flat Fee based Solely on Provider Type

The proposed User Fee sets forth a fee scale that is driven upon the "average" number of hours a survey revisit takes for a given provider type. For instance, nursing facilities will be assessed a revisit fee of $2,072 hours. The amount was derived from multiplying the hourly rate of $112 against the 18.5 hours that CMS determined was the average amount of a time a survey revisit takes. This methodology is flawed in several respects. First, CMS fails to provide the data it utilized in order to determine the average lengths of a survey revisit. To our knowledge, operators were not polled regarding the average length of their survey revisits. Presumably, this information was provided to CMS by the various state agencies. The extrapolated methodology contemplated by the proposed User Fee appears to be nothing more than a revenue generating device that brings no benefit to patients. Unless and until, the data is made public and submitted to a validation process, the assessment of a mandatory flat rate User Fee based solely upon provider type is unfair and legally improper.

Second, as noted above, the survey process can vary greatly from state to state. The failure to address the variances brought solely about by geography will result in a disproportionate impact of the proposed User Fee on certain providers.

The Proposed User Fee Fails to Distinguish Between Medicare and Medicaid Beneficiaries

As noted in the proposed User Fee, it is legally improper to assess such a fee against a Medicaid-only provider as there is no independent authority for a state to impose such a fee. However, the proposed User Fee fails to address how CMS will account for dually certified facilities whose census is predominantly made up of Medicaid patients. Failing to address these distinctions prior to imposition of the proposed User Fee could in essence result in the wrongful imposition of a fee for Medicaid patients without statutory authority.

In Conclusion, Sun believes that the proposed User Fee is flawed in many respects and is bad policy. Medicare funds expended on behalf of its beneficiaries should be used to provide quality of care services to meet their needs. The proposed User Fee drains funding resources from an already under funded industry for purely administrative purposes and in doing so, will deprive beneficiaries of the benefits they would reap by having providers utilize these funds to further enhance the quality of the services they provide. We appreciate the opportunity to provide comments on the proposed User Fee and respectfully ask that this bill be removed from the Senate FY 08 Labor, Health and Human Services and Education Appropriations Bill.

Sincerely,

Kelly A. Priegnitz

Kelly A. Priegnitz
Assistant General Counsel
Regulatory Affairs

KAP/ks

cc: Richard K. Matros - Chairman/ CEO-Sun Healthcare Group, Inc.
William A. Mathies - President/COO-SunBridge Healthcare Corporation

Submitter : Mr. Francis Byrne **Date:** 08/27/2007

Organization : NJAHSA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-37-Attach-1.DOC

#37

New Jersey Association of Homes and Services for the Aging
13 Roszel Road, Suite A104
Princeton, NJ 08540
609-452-1161
(fax) 609-452-2907
www.njahsa.org

August 27, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

This letter represents the formal comments of the New Jersey Association of Homes and Services for the Aging (NJAHSA) in response to the Centers for Medicare and Medicaid Services proposal for the Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities as printed in the June 29, 2007 edition of the *Federal Register* (Vol. 72, No. 125 - CMS-2268-P).

On behalf of the association and its members, residents, staff and family members located here in New Jersey, I would like to thank CMS for the opportunity to comment on the proposal and express our fervent opposition to its adoption. In general we are greatly concerned that this regulation represents yet another unnecessary tax on consumers and health care providers, particularly non-profits, which would have the unintended consequence of driving health care costs even higher. As indicated in the background section of the proposal;

"CMS has in place an outcome-oriented survey process that is designed to determine whether existing Medicare-certified providers and suppliers or providers and suppliers seeking initial Medicare certification are actually meeting statutory and regulatory requirements, conditions of participation, or conditions for coverage."

Indeed, the establishment of a "User Fee" program on top of the existing state and federal Survey, Certification and Enforcement regulations that already includes extensive "Civil Monetary Penalty" provisions for deficient practices has the perverse effect of placing all health care facilities in a financial "double jeopardy" situation.

Furthermore, NJAHSA disagrees with the CMS interpretation of Section 1864(e) of the Social Security Act as giving HHS the "Authority To Assess Revisit User Fees". As indicated in the proposal, Section 1864(e) of the Act states:

"Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title (other than any fee relating to section 353 of the Public Health Service Act)."

Clearly the inclusion and specific wording of this section within the original Act indicates Congress intended that the Secretary *"may not impose"* any fee on any facility for any survey (revisit or otherwise) for determining compliance *"with any requirement of this title"*.

In addition to those outlined above, listed below are the concerns we have regarding the specifics of the proposal:

Section 424.535(a)(1)—REVOCATION OF ENROLLMENT AND BILLING PRIVILEGES IN THE MEDICARE PROGRAM—USER FEE ADDITION:

The very idea of adding a "new sentence" to this particular section of the regulations stating; *"The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter"* substantiates our contention that the original Act did not contemplate the imposition of any additional fees and therefore we respectfully suggest it should not be included as a criteria for revocation of enrollment and billing privileges for noncompliance as proposed.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE:

Although NJAHSA appreciates the inclusion of an exemption from the proposed "user fee" for federal monitoring visits and those regarding Life Safety Code requirements, the proposal is ambiguous as to how CMS will utilize size, number of revisits, scope and severity, and regional cost differences to establish and adjust the Revisit User Fees proposed.

Section 488.30(d) COLLECTION OF FEES:

If the overall goal of this proposal is truly intended to ensure and promote the provision of "quality" health care services in facilities certified by CMS as indicated, then utilizing the proceeds from any "fees" collected under the Act for any other purpose would be inconsistent. NJAHSA believes that, if adopted, any "revisit fees" collected should be placed into a "CMP" type account and utilized to fund quality care initiatives and not be used to offset the CMS operating budget. Therefore we respectfully suggest that the following language contained in the proposal be deleted; *"As they are collected, fees will be deposited as an offset collection to be used exclusively for survey and certification activities conducted by State survey agencies pursuant to section 1864 of the Act or by CMS, and will be available for CMS until expended."* and be replaced with a more appropriate quality based alternative.

Once again, thank you for the opportunity to present our concerns, comments and recommendations. Be assured NJAHSA and its members are committed to providing the highest quality health care services to the elderly residents they serve and stand ready to assist CMS in any endeavor to achieve that goal. If you have any questions or concerns regarding our response, please do not hesitate to contact me at 609-452-1161.

Sincerely,

Francis J. Byrne
Vice President – Public Policy

Submitter : Ms. Mary Carr **Date:** 08/27/2007

Organization : National Association for Home Care

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-38-Attach-1.DOC

#38

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax
Elaine D. Stephens, RN, MPH
Val J. Halamandaris, JD

August 24, 2007

Herb Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2268-P; RIN 0938-AO96 – Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities

Dear Mr. Kuhn:

The National Association for Home Care & Hospice (NAHC) is the largest trade association in the United States representing providers of home health care and hospice and the patients they serve. We appreciate the opportunity to provide comments on the proposed rule for the establishment of a revisit user fee program for Medicare survey and certification activities published in the June 29, 2007 Federal Register. On behalf of the home health industry, we offer the following comments and recommendations.

DEFINITIONS
Issue: We believe that the definition of a revisit survey to include "offsite" activities is beyond a reasonable interpretation of the term. Not until the definition for "revisit survey" is provided, is it apparent that CMS intends to consider activities other than an onsite revisit to the provider to mean a revisit survey. We believe if Congress intended for the term "revisit survey" to mean any thing other than the standard definition of the term it would have been defined in the statute.

Recommendation: Restrict the definition of "revisit survey" to include only onsite revisit surveys.

COLLECTION OF FEES
Issue: CMS proposes to deposit revisit survey fees as on offset collection to be used for survey and certification activities. However, section 20615(b) limits CMS to use the fees as

offsetting collections specifically for revisit surveys, and not applied to general survey and certification activities. This broader application could provide perverse incentives for State surveyors to survey agencies more frequently and cite higher numbers of deficiencies than necessary. Surveyors have a great deal of discretion on how often a home health agency can be surveyed. Agencies can be surveyed for recertification once every one to three years. Although criteria exist for the minimal time a survey must occur, there is nothing to prevent more frequent surveys. In addition, there is wide variation in surveyor interpretations of agency compliance with the Conditions of Participation (CoPs). Furthermore, CMS has never established criteria as to when a condition level deficiency vs. a standard level deficiency has occurred. A condition level deficiency would necessitate at least one onsite revisit survey, while corrections to standard level deficiencies could be determined by an offsite review of the plan of correction.

Recommendation: Fees generated from revisit surveys should be limited to cover costs incurred for revisit survey activities and not applied generally to survey and certification activities. CMS should establish accounting and monitoring mechanisms, and provide transparency for fee allocations.

RECONSIDERATION PROCESS

Issue: The rule proposes that requests for reconsideration must be received by CMS within seven calendar days from the date identified on the revisit user fee assessment notice. This time frame does not allow providers to adequately request a reconsideration. In addition, while CMS proposes a deadline for providers to submit a request for reconsideration, the agency does not specify a deadline for itself to respond to reconsideration requests. Further, when a revisit fee is found to be erroneously charged to a provider, and the provider has already made a payment for the fee, CMS states the payment will be held and credited against any future assessments of revisit fees.

Recommendation: CMS should increase the length of time for providers to request reconsiderations to 30 calendar days from the date of the revisit user fee notice. In addition, CMS should insert into the final rule a deadline by which it will respond to reconsideration requests. Finally, if a revisit fee payment is found to be erroneous, CMS should refund the payment to the provider immediately.

REGULATORY IMPACT ANAYSIS

Fee Schedule Assessment

Issue: It is unclear how CMS is proposing to assess fees for revisit surveys. The discussion within the text and the proposed regulations are contradictory. On page 35680 - under the heading Proposed Fee Schedule for Onsite Revisit Surveys, CMS clearly states ".... we will not adjust fees based on the length of the individual revisit surveys, but will assess a flat fee per revisit survey, based on provider and supplier type". Beginning on the same page, under the heading Proposed Fee Schedule for Offsite Revisit Survey it states: " For offsite revisit surveys, we expect a revisit user fee of $168 assessed despite provider or supplier type...We calculated the base hourly fee of $112 multiplied by an average of one and a half hours to arrive at the $168". However on page 35683 the proposed regulation for 488.30 (b) reads:

"(b) *Criteria for determining the fee.*
The provider or supplier will be assessed a revisit user fee based upon one or more of the following:
(i) The average cost per provider or supplier type.
(ii) The type of revisit survey conducted (onsite or offsite).
(iii) The size of the provider or supplier.
(iv) The number of follow-up revisits resulting from uncorrected deficiencies.
(v) The seriousness and number of deficiencies.
(2) CMS may adjust the fees to account for any regional differences in cost.
(c) *Fee schedule.* CMS will publish in the Federal Register the proposed and final notices of a uniform fee schedule before it adopts this schedule. The notices will set forth the amounts of the assessed fees based on the criteria as identified in paragraph (b) of this subpart."

Assessing revisit survey fees as a flat rate based on the average number of hours for an onsite revisit by provider type and the offsite revisit survey fee on an average number of hours across all provider types will unfairly overcharge some providers while undercharging others. The number and degree of severity of survey deficiencies can vary greatly among agencies. The fee for a revisit survey should align with the cost for the revisit survey. Furthermore, the hourly fee of $112 is not supported by the information given in the proposed rule.

Recommendation: Clarify that criteria used for determining revisit survey fees would be based on the actual number of hours required to conduct the revisit survey and the hourly salary cost of the surveyor, plus overhead costs.

Sincerely,

Mary St Pierre,
Vice President,
Regulatory Affairs

Mary Carr
Associate Director,
Regulatory Affairs

Submitter : Mrs. Stephanie Dyson **Date:** 08/27/2007

Organization : DaVita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

DaVita is a leading kidney care provider serving patients with high-quality specialized prevention and treatment services, spanning 42 states and the District of Columbia. The DaVita network includes more than 1,250 outpatient facilities as well as acute inpatient units in over 800 hospitals. DaVita understands CMS goals and commitment of promoting quality of health care and safety of its beneficiaries and is pleased to have the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with comments about the proposed changes to the survey and certification survey program.

Submitter : Ms. Linda Leone **Date:** 08/27/2007

Organization : Illinois HomeCare Countil

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-40-Attach-1.DOC

#40

ILLINOIS HOMECARE COUNCIL
NATION'S FIRST HOMECARE ASSOCIATION

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Sir or Madame:

Thank you for this opportunity to comment on the proposed rule entitled "Establishment of Revisit user Fee Program for Medicare Survey and Certification Activities", published in the Federal Register on June 29, 2007 (Vol. 72, No. 125, Page 35673). The Illinois HomeCare Council (IHCC) is a trade association representing approximately 200 home care providers and suppliers in Illinois. These comments were developed by IHCC's Regulatory and Reimbursement Committee.

Section 488.30(a) DEFINITIONS

Comment: IHCC members find the definition of "Revisit Survey" to be too vague. Using the proposed definition, CMS could charge a revisit fee in virtually any survey situation. The proposed definition does not give providers or suppliers sufficient information to reasonably predict when a revisit fee will be charged.

Similarly, IHCC objects to the inclusion of offsite, or desk surveys in the definition of a revisit survey, particularly without further clarification. Virtually every Medicare home health agency and hospice survey in the state of Illinois results in the issuance of a statement of deficiencies. The proposed definition implies that the routine review of a plan of correction submitted in response to such a Statement could be considered an offsite revisit survey and could result in a revisit survey fee. IHCC believes that review of a plan of correction in response to a routine survey, particularly when no condition level deficiencies have been cited, should be considered part of the mandated survey process and should not result in any fees.

600 South Second Street • Springfield, IL 62704 • 217/753-4422 • FAX 217/528-6545 • www.ilhomecare.org

These objections are further bolstered by the significant differences in the type and amount of deficiencies cited across the states, and the lack of consistency among surveyors even within a state survey program. IHCC questions whether CMS should initiate a revisit survey fee program before it can demonstrate that the regulatory program is implemented more uniformly nationwide. In the current environment, the levying of the fees is bound to be inequitable.

Recommendation: IHCC recommends that CMS clarify the definition of a "Revisit Survey" to include only onsite surveys required when an initial certification, recertification or complaint survey has resulted in the citation of a deficiency at the condition level. Adopting a narrower definition of a revisit survey will provide significantly greater clarity for the provider community and the general public.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE

Comments: Consistent with our comments above, IHCC finds the criteria for determining the fee to be overly vague. While the Federal Register notice contains a number of tables displaying data regarding estimated costs and 2006 frequencies of revisit surveys, it is clear from the language in Section 488.30(b) that CMS intends to exercise considerable latitude in the actual levying of fees in a specific situation. Again, IHCC finds the criteria included in this section of the proposed rule to be so vague that a provider or supplier would be unable to predict with any accuracy the amount of the fee that might be charged, or to have an adequate basis for arguing against the fee in an appeal situation.

Several questions come to mind. First, what criteria will CMS or the State Survey Agencies use to determine that a provider or supplier is sufficiently larger than the average to justify imposition of a larger fee? Will fees be similarly decreased for smaller than average providers? How will fee increases (or decreases) relate to variations in provider or supplier size? Will CMS use a direct ration, size categories or some other criteria?

Second, does CMS intend to use criteria other than those described in the preamble discussion of the definition of the "Revisit Survey" to exercise the latitude provided in proposed Section 488.30(b)(1)(iv). It appears from this language that a home health agency or hospice would only be potentially subject to two revisit fees—for either one or two revisits following submission of one or more credible allegations of compliance. What other circumstances does CMS anticipate might be used to apply this criterion?

Third, what guidelines does CMS intend the states to use in applying Section 488.30(b)(1)(v)? Neither the home health agency nor the hospice survey processes differentiate among deficiencies based on seriousness other than

through citation at the standard or condition level. Is this the criterion that CMS expects the states to apply?

Finally, proposed Section 488.30(b)(2) states that CMS may adjust revisit fees to account for regional differences in costs. How does CMS intend to determine these regional differences? IHCC believes strongly that if CMS intends to vary the fees based on regional cost differences the means of determining such costs should be objective and specified in the regulation.

Recommendations: IHCC recommends that CMS revise Section 488.30(b) by deleting criteria (iii), (iv) and (v) because they are too vague and ill defined. Recognizing that this is unlikely, IHCC recommends that CMS revise Section 488.30(b) in order to provide more specific guidelines for how actual fees will be determined. Specifically, CMS should:

- Provide parameters for how the size of the provider or supplier will be determined to be outside the average, and the manner in which variations will trigger increased or decreased fees.
- Clarify how 488.30(b)(iv) will be applied. If CMS intends to use the revisit frequency directions provided in the State Operations Manual this should be specified in the regulation.
- Clarify the parameters for identifying deficiencies that are serious and numerous enough to justify an increased fee.
- Identify what measure of regional cost differences will be used to adjust the fees.

Section 488.30(c) FEE SCHEDULE

Comments: IHCC believes that the proposed fee schedule published on June 29, 2007 fails to satisfy the language found in Section 488.30(c) because it does not specify how fees will be varied as described in the comments on Section 488.30(b) (see above).

Recommendation: CMS should revise Section 488.30(b) or the proposed fee schedule to provide a clear view of how fees will be determined.

488.30(d) COLLECTION OF FEES

Comments: IHCC members object strenuously to CMS proposal for collection of revisit survey fees. First, IHCC objects to collection of these fees from payments for services that have been provided to beneficiaries. IHCC believes that CMS should recoup revisit survey fees from claim payments only after a provider or supplier has demonstrated an unwillingness to remit the fee using other avenues for payment.

IHCC also objects to the fact that there is no language in this section of the proposed rule that specifies when or how providers or suppliers will be notified that a revisit user fee is being assessed.

Recommendations: IHCC recommends that CMS invoice providers and suppliers for revisit survey fees when necessary, and that a wide variety of payment options should be made available to them as described in the preamble to the proposed rule, including credit card payments, electronic funds transfer, checks and money orders.

IHCC also recommends that CMS more fully develop this part of the proposed regulation to more fully describe the process and mechanism that will be used to notify providers and suppliers that a revisit user fee is being assessed.

Section 488.30(e) RECONSIDERATION PROCESS FOR REVISIT USER FEES

Comments: IHCC also objects to CMS proposal for reconsideration of revisit user fees. IHCC is confused by the language in the proposed rule that specifies that CMS will review a fee when the provider or supplier believes that "an error of fact has been made." CMS goes on to equate an error of fact with a clerical error. Does CMS mean a clerical error in the manner in which the Statement of Deficiencies is written, a clerical error in agency documentation that resulted in the deficiency being written in the first place, or a clerical error in the revisit user fee assessment notice?

CMS also fails to identify how providers and suppliers will be notified that a revisit user fee is being assessed. Does CMS plan to notify providers and suppliers electronically or via the US Postal Service? Will the notice be issued by CMS or by the state survey agency? Additional details are needed in order to more fully evaluate this proposal.

IHCC also objects to the proposal that a request for reconsideration must be made within seven calendar days of "the date identified on the revisit user fee assessment notice." What determines the date identified on the notice? The language in this section of the proposed rule and in the preamble is too vague.

IHCC objects strenuously to the seven calendar day time frame CMS proposes for submission of a request for reconsideration of a revisit user fee. If CMS plans to notify providers of the fee assessment via the US Postal Service certainly more than seven days will be needed. Even with electronic notification, seven calendar days is not a sufficient time period to prepare a written statement including supporting evidence that a revisit user fee has been assessed incorrectly or inappropriately.

Finally, IHCC objects to CMS plan to credit a reconsidered revisit fee payment against future assessments of revisit fees rather than refunding the money to the

provider or supplier. This statement assumes that future revisit fees will be levied. It is wholly inappropriate for CMS to retain these funds—they should be immediately refunded to the provider or supplier. It is also unclear what CMS means in the preamble when they state that they will "provide a refund following its reconciliation period." Please clarify what "reconciliation period" is being referenced in this language.

Recommendations: CMS should revise Section 488.30(e) to specify how and when notification of a fee assessment will be made, and should allow 30 days from the date of receipt of the notification for providers and suppliers to request a reconsideration of a revisit fee assessment.

IHCC also recommends that CMS clarify what is meant by an "error of fact" and provide additional information about the circumstances in which a reconsideration request will be considered. IHCC believes that CMS should reconsider fee assessments in situations where providers and suppliers are contesting both the content and the level of the deficiencies cited by the state survey agency.

IHCC also recommends that CMS revise its proposed rule to require an immediate refund to a provider or supplier who prevails in the reconsideration process and has already remitted an invoiced revisit survey fee.

488.30(f) ENFORCEMENT

Comments: IHCC also objects to CMS intention to terminate a provider or supplier's provider agreement and enrollment in the Medicare program if the provider or supplier fails to pay the revisit user fee within 30 days. Frankly, this seems like a draconian response to a relatively minor issue, the statutory basis for which is not clear.

Recommendation: CMS should identify a less drastic response to failure to remit the revisit user fee than banishment from the Medicare Program, particularly since in Section 488.30(d) CMS reserves the right to collect the fee from other payables owed the provider or supplier. In fact, perhaps CMS should consider simply collecting the amount out of payables should the provider or supplier fail to remit it within 90 days.

REGULTORY IMPACT ANALYSIS

Comments: IHCC questions the 12% inflation factor that CMS is applying to the FY 2005 survey costs reported by state survey agencies. The inflation factor seems excessive, particularly in light of the fact that CMS has calculated market basket index increases for home health agencies at approximately 3% per year in the same time period. CMS is assuming that cost inflation faced by state

survey agencies is 6% per year, but is only 3% per year for home health provider organizations. This is unrealistic.

IHCC members are also puzzled by some of the data included in the Regulatory Impact Analysis, particularly the distribution of onsite and offsite revisit surveys anticipated for home health agencies and hospices. CMS' data indicates that they anticipate that approximately 2/3 of revisit surveys of home health agencies will be onsite, and approximately 4/5 of hospice revisit surveys will be onsite.

These figures are counter-intuitive if one assumes that offsite revisit surveys are conducted to evaluate responses to survey findings that are at the standard level. Deficiency citations at the standard level are much more frequent than are citations at the condition level, which require an onsite follow up assuming submission of a credible allegation of compliance. IHCC would appreciate clarification from CMS regarding what types of deficiencies will result in an offsite revisit for a home health agency or hospice.

Recommendations: CMS should reduce the inflation factor applier to the revisit survey user fees by half in order to bring it in line with the market basket increases given to the provider and supplier communities.

Again, we appreciate the opportunity to comment on regulations proposed by CMS. Please do not hesitate to contact me or Rebecca Friedman Zuber, IHCC's Regulatory Consultant, if we can be of assistance.

Sincerely,

Linda Leone
President

Submitter : **Ms. Kathleen Smith** **Date: 08/27/2007**

Organization : **Fresenius Medical Care**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-41-Attach-1.DOC

#41

Fresenius Medical Care
North America

August 24, 2007

Herb Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Establishment of Revisit user Fee Program for Medicare Survey and Certification Activities; CMS-2268-P

Dear Mr. Kuhn:

Fresenius Medical Care North America (Fresenius) is pleased to offer the following comments to the Proposed Rule: Comments on Establishment of Revisit user Fee Program for Medicare Survey and Certification Activities ("Proposed Rule"), as published by the Centers for Medicare and Medicaid Services in the Federal Register on June 29, 2007. Fresenius operates some 1,600 dialysis facilities, providing care and services to nearly 120,000 dialysis patients. We are, therefore, frequently surveyed for compliance with the Conditions for Coverage for suppliers of ESRD services and appreciate the opportunity to share our thoughts with you on the Proposed Rule.

GENERAL COMMENTS

We note that the proposed regulations lack the necessary administrative procedures, operational guidelines or criteria for either CMS or its State Agency contractors. We also note by its absence any explicit involvement or oversight role for the CMS Regional Office.

As written, the requirements would be open to arbitrary determinations by surveyors and contractors which could leave suppliers/providers at a distinct disadvantage and open to financial prejudice. State Agencies must be accountable and required to adhere to explicit and defined administrative processes which are known to suppliers/providers and which are overseen by the Regional Offices. *We suggest that administrative review processes or criteria be included in the Final Rule to ensure that there are uniform processes in place to prevent arbitrary practices and*

citations and to maintain the integrity of the contractors. We further suggest that the Final Rule include a requirement that the Regional Office function as the arbiter of supplier/provider requests for reconsiderations.

If the final regulations are issued without such processes and criteria, interpretive guidelines should be developed to accompany the regulations. Further, we believe implementation should be delayed until such the guidelines have been developed, and that this process should include input from the supplier and provider communities.

The proposed regulations have the potential to create an incentive for State Agencies to increase the number and/or the severity of citations. There is no explanation of how monies will be allocated to individual State Agencies. If numbers of surveys are the basis for allocation of funds, it will be in the self interest of each Agency and surveyor to cite at more serious levels of deficiencies thereby generating more surveys, and hence revenue, for the Agency. *We therefore suggest that the Final Rule include explicit criteria that would serve to standardize the process nationwide and, thus, standardize the assessment of fees.*

We believe the Final Rule should clarify that only condition level or immediate jeopardy level citations should result in onsite revisits. An initial or recertification survey where standard level deficiencies are found should not generate onsite revisits, but rather it should require an offsite survey.

We believe the implementation of the proposed regulations should not coincide with the implementation of the Final Rule for the revised Conditions for Coverage for ESRD facilities. The revised conditions are expected to be a significant departure from the existing regulations, with which the industry has complied for over thirty years. It is likely that there will be, upon implementation, a learning curve for the suppliers/facilities, the State Agency personnel, and the Regional Offices. Revisits and assignment of fees could very well be excessive during this "learning period" for all parties. *If the Agency has such discretion, we suggest that the Final Rule reflect that the assignment of user fees to ESRD facilities not apply for the first 12 months of implementation of new Conditions for Coverage.*

Section 488.30(a) DEFINITIONS

We suggest that a specific definition of offsite ("desk") survey be included in the Final Rule. While it is included as a type of "revisit survey," it should be made more clear that the only time a desk review of a facility can generate a user fee is when it is being done consistent with the revisit policies that have already been established based on provider/supplier type, and further clarify that offsite preparation to prepare for an initial, recertification or complaint survey should be considered a required part of the survey visit and not generate desk review fees. In addition, documentation of the desk review, i.e., services performed, documents reviewed, time taken, etc. must be submitted to the supplier/provider if a fee is assessed.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE

We agree with the criteria proposed in §488.30(b)(1)(i) and (ii) to establish the revisit user fee in FY 2007 based on the provider/supplier type and type of revisit. We further agree that State monitoring visits, Federal Monitoring Surveys, and visits to ascertain compliance with Life Safety Code compliance should be excluded.

With regard to the proposal at §488.30(b)(1)(iii), to adjust revisit user fees to account for provider/supplier capacity, number of follow-up revisits, and the seriousness and number of deficiencies, we believe the proposed language lacks sufficient specificity. In addition, these factors affect the average cost of revisits by provider/supplier type, so we believe that continuing to base fees on those average costs is a more reasonable approach. Such averaging accounts for regional differences in cost as well, which negates the need for the proposal at §488.30(b)(2).

Section 488.30(d) COLLECTION OF FEES

At §488.30(d)(1), we agree that multiple options for collection should be established. It may be complicated to have the fees deducted from amounts otherwise payable, so other options should be available to the providers/suppliers. We also agree with the proposal at §488.30(d)(2) that such fees should not be allowable for cost reporting purposes.

Section 488.30(e) RECONSIDERATION PROCESS FOR REVISIT USER FEES

We disagree with the language at 499.30(e). Allowances for reconsideration should include the basis for the determination of a need for revisits in the first place (truly an "error of fact") and not solely upon "clerical errors" related to the fee assessment. The language in this section fails to reflect the very real errors we have experienced over the years in surveyor knowledge and exercise in judgment, citations related more to surveyor opinion or bias than to regulation, and various other misperceptions and misinterpretations.

Medicare survey and certification functions, specifically with the ESRD program, are only as good as its contracted State survey agency personnel. For a number of reasons that do not require iteration, and despite consistent efforts by CMS personnel to train and improve the consistency of ESRD surveyors, these individuals frequently have limited depth of understanding of dialysis facility operations. For these reasons, *we suggest elimination of the "such as clerical errors" language in this section and allow reconsideration based on absolute errors, such as invalid citations, in the fact-finding process of the surveys.*

With regard to the receipt of a request for reconsideration no later than 7 calendar days from the date identified on the fee assessment notification, we contend that this process needs more comprehensive revision and 7 calendar days is too short a window. It does not account for simple delays, such as holidays or weather. It also is not consistent with survey/certifications timeframes, which require the return of a plan of correction no later than 10 days after receipt of a statement of deficiencies (SODs).

SODs are frequently received two weeks or more, sometimes many weeks, following a survey. The notification of fee assessment should be delivered along with the SOD. Without the formal SOD in hand, which would be the basis for any need for revisits and related fees, the supplier/provider is at a disadvantage in trying to determine the validity of the fee and whether to request reconsideration. Administrative processes would be helpful in this regard.

Further, fees for additional desk reviews related to a request for reconsideration should be waived. Otherwise there is a potential for reconsideration-related desk reviews and thus increased desk review fees in cases where the initial citation and fee remains in question. This should be clearly delineated in established administrative process policies and criteria, as mentioned previously.

With regard to the timeframes proposed in this section, we suggest the following:

(1) Notification of fees in conjunction with the delivery of the statement of deficiency. If notification of assessment precedes the receipt of the SOD, and the window to request reconsideration passes, fees should be waived.
(2) The facility is given a 10 calendar-day window to review the SOD and any related fees and either accept them or submit a request for reconsideration.
(3) In the event that the supplier/provider decides to request a reconsideration of the assignment of fee - based on the nature of the citations or perceived need for a revisit – all action relative to the fee, i.e. supplier/provider payment, should remain pending until the outcome of the reconsideration.
(4) If the supplier/provider reconsideration is successful, the supplier/provider will receive written confirmation that the fee is rendered null and void.
(5) Reconsideration requests must be resolved within 30 days from request.
(6) Repayment to the provider within 30 days of a reconsideration determination in the supplier/provider's favor.

CMS proposes that it shall hold, for future credit, any revisit fee that has been paid but determined to be invalid due to a reconsideration determination. We strongly object to this because of the imbalance of burden on the supplier/provider. If a supplier/provider successfully challenges a revisit fee, the amount must be reimbursed within 30 days of the decision. Should a supplier/provider fail to receive timely refunds for invalidated fees, there should be a process at the Regional Office that gives them recourse to appeal for remedy.

Section 488.30(f) Enforcement

We do not disagree with the requirement to pay the fee within 30 calendar days, however, please refer to General Comments at the beginning of this letter and to the comments under §488.30(e) above.

We appreciate the opportunity to comment on this Proposed Rule.

Sincerely,

Kathleen T. Smith, RN, BS, CNN
Vice President, Government Affairs

Submitter : Mrs. Stephanie Dyson **Date:** 08/27/2007

Organization : DaVita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

REVOCATION OF ENROLLMENT AND BILLING PRIVELEGES IN THE MEDICARE PROGRAM USER FEE ADDITION - DaVita is concerned about the assignment, transition and operational aspects of the new User Fee program, particularly in light of the fact that it is untested and potentially unpredictable. We request CMS to ensure providers and suppliers are given reasonable opportunity to correct all matters before a final determination to revoke billing privileges is made. We further request a written notice be provided to providers and suppliers giving a 30 day notification of such action.

DEFINITIONS - Expansion of user fees to initial surveys--Patients access to dialysis facilities is currently hampered by the lack of CMS and state resources for survey and certification activities. Unlike other providers that may achieve deemed status through accreditation, ESRD facilities must obtain Medicare certification solely through the initial survey process conducted by state survey agencies. Today, many dialysis facilities that are built and ready to serve patients instead stand unused due to CMS budgetary shortfalls, CMS survey priorities set for states, and state surveyor shortages. In response, CMS has directed states to perform dialysis facility surveys ASAP. We request CMS to consider user fees to be expanded to include initial surveys to facilitate timely certifications (within 30 days of application). With this expansion, we agree that the establishment of user fees is sound policy that could lead to positive change in the Medicare program. Including timely initial surveys reflects a proactive approach by the industry to ensure the CMS funding level is sufficient to meet its program responsibilities. A user fee program for initial surveys will: 1)Off-set and administrative fees that occur as a result of initial surveys 2)Significantly reduce delays and review times 3) Have no influence on quality of care or ESRD supplier standards

Revisit surveys --We disagree with CMS imposing user fees for any type of survey, including revisits that do not require an onsite survey. Desk (offsite) surveys fall under the purview of expected work assignments and do not impose additional burden to CMS or the state agency. Therefore, we believe there should not be a fee associated with off site (desk surveys). Additionally, we agree with the proposed rule regarding assessing only one user fee if off site surveys require desk preparation.

CRITERIA FOR DETERMINING THE FEE Adjusting user fee by capacity (number of beds or dialysis stations), by size, the number of follow-ups, and/or seriousness of deficiencies seems arbitrary and is not well defined. CMS should impose a fee based on the total or estimated hours of service, not by the specific actions that are performed during a survey. Although the activities have an effect on the number of hours needed for a revisit, the activities themselves are well defined and can be anticipated. Additionally, regional adjustment of fees should not be imposed. It is difficult to anticipate if certain regions of the country require more or less resources during a survey. Prior to permitting regional adjustments, data collection should be conducted over the next 3 years. Lastly, we are requesting disclosure of the method use to determine specific user fees by provider type. We question the rate imposed upon dialysis facilities especially when compared to other providers such as hospitals that are clearly more complex in nature.

Submitter : Ms. Gwen Toney **Date:** 08/27/2007

Organization : Ohio Home Care and Hospice Organization

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2268-P-43-Attach-1.DOC

#43

Ohio Hospice and Palliative Care Organization
Ohio Home Care Organization

August 27, 2007

Herb Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS -2266-P Medicare Program: Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities

To Whom It May Concern:

The Ohio Hospice and Palliative Care Organization and Ohio Home Care Organization are industry organizations committed to providing education, support and advocacy for hospice and home care in Ohio. We are commenting on behalf of our members to the proposed rules on the "Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities."

OHPCO and OHCO have concerns of an additional financial and administrative burden these rules will place upon our providers. We hope that the provided comments discourage CMS from proceeding with these rules.

"424.535(a)(1)—REVOCATION OF ENROLLMENT AND BILLING PRIVILEGES IN THE MEDICARE PROGRAM—USER FEE ADDITION"

We disagree that the intent of Congress was to charge a fee for revisit surveys for home care and hospice agencies.

According to CMS, "Providers, in Medicare terminology, include patient care institutions such as hospitals, critical access hospitals, hospices, nursing homes, and home health agencies." The rule identifies "facilities". "Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management" for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaints surveys. Not withstanding section 3302 of title 31, United States Code, receipts from such fees shall be credited to such account as offsetting collections, to remain available until expended for conducting such surveys."

Home Care agencies are service providers, not facilities. We believe home care and hospice agencies should not be included in the ruling.

Part 488—Survey, Certification, and Enforcement: Subpart A—General Provisions

SECTION 488.30 REVISIT USER FEE FOR REVISIT SURVEYS

The fact that Congress did not make the "Continuing Resolution" permanent, but allows it to expire at the end of 2007, speaks loudly to the true intent of Congress.

Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title (other than any fee relating to section 353 of the Public Health Service Act).

Since the Congress did not expressly state otherwise, and the authority under section 1864(e) of the Act is permanent, the authority under section 20615(b) of the Continuing Resolution extends only through FY 2007.

Several years ago, the OIG issued a publication (**SEPTEMBER 2000 OEI-02-99-00532, http://oig.hhs.gov/oei/reports/oei-02-99-00532.pdf)** stating that the state survey agencies were not reviewing the home care agencies appropriately. According to the OIG too few deficiencies were given to home care agencies by the state survey entity. Since that time, Ohio survey deficiencies have increased from 61.12 per cent agencies with deficiencies in 2003 to 81.82 per cent of agencies with deficiencies in 2007.

Agencies that never received a deficiency in fifteen years of business, and had not changed practices, were suddenly receiving deficiencies from the surveyors. CMS contends that agencies have increased their HHPPS coding resulting in "case mix creep". This appears to be "survey creep"; all the while, CMS talks about outcome-based practices while continuing to use punitive survey measures.

If the survey entities receive reimbursement for re-survey, based on the figures above, expect that deficiencies will to continue to increase due to the enticement of money for the re-visits. Health care providers are closely monitored under Stark laws and any enticement for patient referrals for forbidden. This proposed rule appears to be an enticement for survey citations.

Section 488.30(a)—DEFINITIONS

CMS intends to define revisit survey as any survey performed for deficiencies. According to the proposed rule, this will include both onsite and offsite, or "desk" surveys. Generally revisit surveys for home health agencies and hospices are made in accord with CMS policy, with two onsite resurveys allowed, one within 45 days and a second, if necessary between the 46th and

90th day based on a credible allegation of compliance. However, there are no specific policies for desk resurveys.

CMS has not seen fit to authorize telehealth visits for home care or hospice nor to provide reimbursement for these services. How does that differ from a desk survey by the state entity. CMS provides a budget to each state department under which they must operate. To invent an additional survey seems to be a way to increase the operating budget for the state without the federal government providing the money. If CMS believes that money is an enticement that changes behavior, why would this instance be different?

SECTION 488.30(B)—CRITERIA FOR DETERMINING THE FEE

While we appreciate the fee exceptions allowed in the proposed rule, the end result is still that the state receives more operating capital the more re-visits it performs. This is counterintuitive to all instructions given to providers to monitor enticements of any type that might result in financial gain. We have deep concerns that this proposed rule imparts the wrong message to state agencies.

There is also no information on whether the surveys will be for condition level citations or for standard citations. If the follow-up activities required by the state agencies are for standard deficiencies, this could become quite lucrative for the state departments.

If the survey visit is for a complaint and it is not substantiated, then no fee should be assessed.

SECTION 488.30(C)—FEE SCHEDULE

Below are the proposed fees for home care and hospice. An observation is that, in Ohio, hospices are not having the normal three-year resurvey. Our understanding is that CMS has informed state departments that hospices are on the last tier of work they should complete and suggested that the hospice surveys should be expanded to every eight years from six. In the second quarter of 2007 no Ohio hospice had complaint surveys. According to Table A, only 7.9 percent of hospices required resurvey. By inference, that means that 92.1 per cent of hospice providers in the United States are providing appropriate care. It is interesting that the average length of onsite survey for hospices requires more hours than home care.

HHA
-- Average length onsite revisit survey 14.4 hours
-- Fee $1,613

Hospice
-- Average length of onsite survey 15.5 hours
-- Fee $1,736

Offsite revisit surveys are expected to require 1.5 hours at a cost of $168 for all provider types. Future notices will include adjustments based on increases to cost of living, labor, and overhead.

We again object to initiation of an offsite revisit survey. We believe it is beyond CMS' purview to expand its authority in instituting a new survey type.

SECTION 488.30(D)—COLLECTION OF FEES

CMS plans to use the fees for all survey and certification activities thus supplementing it operating revenue. The proposed rules say that the money will be used in revisit activities only. We point out that CMS has often considered money an incentive for behavior change; if we follow that logic, would that not be an incentive for more revisit surveys?

SECTION 488.30(E)—RECONSIDERATION PROCESS FOR REVISIT USER FEES

We are gravely opposed to the reconsideration process outlined in this rule. CMS allows a mere seven days for provider appeal, and if an error is found, money is not refunded but rather kept with the assumption that there will be a future revisit fee.

CMS requires timely return of funds and providers expect similar treatment. Secondly, the procedure is based on a faulty premise that the provider will have revisits. Again, this provides the state with additional revenue, and that revenue could be held indefinitely at the expense of the provider.

SECTION 488.30(F)—ENFORCEMENT

Termination from the Medicare program is excessively punitive. CMS is again placing the provider in an adversarial position instead of considering it a partner in patient care. If the provider lacks financial reserves, as home care and hospice often do, the care they provide to countless beneficiaries would be summarily eliminated, resulting in beneficiaries not receiving care from their "provider of choice".

Supplier Approval Subpart B—Essentials of Provider Agreements Section

489.20 BASIC COMMITMENTS

We object to this section being added to a provider agreement. As stated above, it does not consider a providers financial wherewithal and puts the provider in an untenable position in regard to patient care.

Subpart E—Termination of Agreement and Reinstatement After Termination Section

489.53 TERMINATION

We object to this section being added to the provider agreement. Subpart E includes reinstatement after termination and there is nothing in this section that addresses reinstatement. This again robs the beneficiary of their "provider of choice."

IV. REGULATORY IMPACT ANALYSIS

It is not surprising that CMS touts there will be little impact to providers. One only has to look back to 1997 and the Interim Payment System and the 3,000 plus providers that closed their doors to assess CMS' proficiency in foreseeing impact. With the BBA, home care spending was reduced by 45 per cent in just two years, resulting in savings of $53 billion more, than the $16 billion anticipated for fiscal years (FY) 1998-2002, or more than four times the targeted savings. Home health services were reduced from 9% of the Medicare program to 4%, and over 500,000 Medicare beneficiaries lost home health services in the first year alone.

With the implementation of the Prospective Payment System, CMS projected that home care profit margins would increase, and they did not. The National Association for Homecare and Hospice prepared a study during that period and established that 30.7 percent of all HHAs experienced financial losses under Medicare in 2001-2002, and estimated that figure would increase to 36.7 percent in 2003. All the data indicates that costs have risen, visits per episode have not been reduced, and profit margins have declined. In January 2006, Report OEI-01-04-00160, the OIG's findings indicate that home health agencies continued to meet patients' needs despite PPS financial incentives to reduce care. Hospital readmission rates showed no difference from the pre-PPS era in 2000 and the first three years of the new system. There were slight decreases in readmissions for certain diagnoses such as quadriplegia (down 2 percent) and dementia (down 1 percent), along with small increases for renal failure (up 4 percent), multiple sclerosis (up 5 percent), and pulmonary disease (up 5 percent). OIG determined there was no change in readmission rates for diabetes, Alzheimer's, or heart failure.

Home care is already facing the huge financial repercussions of the new HHPPS payment reforms. Data was submitted to CMS by the Lewin Group that correlated the findings of rehabilitation patient decreases with findings of increases in the clinical and functional severity levels of all home health patients, but to no avail.

RECOMMENDATIONS:

With CMS' track record of faulty predictions of the impact of its decision on providers, we would hope that these revisit charges proposed rules would be viewed with a skeptical eye. We request that CMS not initiate user fee funds during the remainder of fiscal year 2007 and that CMS neither levy nor collect revisit user fees in fiscal year 2008. Thank you for the opportunity to provide these comments.

Sincerely,

Gwen Toney
VP of Government Affairs
Ohio Hospice and Palliative Care Organization
Ohio Home Care Organization
555 Metro Place North, Suite 650
Dublin, OH 43017
614-763-0036 EXT 202

Submitter : Mrs. Stephanie Dyson **Date:** 08/27/2007

Organization : DaVita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

COLLECTION OF FEES We believe CMS should specifically define and describe the anticipated collection methods and do not agree with the language stating CMS may devise other collection methods as it deems appropriate. Although we appreciate CMS considering the efficiency, effectiveness and convenience for the providers and suppliers, we respectfully request notification of collection methods (and the ability to comment on them) prior to initiation. CMS specifically p[illegible]ses that user fees not be allowable items on a cost report. We disagree and suggest user fees are recognizable expenses and thus should be allowable cost rep[illegible] items.

RECONSIDERATION PROCESS We agree with CMS creation of a reconsideration process and concur with ensuring providers and suppliers have a process to make CMS aware of errors. We request for reconsideration should be submitted to CMS within 15 calendar days from the date identified on the revisit user fee assessment notice is reasonable. Further, we agree with CMS crediting revisit payment fees against future assessments if a provider or supplier has made a payment in error.

Submitter : Mr. Neil Johnson **Date:** 08/27/2007

Organization : Minnesota HomeCare Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-45-Attach-1.DOC

#45

Minnesota HomeCare Association
1711 West County Road B, Suite 211 South
St. Paul, MN 55113

August 25, 2007

Centers for Medicare & Medicaid
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

To Whom It May Concern:

The Minnesota HomeCare Association (MHCA) is supportive of the efforts of CMS to promote quality of health care and to reduce deficit spending.

The MHCA, however, wishes to make the following comments regarding CMS-2268-P:

Section 488.30(a):

Comment: We propose that resurveys for home health agencies would be assessed a "resurvey fee" only when the resurvey would qualify as a "partial extended" or "extended" survey.

Justification for this change: Resurveys for deficiencies that do no rise to the level of partial extended or extended do not indicate a same level of concern for the patient that would be present when there is a need for these other types of surveys and where a home health agency has only a small number of deficiencies that require only minimal follow-up, we believe that they should not be penalized in this manner.

Section 488.30(e):

Comment: We propose that a request for reconsideration be required to be received in 30 days rather than 7 days.

Justification for this change: The seven day window does not give the home health agency adequate time to evaluate the issue, prepare supporting evidence and submit a written statement to CMS. If you choose to maintain the seven day window, we offer the suggestion that it be changed to "seven business days". We also propose that when there is a request for reconsideration, that the payment of revisit fees be suspended until the reconsideration is completed.

Section 488.30(e):

Comment: In addition, we also propose that if a payment was made and a determination is made upon reconsideration that the fee assessment was an error in fact, the fee be reimbursed to the home health agencies, rather than crediting the payment against any future assessments of revisit fees.

Justification for change: Leaving the language as it is currently written, creates an assumption that there will be future "resurvey" fees for this agency, which is not an appropriate expectation. We believe the home health agency should have the funds returned to them within a 30 day time-period.

Regulatory Impact Analysis:

Comment: Even though survey teams work off of the same worksheets, there is variation in how different survey teams assess similar situations. Requiring "revisit" fees for all resurveys (either on-site or off-site) will increase the number of times that home health agencies will contest the survey findings. They may then enter into an informal dispute resolution process not only to avoid the revisit fee but also to respond to the issue of variation in how statutory requirements are interpreted.

Justification for change: Most Minnesota home health agencies have very little profit margin, if any, in the services that are provided and will find it difficult to pay fees, specifically those that are believed to be based on an invalid assessment and will contest deficiencies that are believed to be questionable.

Sincerely,

Neil Johnson
Executive Director

Barbara Burandt RN, CNAA, BC, JD
Government Relations Director

Submitter : Mrs. Kimberly Skehan **Date:** 08/27/2007

Organization : The Connecticut Association for Home Care, Inc

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2268-P-46-Attach-1.DOC

#46

THE CONNECTICUT ASSOCIATION
for **Home Care,** *Inc*

Incy S. Muir, RN, CNAA, MPA
Chair, Board of Directors

Brian Ellsworth
President/Chief Executive Officer

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1541-P
P.O. Box 8012
Baltimore, MD 21244-8012

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

On behalf of 82 certified home health agencies and hospice providers serving over 50,000 elderly & disabled Medicare beneficiaries annually, the Connecticut Association for Home Care, Inc. (CAHC) is pleased to submit the following comments on the proposed rule to establish a revisit user fee program for Medicare survey and certification activities that was published as a proposed rule in the *Federal Register* on June 29, 2007.

CAHC strongly opposes the imposition of the revisit user fee and has identified significant policy and implementation concerns with this proposed rule. These include:

1) Concerns with the definition of "deficient practices" and the broad implications of this definition as to the type of deficiencies for which this would apply.
2) Unclear reconsideration process/appeal process at state level for non-factual errors.
3) Insufficient timeframe for reconsideration and payment; and
4) Unclear estimated costs and CMS ability to adjust user fees.

We have outlined our concerns and recommendations in the following sections:

Section 488.30(a) DEFINITIONS:

CAHC is particularly concerned about the lack of clarity as to whether revisit user fees will be limited to condition level deficiencies or will include follow-up of standard level deficiencies. It also appears that the revisit user fee will apply to all deficiencies, not limiting to those deficiencies that may significantly impact patient care. Including all standard deficiencies regardless of consideration of the seriousness or pattern of compliance with the agency will place an undue financial and operational burden on all

providers, including those who have an excellent track record and one poor survey, which, at times can be traced to inconsistencies in interpretation between surveyors.

In addition, we have concerns regarding the definition of a *Substantiated Complaint* survey which includes the imposition of the revisit user fee if a finding of non-compliance was proven to exist, but was corrected prior to the survey. If the agency has successfully addressed a compliance issue, the agency should not require a revisit. This follow-up for continued compliance may occur during the next regularly scheduled survey, which is current practice for standard deficiencies in home care.

Section 488.30(b) CRITERIA FOR DETERMINING THE FEE:

CAHC is concerned about the statement that CMS can adjust the fees based on different provider characteristics (such as patient census). It is unfair to providers to impose fees without advanced notification of the actual costs based on any adjustment criteria. It is also unclear how this payment will be required to be made (i.e. one-time payment or payment installments). Clarification of these issues is necessary as the actual fees and the payment options will have a significant impact on the financial health of a provider and may unduly harm a home health agency's ability to provide care.

Section 488.30(e) RECONSIDERATION PROCESS FOR USER FEES:

CAHC is concerned that there does not appear to be an appeal process for survey findings that involve surveyor judgment. CAHC receives feedback from agencies regarding surveys and meets quarterly with the State of Connecticut Department of Public Health to review the aggregate feedback results and communicates provider and surveyor issues. This has been a largely successful collaboration, and many issues have been clarified. But it is also clear that at times there are inconsistencies between surveyors in determining what is considered a deficiency warranting a plan of correction, an onsite revisit, a directed plan of correction or a consent order.

In reviewing OSCAR Report 20 data for FY 2006, it is apparent that CT ranks higher than the New England states and nationally in several deficiency areas. We attribute this partially to the fact that we are a licensure state and have some of the most restrictive regulations and oversight processes in the nation. This has helped us in maintaining the quality of care provided, but it has led to a frequent need for follow-up by state surveyors. We feel that applying the revisit user fee for all onsite and offsite follow-up will unfairly impact CT providers and will place an undue operational and financial burden on the agencies and may ultimately limit resources necessary for patient care and service accessibility.

CAHC is also concerned that the agency process for appeal/resolution at the state level is unclear and does not indicate at what point the revisit user fee becomes effective if there is an agency dispute regarding survey results that could be considered judgment-based. In addition, the proposed rule does not define any accountability on the part of the state agency to insure that surveyors are competent, maintain working knowledge of current

clinical and operational practices, and that substantiated agency complaints regarding surveyors are acted upon accordingly.

Section 488.30(f)-ENFORCEMENT:

CAHC believes that the timeframe for submission of a request for reconsideration (7 days) or payment (30 days) is too restrictive. These timeframes do not provide agencies with enough time to review the deficiency, prepare a written statement and compile supplementary evidence. In addition, this process only addresses "errors of fact" or "clerical" errors, not issues arising from surveyor interpretation. In addition, there is also no defined timeframe for CMS to respond to an agency request for reconsideration.

In conclusion, CAHC strongly opposes the implementation of the revisit user fee based on the fact that there are many issues that are unclear to providers and that there are substantial flaws in this proposed policy, as we have outlined in this letter. We concur with the National Association for Home Care in their significant concern that the implementation of this fee will divert limited financial resources, currently devoted to patient care, to CMS administrative efforts. Ultimately, this diversion of resources may impact the quality of care provided to home health care patients.

Thank you for consideration of these comments. Please contact me at 203-265-9931 or skehan@chime.org if you have any questions or concerns.

Sincerely,

Kimberly Skehan, RN, MSN
Vice President for Clinical & Regulatory Services
Connecticut Association for Home Care, Inc.

ks

Submitter : Mr. David Hebert **Date:** 08/27/2007

Organization : American Health Care Association

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-47-Attach-1.DOC

CMS-2268-P-47-Attach-2.TXT

#47
attach 1

ahca
American Health Care Association

1201 L Street, NW, Washington, DC 20005-4046
Main Telephone: 202-842-4444
Main Fax: 202-842-3860 2nd Main Fax: 202-289-4253
Writer's Telephone: 202-898-2808
Writer's E-Mail: dhebert@ahca.org
www.ahca.org

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

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.

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,

David Hebert
Senior Vice President
Policy and Government Relations

CMS-2268-P-48 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : **Ms. Barbara Biglieri** **Date & Time:** **08/27/2007**

Organization : **California Association for Health Services at Home**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment (PDF File: Comment - Revisit User Fees California.pdf)

CMS-2268-P-48-Attach-1.PDF

#48

California Association for Health Services at Home

3780 Rosin Court, Suite 190, Sacramento, CA 95834
(916) 641-5795
Fax (916) 641-5881
www.cahsah.org

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2268-P

Dear CMS Policy, Data and Budget Staff:

On behalf of our more than 350 member organizations who provide Medicare home health and hospice services, the California Association for Health Services at Home (CAHSAH) is writing to comment on the proposed rule published in the June 29, 2007 Federal Register entitled "Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities." This proposed rule would allow CMS to charge revisit user fees to health care facilities, including home health agencies and hospices, for deficiencies during initial certification, recertification, or substantiated complaint surveys. The proposed fee would charge home health agencies $1,613 per onsite revisit survey fee, as defined, and $1,736 for hospices. Both home health and hospice offsite revisit survey fees are $168. The authority for this fee is authorized through September 30, 2007. Unless Congress extends the authority in its Appropriations bills in 2007, the authority would not continue past the above date.

California is Currently Increasing Home Health/Hospice and Other Provider Fees:
It is important to note the California is currently "right-sizing" home health, hospices, and other provider fees, which have resulted in a 472% increase from $677.75 for home health agencies to $3,876.23 for every annual renewal of a parent, branch, and change of ownership. This fee is the same for every agency regardless if any survey activity occurred, including routine survey, a survey prompted from a complaint, or starting up an additional parent or branch of an established agency, or a brand new agency starting up in California with no history. Hospice fees have been increased from $622 to $727.96.

Additionally, the California State Legislature just passed a health trailer bill, AB 283, Statutes of 2007, which indicated that all licensing for "health facilities" in California would be fully fee supported with providers paying for all costs and no state General Fund support. The fees are to be phased in over for years until 2009-10 State Budget. Each year fees are increased and by 2009-10 home health agencies and hospices will eventually pay approximately $5,568.93 per year and hospices $2,517.39 per year for all "transactions" (as described above).

Interestingly, CAHSAH has proposed over the last two years a lower annual fee for home health and hospices with a higher fee for initial licensing, including an application fee, to cover the higher costs associated with application, paperwork, and surveying "brand new agencies." However, California's Department of Public Health cited prohibitions from CMS for charging fees for individual surveys. Recent communication with the Department indicates otherwise, and references the authority cited in the proposal, such as the "last-in-time" rule.

"The proposed regulation allowing CMS [Section 20615(b)] to charge revisit fees (Revisit User Fee) to health care facilities does contradict with pre-existing regulation [Section 1864(e)] which

stipulates that such a fee can not be assessed. However, Congress has the power to abrogate or modify a treaty or earlier legislation that it created based on the principal of the "last-in-time" rule. This rule stipulates that where two statutory provisions appear to conflict the later in time prevails. (See Fund for Animals, 472 F.3d at 878). This correlates to the concept that interpretation and application of statutes should reflect the most recent expression of Congress' intent. In addition Section 20615(b) proposes a deviation from the prohibition of fees for a prescribed period of time from October 1, 2006 through September 30, 2007."

Therefore, CAHSAH believes it is very important to note that, while you are proposing revisit fees, that this proposal take into consideration that California home health and hospice providers are currently paying increased fees to pay for all of the state costs. For example, a home health parent agency with three branches went from paying $2,711 for all four locations in 2005 to $10,800 in 2006. Under this proposal, this home health agency will now pay $22,275.72, which is an increase in $20,000 over two years. It is important to note that we are paying these fees based on standard average hours rather than actual timekeeping survey data, which the Department implemented in October 2006.

Under the scenario of the proposed rule, California agencies will also begin to pay for federal revisit survey fees, in addition to the current right sized fee. Essentially, under this proposal, home health and hospice providers will be paying for all state and federal costs, except routine federal surveys that do not originate from complaints or deficiencies.

At the same time, California's home health agency has the greatest backlog of applications for any other provider type in the 15 licensing and certification district offices in California. **There has been no discernible improvement in services despite having received increases in fees over the last two years making it very difficult to understand why the Department needs more money from providers.** Making providers fund the program with the state having NO accountability or timelines to license or certify home health or hospices in a timely manner and/or send out renewals in a timely manner, has caused providers great hardship over the last four years, which has resulted in a backlog of 190 agencies as far back as 2003 in Los Angeles County and 2004 in Orange County.

Issues with Proposal:

1. Section 424.535 (a) (1) – Revocation of Enrollment and Billing Privileges in the Medicare Program – User Fee Addition

We take exception to add a provision of non-compliance for failing to pay any user fees to revoke enrolment and billing privileges in the Medicare program. Should a final rule be published on this issue, we ask that a different remedy is put in place to collect the fees, but that it does not stop providers from billing. This would become especially acute, since providers are not currently familiar with this new proposal and might not understand that they are subject to the user fee. Additionally, why is this section necessary if Section 488.30 (d) Collection Fees proposes to deduct fees from the Medicare claims to the provider making a fee collection process moot?

2. Section 488.30 (a) Definitions

In the definition of "certification," the rule proposes a user fee to be assessed for revisit surveys conducted to evaluate the extent to which deficiencies were identified during the initial certification or recertification. In California, the typical period for initial home health agencies to get their initial certification survey is two or more years. Owners of agencies often must get other jobs while they wait for the survey, and, therefore, would be more likely to be subject to deficiencies related to their pending certification survey because of issues related to huge gaps in time to become surveyed. We ask that initial certification surveys for home health and hospice agencies in California be stricken from this definition of initial certification agencies.

These providers should not be faulted for the state taking over two years to complete a survey for a parent and/or a branch for an existing agency. These new and existing agencies are at a huge disadvantage for compliance in California.

In the definition of "substantiated complaints survey", the term "any deficiency" is used. It is not clear whether this refers to standard level deficiencies, condition level deficiencies or both. We recommend that the threshold be a condition level deficiency only since this is the level of deficiency that results in non-certification or decertification.

Additionally, we find the definition for "substantiated complaint surveys" to be problematic as it allows CMS too charge user fees if the surveyor can prove that there was previous non-compliance to the survey but was corrected during the survey. This is truly counterintuitive to what CMS wants – good outcomes. To indicate to a provider that they will be charged a fee if they see a problem and correct it does not encourage provider quality assurance to find problems and fix them as soon as possible. It encourages the opposite behavior of the agency to "dare the surveyor" to find the problem and require the agency to fix it rather than a proactive approach. We ask that the following is struck from the definition: "substantiated complaint means a complaint survey that results in the poof or finding of noncompliance at the time of the survey, ~~a finding that noncompliance was proven to exist, but was corrected prior to the survey,~~ and includes..."

Since California is going through "right sizing" fees of up to 721 percent since July 1, 2006 projected through July 1, 2010, we ask that California home health agencies are taken out of the "provider of services, provider or supplier" definition.

In the definition of "revisit survey", "deficiencies" are again referred to without respect to level. Again we recommend that this be clarified as "condition level deficiencies" only.

3. Section 488.30 (b) Fee Schedule

On July 17, 2007, CMS revealed the California providers in Orange, Riverside, San Bernardino and Los Angeles Counties would be under a two year demonstration to re-enroll in Medicare, as well as be subject to a survey should the provider had a Change of Ownership within the last two years. We ask that providers are not assessed a fee if the visit is associated with this Demonstration and that it be mentioned in this section.

Additionally, California is similarly basing costs of "right sizing" our fees on average costs as does this proposal. There are definite winners and losers in using average costs. Agencies that may have a revisit survey once every few years would pay the same costs as an agency that is a problem agency. At the same time, state's such as California, would need to be assured that there were accountability measures in place by CMS to ensure that surveyors are conducting the surveys on a timely basis, if providers were to pay for their survey based on the number of staff and time spent. We would recommend accountability measures costs for providers to ensure that providers are paying for efficient practices based on accountabilities rather than open ended accountabilities for surveying agencies.

4. Section 488.30 (c) Fee Schedule

We are concerned that there are no criteria regarding onsite versus offsite revisits. We recommend that criteria be developed to determine the appropriateness of onsite versus offsite revisits. To reduce costs for providers and to maximize surveyor time, the definition should encourage the use of offsite surveys, except when patient safety is jeopardized. How will this fee schedule take incorporate accountabilities and targets for survey staff? Any proposal that assumes provider responsibility for fees and has no accountability measures for staff in is not aware of the lack of accountability measures in California. Providers should not have to bankroll

inefficient surveyors or surveyors who do not know the home health or hospice regulations. How do we ensure that providers are not paying for surveyor education rather than a violation of the Conditions of Participation?

5. Section 488.30 (d) Fee Collection
This section proposes to deduct fees from the Medicare claims to the provider. However, Section 424.535 (a) (1) proposes to revoke enrollment and billing privileges in the Medicare if user fees are not paid. We take exception to adding a new sentence to add a provision of non-compliance for failing to pay any user fees provision to revoke enrolment and billing privileges in the Medicare program and believe it is not necessary with this section.

6. Section 488.30 (e) Reconsideration Process For Revisit User Fees
If a home health or hospice agency, defined as providers, was assessed a fee in error, we ask that the agency is refunded and not credited for any future assessments of revisit fees. The error was CMS' and not the providers. The provider has already gone through enough hardship to have to prove the clerical error and should be refunded. Additionally, this is a negative approach. It is assumed that the provider will be levied a user fee for a revisit survey. It should not be assumed that the provider will have a future assessment and the fee should be refunded on the next claim and/or a check should be cut. We should work to have positive working relationships with providers based on trust.

7. Regulatory Impact Analysis
We would ask that this section take into account state differences, such as California's increased costs for all home health and hospice providers, who are subject to increased fee. It could have a disproportionate impact in California, where we are facing increased fees on an annual basis through 2009-10.

8. Alternatives Considered
We believe that alternatives could be implemented to decrease the need for conducting revisits, including application fees for new provider agencies that want to start up a parent or branch/alternative site home health agency or hospice, as well as timelines and accountabilities for state initial certification surveys to guarantee that serious providers could get moving and would not be subject to the current 2 year delay. Initial application fees of an appropriate amount we believe will help create entry-level standard through a financial commitment for "would-be" home health agencies for only serious, well meaning providers. The fee would be in addition to the annual fee. Additionally, accountabilities, set up by CMS, would ensure that, as part of the contracts that CMS has with their states and their state subcontracts (e.g. Los Angeles County), that providers could be assured of receiving a service for their payment. It doesn't imply a guarantee of passing the survey, as it is critical that CMS ensure that they are only allowing agencies that are qualified to be certified pass through. However, it would eliminate the vulnerability that providers currently face with the state surveying process.

Thank you for the opportunity to comment on this proposed regulation. We can be reached at (916) 641-5795 ext. 118 for Joseph and ext. 123 for Barbara.

Sincerely,

Joseph H. Hafkenschiel
President

Barbara Biglieri
Director of Policy

CMS-2268-P-49 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Mr. David Hebert **Date & Time:** 08/27/2007

Organization : American Health Care Association

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2268-P-49-Attach-1.DOC

#49

ahca
American Health Care Association

1201 L Street, NW, Washington, DC 20005-4046
Main Telephone: 202-842-4444
Main Fax: 202-842-3860 2nd Main Fax: 202-289-4253
Writer's Telephone: 202-898-2808
Writer's E-Mail: dhebert@ahca.org
www.ahca.org

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2268-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

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.

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,

David Hebert
Senior Vice President
Policy and Government Relations

Submitter : **Mr. Jeff Buska** **Date: 08/27/2007**

Organization : **Montana Dept. Public Health and Human Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

August 27, 2007
From: Jeff Buska, Administrator, Quality Assurance Division

Comments Regarding the Proposed Changes to 42 CFR Parts 424 and 488
(CMS 2268 P)
RIN 0938-A096

?424.535(a)(1) REVOCATION OF ENROLLMENT AND BILLING PRIVILEGES IN THE MEDICARE PROGRAM USER FEE ADDITION

The Montana State Survey Agency (Agency) appreciates the creative approach to address consistent deficient practice. The proposed change endorses a spirit of accountability and responsibility to the beneficiaries. The Agency also recognizes that the revisit user fee may assist in reducing the number of long term care facilities that vacillate between being in compliance and not in compliance. Conversely, the proposed fee has the potential of creating an adverse relationship between the Agency and providers. The Agency asks that CMS consider the local pressures that will result from this fee.

?488.30(a) DEFINITIONS

The Agency encourages CMS to further define the criteria for identifying the need for a revisit survey to promote consistency among state survey agencies in the country. Currently, some state agencies only perform onsite revisits if a deficiency is identified at level G or above; some state agencies perform revisits on deficiencies cited at levels E and F.

?488.30(b) CRITERIA FOR DETERMINING THE FEE

The Agency acknowledges the intent of the proposed change, and encourages CMS to adjust revisit user fees according to particularities of the states. Staff travel time is considerable in Montana and impacts productivity considerably. Furthermore the number of follow-up visits speaks directly to the quality of administrative oversight and ultimately the care provided by a facility.

?488.30(d) COLLECTION OF FEES

The Agency recognizes the intent of the proposed change, and would like CMS to recognize the additional burdens and pressures that this proposal will place on the Agency. The Agency encourages CMS to take whatever action(s) possible to prevent facilities from passing the cost of revisit user fees to its patients/residents who pay privately. The Agency frequently hears reports of private pay fees increasing shortly after a civil monetary penalty has been imposed.

Submitter : Mr. Frank Sokolik **Date: 08/27/2007**

Organization : The Joint Commission

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Joint Commission Comments on Revisit User Fee Proposed Rule

File Code: CMS-2268-P

Authority to Assess Revisit User Fees

The authority cited for the proposed rule is the Continuing Appropriations Resolution for Fiscal Year 2007, which expires on September 30, 2007, yet CMS is proposing a permanent change to the applicable regulations. We believe the proposed regulations should be revised to indicate that they will expire on that date. At a minimum, CMS should explain how it will handle the expiration of the statutory authority to assess these fees, as well as how it will accommodate the additional notice and comment necessary to extend the effective date of these regulations should the Congress act to extend this authority.

Section 488.30(a) DEFINITIONS

The proposed definition of a revisit survey is:

&a survey performed with respect to a provider or supplier cited for deficiencies during an initial certification, recertification, or substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider or supplier is in substantial compliance with applicable conditions of participation, requirements, or conditions for coverage. Revisit surveys include both offsite and onsite review.

Accredited providers and suppliers with deemed status in the Medicare program are not subject to initial certification or recertification surveys, but rather validation surveys, which are either perfomed on a sample basis, or in response to a substantial allegation of non-compliance (i.e., complaint survey). See Section 3240 of the State Operations Manual. CMS should clarify through another proposed rule if intends to impose a revisit user fee on an accredited, deemed provider or supplier for a revisit following a sample validation survey.

Additionally, when an accredited, deemed provider or supplier has a substantiated complaint survey, and the condition level deficiencies do not pose an Immediate Jeopardy, the deemed provider or supplier must be placed first under State Agency jurisdiction before further enforcement action is initiated. CMS first requests that the State Agency conduct a full survey of all Medicare conditions within 60 calendar days from the date of the deemed status removal. If the State Agency confirms during the full survey that the provider/supplier is in compliance with the Medicare conditions, the provider or supplier is in substantial compliance. There may or may not be Standard level deficiencies cited. Deemed status of the provider/supplier is restored. See Section 5100.2 of the State Operations Manual. CMS should clarify that a full survey following a substantiated complaint that does not pose immediate jeopardy in a deemed provider or supplier IS NOT a revisit as defined in the proposed 488.30(a).

Alternatively, CMS may wish to consider revising the proposed definition of revisit survey to include and is subject to an enforcement action under Subpart B of Part 489, between ..complaint survey and that is designed to evaluate&.

Regulatory Impact Analysis

In its impact analysis and fee proposals, CMS has chosen to include critical access hospitals in a single grouping with all other hospitals, even though section 1861(e) of the Social Security Act states that The term hospital does not include, unless the context otherwise requires, a critical access hospital (as defined in section 1861(mm)(1). Since critical access hospitals are typically smaller and less complex organizations than most other hospitals, the context clearly does not require their inclusion with hospitals in this analysis. Because critical access hospitals are smaller, less complex organizations, it would seem that the average length of an on-site revisit survey, and the corresponding assessed fee, would be less than that of other hospitals. CMS should at least present the relevant data on critical access hospi

CMS-2268-P-52 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Ms. Helen Meeks **Date & Time:** 08/27/2007

Organization : NE Survey Agency

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

CMS-2268-P-53 **Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities**

Submitter : Ms. Candy Bartlett **Date & Time:** 08/27/2007

Organization : Golden Living Centers, Beverly Living Centers

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#53

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. Coral Andrews** **Date: 08/27/2007**

Organization : **Healthcare Association of Hawaii**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

The Healthcare Association of Hawaii, representing hospitals, long term care facilities, home care and hospice providers, opposes the establishment of a revisit user fee program for Medicare Survey and Certification Activities. We believe that the existing survey and certification process already provides a venue to levy civil money penalties on providers for lack of compliance. The proposed rule would create a duplicative system.
Our recommendation is that CMS delay implementation of the proposed rule and continue to dialogue with our national affiliate partners (AHA, AHCA, and NAHC) to explore opportunities to streamline and strengthen the consistency in the existing survey and certification process rather than to create a new requirement. We support programs that demonstrate a shared partnership with CMS and ones that are directed toward improving the quality of patient/resident care (Ex. Advancing Excellence Campaign, Home Health Quality Initiative, etc).

Following review of this proposed rule, it appears that its intent is to supplement an underfunded administrative budget through the recoupment of direct care dollars to offset costs incurred during the revisit survey process. In an environment of care here in Hawaii where we need to retain sufficient capacity to care for the health care demands of Hawaii's residents, we cannot support a proposed rule that negatively impacts a provider's ability to cover the cost of caring for its patients/residents.
Thank you for this opportunity to comment.

Coral Andrews, RN, MBA
Vice President
Healthcare Association of Hawaii
808-521-8961