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June 6th, 2022

The Office of Management and Budget
725 17th St NW
Washington, DC 20503
Submitted via www.reginfo.gov

RE: [OMB No. 0938-0236] Independent Renal Dialysis Facility Cost Report Form CMS-265-11

To whom it may concern,

DaVita is pleased to comment on the Paperwork Reduction Act (PRA) package *Reinstatement with change of a previously approved collection for Independent Renal Dialysis Facility Cost Report Form CMS-265-11.* We are dedicated to transforming the delivery of kidney care. DaVita has a tenured cost reporting team with significant expertise in general and health care cost accounting principles and practices. We share CMS's goal of ensuring that facility cost reports capture data necessary to inform policymaking under the Medicare ESRD Program, including the development of market basket updates and analyses conducted by the Medicare Payment Advisory Commission (MedPAC) and other Congressional support agencies.

This PRA outlines proposed changes to the reporting of pediatric labor statistics and supplies, including the allocation of such supplies across cost centers. It also proposes changes to the reporting of capital costs and dialysis-related equipment costs into separate cost centers and differentiating between in-facility and in-home equipment costs. Finally, it includes new lines for the reporting of payments for TDAPA, TPNIES, and the Home Dialysis Payment Adjustment (HDPA). We believe these changes are positive overall, and DaVita can implement most of these changes with relative ease; however, we caution that not all providers have the automated processes in place that would allow them to quickly and effectively implement the changes. CMS should consider that the more complex the request the higher the potential for unreliable data. Again, DaVita can implement these changes without undue burden, but we ask that CMS consider that other providers may need additional time to report at this level of detail.

DaVita has worked through several sample cost reports attempting to implement the aforementioned list of changes. We will need to make several ledger/internal coding updates, and we note the following observations and requests.

- Pediatric labor –
    - We assume allocation is based on treatments unless timekeeping is updated with pediatric modality. We would appreciate clarity from CMS on this.
- Pediatric supplies –
    - Since this will need to be added as a modality, we ask that CMS give ample lead time, not sooner than January 1, 2023, to make the charge capture meaningful.
    - We ask for clarification on if the remainder of the supplies that are reported on Worksheet A, line 9 is to be allocated to pediatrics on Worksheet B-1, column7. Since column 7 is not shaded out, the cost for supplies as a whole may be allocated to pediatrics and could result in a potential overstatement.
    - Allocations based on treatment count, etc. would be possible, in a transition period. However, we recommend updates on a fiscal calendar for actual expenses, if such recommendation is reasonable for the industry.
- Worksheet A-7 Part II –
    - We ask that CMS provide additional clarity on the instructions.
    - For example -
        - Worksheet A, line 6 does not match Worksheet A-7 Part II due to salary and benefits.
        - Instructions state Part II must equal line 6, column 8; however, salary and benefits for Biomed are currently included on this line, these are not considered on Worksheet A-7.
        - Column headings on Worksheet A-7 are Depreciation and Capital lease. We recommend a change since R&M; Personal Property tax is also included in these columns (5-8).
- Worksheet E and E-1 –

    We believe these are good updates for consistent treatment of sequestration and TDAPA, TPNIES, and HDPA. Consistent reporting of TDAPA and TPNIES costs is crucial to conducting accurate assessments of the overall Medicare ESRD program and making informed policy decisions, especially as those products roll off a TDAPA or TPNIES. Reporting instructions should clearly indicate when and where organizations should report TDAPA and TPNIES reimbursements and costs.

We suggest that CMS amend the instructions related to the new reporting on pediatric labor, pediatric supplies, and capital assets to make clear that such reporting will commence with costs beginning on January 1, 2023. However, in this unique instance, we are supportive of the retroactive effective date of January 1, 2022, for data collection related to TDAPA, TPNIES, and the ETC Model to ensure accurate reporting of current-year costs. In addition to these specific comments and having hours included in every category the providers currently cover, it is crucial that CMS continue to provide ample clarity on cost report definitions and instructions to providers. Ample and clear instructions will help ensure the integrity and accuracy of cost-report data, and consistency in reporting across providers.

We urge CMS to provide further information on the allocation of capital costs. Capital cost centers/allocations are problematic with multiple modalities. Cost reports currently include

data on capital-related operation and maintenance by modality for ten categories. Cost data also are reported on dialysis machine maintenance, stratified by modality, and adult and pediatric patients. Capital costs are not always captured correctly and are non-sequential numbers. Proportional allocation is fundamental to all Medicare payment systems, and there is no evidence to suggest that it is problematic. Requiring the type of reporting that would necessitate having separate agreements based on modality could take years to achieve. Although some providers may have the systems' capacity to report the data, the changes necessary to collect it will likely increase administrative costs while providing minimal, if any, benefit to patients or Medicare overall. In this case, the administrative burden of reporting would outweigh the value of the additional data.

Lastly, to further ensure the accuracy of program-level analyses, we reiterate our previous requests that CMS add the network fee as a reduction on Worksheet D. In response to a prior recommendation on this issue, CMS suggested that it does not have the statutory authority to include the network fee on cost reports. However, the *Omnibus Budget Reconciliation Act of 1986 (OBRA 86)*, which established the network fee, does not address its inclusion or exclusion. The House Report accompanying OBRA 86 elaborates on Congressional intent with respect to the network fee, but it too does not address the fee's inclusion or exclusion. For future cost report updates, we urge CMS to reexamine its interpretation of the statute, which we believe affords CMS the necessary authority to add the network fee.

DaVita appreciates the opportunity to provide public comment on *[OMB No. 0938-0236] Independent Renal Dialysis Facility Cost Report Form CMS-265-11.* With any modification to the cost report, CMS should afford dialysis providers sufficient time to implement necessary organization- and facility-level changes to accommodate the new rules. Although organizations could likely implement smaller-scale changes more quickly, larger adjustments will require time to implement and necessitate changes spanning numerous operations including accounting, human resources, procurement and contracting, and clinical care. As such, we encourage CMS to give providers at least a 12-month notice period in the event of significant amendments to the cost report. If you have questions or need any additional information regarding any portion of these comments, please contact Kayla L. Amodeo, PhD, Director of Government Affairs at kayla.amodeo@davita.com or via phone at 202-210-1797.

Sincerely,

Vicki Kertzman
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DaVita Inc.