William N. Parham, III, Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Office of Management and Budget
Attention: OMB Control No. 0938-0022

August 21, 2023

SUBMITTED ELECTRONICALLY VIA REGINFO.GOV

Re: Agency Information Collection Activities: Submission for OMB Review; Comment Request; OMB Control No. 0938-0022; ICR Reference No. 202307-0938-008; CMS-1728-20

Dear Director Parham,

We are pleased to submit to OMB the following comments on the Home Health Agency Cost Report. Enhabit Home Health & Hospice operates 253 home health agencies (HHAs) and 107 hospice locations across 34 states and is a leading provider and innovator in how care is delivered in a patient's home.

The significance of the Home Health Agency Cost Report plays a central role in delineating the reasonable expenses incurred by providers delivering covered home health services to Medicare beneficiaries. The cost report is used for yearly rate configuration and the formulation of the home health market basket. Furthermore, the information from HHA cost reports serves as a cornerstone for the Medicare Payment Advisory Commission's (MedPAC's) calculation of HHA Medicare financial performance, including HHA margins. This information in turn informs MedPAC's policy recommendations made to Congress regarding the HHA financial and operational landscape, and ultimately forms the basis of MedPAC's recommended changes to the Home Health Prospective Payment System (HH PPS). If cost report data is inaccurate and/or unrepresentative of the actual costs of providing care, government estimates of home health agency financial performance – and policy choices based on those estimates – risk significant inaccuracy.

Given the importance of these functions of home health cost report data, there are several specific aspects of the HHA cost report that could be enhanced: (1) expansion of allowable costs to include bad debt and centralized management costs; (2) inclusion of cost information for payors other than traditional Medicare; (3) reduction of redundancy in FTE reporting; and (4) more granular clinician information on the Provider Statistical & Reimbursement Report (PS&R). These enhancements would contribute to offering a more accurate portrayal of the actual workings and dynamics of home health agencies.

1. **Additional allowable costs**

Certain costs, although categorized as non-allowable, are common to the operation of home health agencies nationwide. Specifically, we recommend that bad debt costs and costs from centralized or "home office" support services be deemed allowable on HHA cost reports. Allowing these costs would more accurately reflect actual costs of operating an HHA. Bad debt is particularly common and may arise based on technicalities associated with coverage

documents or other circumstances outside of the HHA's control. In addition to bad debt, many HHAs, particularly those that are part of a larger regional or national chain, are supported by a central or "home office" function that provides key back-office services that allow the HHA and its staff more time to focus directly on patient care. While CMS does not have a specific non-allowable policy about these costs, costs that arise from centralized management and are associated with the ability of an HHA to deliver care to existing and prospective patients should be recognized.

2. **Inclusion of all payors**

Another critical area requiring attention is the exclusion of payors other than traditional Medicare from the HHA cost report. The omission of payors such as Medicaid and Medicare Advantage (which now represents the predominant payor amongst Medicare-age patients) results in a limited perspective on an agency's revenue streams. Ignoring these other payors from a cost report perspective neglects important and growing revenue sources that can significantly impact an HHA's financial well-being. We recommend expanding the report's scope to encompass all payors, offering a comprehensive overview of the agency's financial landscape.

3. **Reduction of redundancy of FTE reporting (Worksheet S-3 Part II)**

Reducing redundancy on the cost report lessens reporting burden. To that end, the information on full-time equivalents (FTEs) as reported on worksheet S-3 Part II is redundant with the addition of worksheet S-3 Part V, which requires all paid hours for both full-time and contract direct care staff. Part II is also not utilized in any calculations regarding cost per visit or hourly wage in the cost report. There are also no Level 1 edits for failure to complete S-3 Part II. Since Part V of worksheet S-3 already covers the full paid hours for different types of clinical staff, Part II is not necessary, and we recommend removing it.

4. **More granular clinician information on the PS&R Report**

Since HHAs are required to break out visits by professional and paraprofessional clinician type (RN v. LPN, PT v. PTA, OT v. COTA), the PS&R should likewise provide that same level of detail throughout the form and on worksheet S-3 Part IV. As it stands, HHAs are only able to see Medicare visits and charges by general categories of skilled nursing, physical therapy, and occupational therapy. But this visit and charge information does not indicate whether the underlying services were conducted by a professional or paraprofessional clinician. Doing so would create better consistency throughout the cost report between S-3 Part I, S-3 Part IV, Worksheet A, and Worksheet C.

We appreciate your attention to these recommendations and their potential to contribute to a more useful and accurate HHA cost reporting function. If you or your staff wish to discuss these comments further, please contact Andrew Baird via email at andrew.baird@ehab.com.

Sincerely,

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Enhabit Home Health & Hospice