VonLehman
CPA & ADVISORY FIRM

November 3, 2015

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier / OMB Control Number
CMS -1728-94 and CMS-2567
Room C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Electronic Submitted: http://www.regulations.gov

Dear CMS:

We have reviewed the proposed changes to the Medicare Cost Report forms and instructions for the CMS Form 1728-94 – Home Health Agency per the Federal Register Notice dated September 4, 2015. As a preparer of Medicare Cost Reports for many home health agencies, we appreciate this opportunity to provide comments and feedback to CMS on the revised new forms that are mainly the result of the changes for the home health based Hospice agencies. Following is a summary of our comments to the proposed changes to the forms and instructions.

Effective Date

Can you please clarify the effective date of the proposed changes? There are minor changes to the home health sections which include incorporation of the CMS Form 339 into Worksheet S-2-1. The most significant changes will be the Worksheet O Series for Hospice, which are proposed to be effective for cost reporting periods beginning on / after October 1, 2015. Will all the changes be effective at once or will the home health changes be effective sooner?

Worksheet S-3, Part I – lines 10.01 and 10.02

These lines were applicable in 2000 during the transition from IPS to PPS but have been previously eliminated. These lines are on the draft form. We believe that these lines should still be eliminated.

Worksheet B-1, Allocation Statistic for Capital Related Costs - MME

Currently, home health agencies have the option to use square footage or dollar value. The vast majority of HHA's use square footage. This was originally proposed to be dollar value for the Freestanding Hospice cost reports, CMS Form 1984-14. We understand that CMS has recently modified their position on this issue and are allowing Freestanding Hospice Providers to use square footage if it was used on a cost report beginning before October 1, 2014 but otherwise they must use dollar value. We believe that HHA based Hospice agencies should also be allowed to use square footage. An added problem arises when square footage is used on Worksheet B-1 but Worksheet O-6, Part II, column 2 requires dollar value. This inconsistency is not possible on the cost report. Therefore we recommend that the instructions for Worksheet O-6, Part II, column 2 be changed to allow square footage. While we

understand CMS's position that dollar value is more accurate, all providers including -- Hospitals and SNF's have the option to use square footage. On those cost reports, the equipment cost per square foot is even greater. We are also concerned about the differences going forward in allowing some Hospice agencies to use square footage and requiring new Hospice's to use dollar value. We recommend that square footage be the standard basis and allowing dollar value as an alternate upon request by the provider as it currently stands.

Cost Reclassifications and Adjustments

On the existing cost report, cost reclassifications are reported on Worksheet A-4 and flow back to Worksheet A, column 7. Cost adjustments are reported on Worksheet A-5 and flow back to Worksheet A, column 9. This is used to report reclasses and adjustments for Worksheet A cost centers. In order to make reclassifications inside Hospice between levels of care, there is no Worksheet to separately report them. A reconciliation off the cost report will be necessary and the net amounts entered directly on Worksheet O to O-4, column 4. Likewise, the adjustments will be posted to Worksheet A-5 and flow to Worksheet A but must be manually entered on Worksheet O to O-4, column 6. We suggest a separate reclassification and adjustment worksheet just for the O series to provide a better trail for these entries.

Census Statistics

On Worksheet S-5, the census data for number of patients, unduplicated census count and average length of stay have been removed. We believe that this is important statistical information and recommend that CMS restore these statistics back on the cost report.

Sequence of cost centers

The O Series of the HHA based Hospice cost report greatly increased the number of cost centers and also dramatically altered the sequence of allocation. Historically, cost centers were ordered on the degree to which the specific cost center provides benefit, with most benefit listed first and least benefit listed last. We are most concerned about the following cost centers.

Plant Operations (line 5), Staff Transportation (line 12) and Volunteer Service Coordination (line 13) – All of these cost centers are allocated after Administrative and General (line 4) is closed out. A significant portion of these of the cost in these cost centers would normally be allocated to Administration. On the current Hospice cost report, all of these cost centers are allocated BEFORE Administration and a portion of the cost allocated to Administration. By these cost centers coming after Administration, this will cause a significant distortion in the allocation of costs to other cost centers.

The Pharmacy cost center is reported on line 14. We believe that these costs are directly related to the delivery of patient care and should NOT be classified as a General Service Cost Center. This is consistent with the current reporting on the cost report as a direct patient care.

Shared Services (Worksheet O-7)

For apportionment of shared services costs with HHA, the cost to charge ratio in column 3 is based on HHA costs in column 1 divided by HHA charges in column 2. Since this is for shared services, the cost in column 1 which comes from Worksheet B, column 6, lines 7 to 14, would have cost for home health and hospice combined. Therefore, in order to get the proper cost to charge ratio and apportionment on

this worksheet, the charges in column 2 should include home health and hospice charges combined. This will compute an accurate cost to charge ratio.

CBSA Codes

On the freestanding Hospice Cost Report (Form 1984-14), there is a section to report CBSA information – Worksheet S-1, Part I, lines 20 and 21. This is not included on Worksheet S-5 of the HHA Based Hospice cost report. We recommend that CMS include this information on the HHA based cost report.

We appreciate the opportunity to make comments regarding the proposed changes to the home health / hospice cost report.

Sincerely,

VonLehman & Company Inc.

David C. Macke, CHFP, FHFMA
Shareholder
Director of Reimbursement Services

DCM/

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October 20, 2015

Center for Medicare & Medicaid Services (CMS)
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: **0938-0022**
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

For the attention of: William N. Parham, III
RE: Form CMS-1728-94, Home Health Agency Cost Report

Dear Mr. Parham:

As a Health System based Home Health and Hospice organization, we are pleased to have this opportunity to comment on the proposed revisions to the annual home health agency cost reporting form, specifically those issues relevant to hospices owned or operated in conjunction with Medicare certified Home Health agencies. Please be advised that while we understand that these proposed changes are cited by CMS as necessary to meet requirements under the Patient Protection and Affordable Care Act (ACA) to obtain appropriate information to facilitate hospice payment reform, we do have issues with the proposed changes as follows:

- The form's instructions indicate that all data must be actual, not estimated, for each cell of information being requested with these revisions, clearly stating that estimates would not be a generally acceptable basis upon which to complete the requirements specified. We believe that requiring actual data for expenses such as administrative overhead, utilities, taxes, etc. is overly burdensome, for both small organizations that may not have the accounting systems in place to specifically assign costs to individual information cells specified by these proposed revisions, and for large Health System owned Home Health and Hospice organizations (like ourselves) who utilize Generally Accepted Accounting Principles (GAAP) to allocate Division and/or System overhead costs among various service lines, cost centers, departments, etc. The posting of "actual" data for each cell element would require us to modify our Payroll tracking processes, to modify our Accounts Payable processing submission practices, to modify our internal monthly reporting practices, and to develop numerous new General Ledger Chart of Accounts categories... in our opinion all unnecessary expenses to be incurred merely to produce data that will most likely not differ significantly from data produced through the utilization of GAAP acceptable estimating practices.

- Apparently, these proposed changes will be effective for Home Health and Hospice organizations' reporting for cost reporting year beginning (on or after) October 1, 2015. We believe that due to the scope of procedural, process and system changes we have mentioned above, organizations such as ours may not be ready to comply within the aforementioned timeframe due to either manpower requirements or funding requirements (or both) that would be necessary to implement such significant changes.

- Since 2009, CMS has utilized the services of an outside consulting firm to assess home health agency costs. During this time the outside consultant has routinely disclosed that home health agency cost reports related to home health organizations affiliated with a hospital or health system have been excluded from their overall cost assessments. As we have specified above, changes necessary to comply with these new requirements will be both costly and time consuming...and it would appear unecessesarily so, for an organization such as ours, if past history continues and our information is excluded from CMS's data compilation.

RECOMMENDATION:

We recommend that all hospital/health system affiliated agencies be exempted from annual cost reporting. No longer is there any "cost-dollar" settlement related to this filing, and if CMS has operationalized the exclusion of data from these submissions by hospital/health system affiliated agencies in assessing payment changes (presumably also hospice payment reform), this requirement is an unnecessary reporting burden.

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We appreciate your taking the time to review our comments. We are also attaching some SUPPLEMENTAL observations. Should you require any further information, please do not hesitate to call me, at: 484-580-1402. We trust you will give serious consideration to our SUPPLEMENTAL observations and our RECOMMENDATION.

Very truly yours,

Theodore A. Bean

Theodore A. Bean
Financial Administration
Main Line Health- HomeCare & Hospice

TAB/kjh

SUPPLEMENTAL Observations: **FORM CMS-1728-94**

(from review of the Supporting Statement)

B. 1. While reporting on CMS-1728-94 is cited as being required under statute and the Code of Federal Regulations, this document notes the cost report data is needed to determine a provider's reasonable cost incurred for furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. Since adoption of the Home Health Prospective Payment System, effective October 1, 2000, this need has been moot. In addition, other information now available, such as the PEPPER report, can better serve CMS with information regarding possible monies due from any provider.

B.2. Cited information users/uses also include: the MACs, CMS staff supporting program operations, payment refinement and for use in making Medicare Trust Fund projections. Unspecified, general uses should not be justification for collection of this extensive expansion of reporting. As noted in our comments, the CMS contractor developing payment refinement suggestions annually for home health agencies routinely excludes hospital/health system affiliated cost report filings. Using the cost report data in support of Medicare Trust Fund projections seems to be a curious reference, as Trust Fund activity is based upon payments made on behalf of beneficiaries, not provider costs.

B.16. Since no data is tabulated or published, the reporting process provides no intrinsic value to the 11,000-plus home health agencies which complete these annual filings. While data can be obtained, it is beyond any individual agency to assemble such data into a coherent analytical base for its own use.

General:

Overall, the Supporting Statement and the related detail reflect a burden estimate which we judge as not being too low. Not only are the changes extensive, they will be costly to implement, involving senior finance staff and financial specialists, senior information services staff, and coordination with outside vendors who supply software to the industry, These software suppliers will also have a considerable level of costs to be incurred, we suspect.

The CMS' estimate of a cost of $20.00 per hour for all necessary tasks is low, in our opinion. We believe this Estimate is the cost equivalent of $15.00 of wages and $5.00 of benefits (using a 33% benefits allocation rate derived backwards from the CMS $20.00 estimated cost per hour). We suggest a more reasonable cost rate of $60.00 per hour, fully loaded for benefits ($45.00 for an average wage per hour, plus a $15.00 benefit add-on).

Using our agency's cost per hour estimate of $60.00, fully loaded, we show this form to have an annual cost to respondents in excess of $150,000,000. Accordingly, we observe that this is a 'major' paperwork reporting burden under the requirements of the Paperwork Reduction Act, as amended. We believe OMB needs to obtain additional data from CMS regarding two questions: # 1 – provide a detailed makeup of the estimated 227 hours per respondent used to calculate its burden and # 2 – provide an explanation as to why there are no other alternative sources of data that might suffice in developing the information required of the ACA.