VonLehman
CPA & ADVISORY FIRM

June 11, 2019

Centers for Medicare and Medicaid Services
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

RE: COMMENTS REGARDING REVISED FORM CMS-1728-19 AND RELATED MATTERS

The following comments are provided regarding the proposed Form CMS-1728-19, and proposed instructions for completion of the Form CMS-1728-19. We commend CMS on its efforts to make cost reporting by all provider types as uncomplicated as possible yet producing that information necessary to meet CMS's obligations by regulation and for use in determining the costs incurred to render Medicare covered services. The following comments are largely based on feedback from a collaborative effort by a group of leading cost report experts, many of whom are members of the National Association of Home Care and Hospice's ("NAHC") Home Care and Hospice Financial Managers Association ("HHFMA"). **VonLehman was part of this group effort**. This group has extensive experience in preparing many cost reports for providers across the country including freestanding providers, provider-based providers, tax-exempt providers, and proprietary providers.

EFFECTIVE DATE OF THE NEW COST REPORT FORMS

The draft instructions states in Section 4700 that the effective date is for cost reporting periods beginning on or after January 1, 2019, and ending on or after December 31, 2019. We are already six months into calendar year 2019 and the form is still in the proposed stage. Given that it will take some for providers to make the changes to their accounting and billing records, we recommend a delay in the effective date. In addition, software vendors will need to be able to make the appropriate changes to generate the new census statistics needed for the cost report. Providers will have to modify the recording of expenses for nursing, physical therapy and occupational therapy on their financial statements as well as the billing systems to generate the new visit statistics. We recommend that the effective date be six months after the finalization of the proposed forms and instructions and publication of the changes to the industry.

ACCEPTABLE COST REPORT SIGNATURE

Several years ago, the required signature on Worksheet S, Part II was modified to be the "Chief Financial Officer or Administrator" of the Provider. We believe that any "Authorized Official", as identified in the Medicare enrollment record, should be an acceptable signatory to the Home Health Agency Cost Report unless there is some other justification for limiting the signatory authority. The instructions to the Home Health Agency Cost Report could provide that an acceptable cost report would be signed by the Administrator, Chief Financial Officer, or any other Authorized Official who is identified in the Medicare enrollment record of the Provider. This would be an authorized official on record in CMS Form 855A, Section 6 (Ownership Interest and / or Managing Control). Many home health agencies are smaller agencies that may not have someone with the title of Chief Financial Officer but has some responsibilities for the financial operations of the provider (Director of Finance, etc.). We believe that an owner or someone with management responsibility as identified in the enrollment records should have the ability to sign the cost report.

810 Wright's Summit Parkway, Suite 300
Fort Wright, KY 41011
main: 859.331.3300
main fax: 859.331.4358 vlcpa.com

HOME OFFICE IDENTIFICATION (WORKSHEET S-2, LINE 16)

We applaud CMS for providing a mechanism for reporting multiple Home Offices on Worksheet S-2. We are hopeful that this change will be made for the cost reporting submissions of other types of providers as well. While it may be beyond the scope of the proposed cost report revisions, we encourage CMS to provide for, or require the Medicare Administrative Contractors to provide for an application of a new Home Office Provider Number. Currently, there is no standardized form for applying for a Home Office, a CMS-Form-855A is not required to be submitted for a Home Office, and the Medicare Administrative Contractors ("MAC") do not provide instructions on their websites for such a submission. Certain Medicare Administrative Contractors are quite responsive to a written request for a Home Office Provider Number; others seem to ignore the request. We also request that CMS provide some clarification as to when a formal home office provider number is needed as opposed to simply reporting a transaction as a related party transaction on the cost report, not as a home office transaction requiring a Form 287-05. Both transactions, home office and related party transactions are required to be submitted on the related party Worksheet A-8-1.

VISITS AND PATIENT CENSUS BY PAYOR BY DISCIPLINE (WORKSHEET S-3, PART I)

This Worksheet now breaks out "Medicaid" from "Other" patients on this Worksheet for visits and patient statistics. In the past, it has been understood by some preparers that the Medicare census totals in column1 and 2 are only the Traditional Medicare services that would be billed to the MAC. Medicare Advantage statistics have been included in with "Other" services. The instructions are silent as to the description for Medicaid and Medicaid Managed Care. We recommend that CMS modify the instructions for this section to clearly indicate how Medicare Advantage and Medicaid Managed Care census statistics should be reported.

PPS ACTIVITY (WORKSHEET S-3, PART IV)

PDGM reimbursement will begin January 1, 2020. Worksheet S-3, Part IV captures episodic data for episodes that end during the cost reporting period. Unless there is a change in the instructions for reporting episodic information, effective with cost reporting period ending in 2020, information regarding 60-day episodes would be comingled with 30-days episodes (PDGM). Is it CMS's intention to provide for two (2) separate Part IVs for 2020 or will some other reporting change be made to accommodate two separate episodic periods?

Additionally, Worksheet S-3 Part IV does not include the same visit statistic breakout as is required on Worksheet S-3 Part I. Part I requires reporting LPN visits and patients served; however, LPN visits and charges are not required on Part IV. The same applies to physical therapy / physical therapy assistants and occupational therapy / occupational therapy assistants for visits and patients. However, Medicare visits are broken down on Worksheet C the same as Worksheet S-3, Part I. The PS&R report does track visits by RN, LPN, and therapists and therapy assistants but not visit charges in the same detail. If the three cost repot worksheets are made to be consistent, additional PS&R information would need to be generated for charges to this same level of detail.

DIRECT CARE EXPENDITURES (WORKSHEET S-3, PART V)

The revised cost report includes a new Worksheet (Worksheet S-3, Part V) which captures salaries, fringe benefits, paid hours, and then computes an average hourly wage by occupational category. The new Worksheet also captures contracted payments and the computation of an average hourly rate for those contracted services as well. The categories of direct care employees and independent contractors differs from those reported on Worksheet S-3, Part II and Worksheet A. Medical Social Services is not separately listed on Worksheet S-3, Part V.

Total Paid Hours is to be reported in column 4. This would include admin time as well as paid time off (PTO). There may be instances where home health providers do not have total hours. In the home health industry, pay per visit is a very common compensation method for direct care personnel. In addition, many agencies contract from outside companies for physical therapy, occupational therapy and speech therapy services and sometimes medical social service and are paid per visit, not hourly. They may also pay some nurses per visit during peak times. Total paid hours may not be readily available.

During cost reimbursement days prior to PPS on 10/1/2000, there was a cost limit for contracted therapy services known as the Adjusted Hourly Salary Equivalency Amount (AHSEA). This calculation used 1.0 hour per visit as a proxy in the absence of actual time records.

What should a home health provider use in the absence of actual time records?

REMOVAL OF WORKSHEETS A-1, A-2, AND A-3

We appreciate that CMS removed Worksheets A-1, A-2, and A-3. This makes the Home Health Agency Cost Report more consistent with cost report submissions of other providers.

NEW GENERAL SERVICE COST CENTER (REMOTE PATIENT MONITORING)

Form CMS-1728-19 Worksheet A adds a new General Service Cost Center (Remote Patient Monitoring), Line 5. This cost center is defined in a manner consistent with 42 CFR §409.46(e). A specific definition of Remote Patient Monitoring is provided for in the cost report instructions. The instructions to the cost report need to also address patient monitoring equipment costs incurred that may be subject to acceptable equipment capitalization requirements and specific depreciation policies of the provider. If any equipment needs to be capitalized, the instructions should include whether the depreciation can be directly charged to the Remote Patient Monitoring cost center. Additionally, the recommended basis for the allocation of these General Service Costs is “Time Spent”. Can providers select an alternative basis for the allocation of these costs for the first year and subsequent years inasmuch as these costs have not been previously included as a General Service Cost?

We also request that “Time Spent” be defined in the instructions or the final rules. Does time spent mean the time that registered nurses, licensed practical nurses, etc. spend in the installation of the in-home systems as well as the time spent in monitoring and transmitting information to physicians and/or others? Any guidance is appreciated to better ensure consistent reporting by home health agency providers.

WORKSHEET A, LINE 30 (TELEHEALTH COSTS)

Remote Patient Monitoring is now an allowable cost for home health agencies (costs reported on Worksheet A, line 5). Telehealth services are not part of the home health benefit and are segregated in the revised Home Health Agency Cost Report on Worksheet A, line 30. Specifically, the revised cost report instructions state, “Telehealth services are outside the scope of the Medicare home health benefit and home health PPS”. Our question is why are Telehealth costs reported under the HHA Reimbursable Services on Worksheet A, line 30 of the cost report rather than being reported as an HHA Nonreimbursable Service below line 39.

WORKSHEET A-7 (ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES)

We request explanation as to the value of Worksheet A-7 and how this information is used by CMS in assessing the financial activities of the home health agency or potential rate setting. If there is no use of the data provided on Worksheet A-7, this would appear to be an appropriate time for removing this Worksheet from the cost report?

WORKSHEET A-4, A-5 and A-6

These worksheets provide for the reporting of cost report reclassifications, adjustments and related party transactions. These worksheets have been renumbered to Worksheet A-6, A-8 and A-8-1 respectively to be consistent with other CMS cost report form sets for other provider types. We appreciate this move by CMS to be consistent in the identification of the worksheets.

REPORTING ADVERTISING COSTS

The Home Health Agency Cost Report provides that advertising costs (assumed to be advertising and marketing) are removed from allowable costs via line 11 on Worksheet A-8. Reference in the instructions is specifically made to CMS Pub. 15-1, Chapter 21, §§2136-2136.2. While it commonly recognized and understood that advertising and marketing costs intended to solicit patients and/or services are not deemed an allowable cost for Medicare reimbursement purposes, the adjustment of these costs as nonallowable is inconsistent with the handling of advertising costs on Worksheet O for those home health agencies that operate a HHA-based hospice.

Worksheet O, Line 67 is labeled as Advertising Costs. Are home health agencies required to record advertising for the home health portion of the activities separately from the hospice portion? It would be expected that a significant portion of the home health and HHA-based hospice advertising and marketing activities would be conducted in concert with one another. Allowing home health agencies to record all advertising and marketing activities and then to adjust these expenses off the cost report would cause free-standing hospice providers to handle these costs differently from HHA-based hospices. This inconsistent treatment would cause free-standing hospices to report lower per-day costs than HHA-based hospices as advertising and marketing costs at the free-standing hospice currently absorb General Service Costs that would otherwise be allocated to Level of Care (“LOC”) costs.

VOLUNTEER COORDINATION COSTS

A Home Health Agency with an HHA-based hospice is required to report Volunteer Service Coordination costs on Worksheet 0, line 13. Typically, these combined providers would have a Volunteer program benefitting administrative activities and perhaps both the home health component of operations and the hospice component. No guidance is provided in the forms or instructions regarding the handling of volunteer service coordination activities in this situation. Any guidance from CMS would be greatly appreciated. The creation of a General Service Cost Center (Volunteer Service Coordination) on Worksheet A would cause an allocation to occur for the entire HHA, including a portion being allocated to the Hospice (Worksheet A, Line 57).

WORKSHEET B-1 – ADMINISTRATION AND GENERAL COSTS TO CONTRACTED SERVICES

Section 4714 of the cost report instructions states A&G costs applicable to contracted services may be excluded from the total cost (Worksheet B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, column 6) of the A&G costs. We have understood in the past that CMS allows for the contracted inpatient costs for inpatient respite, general inpatient care and Medicaid room and board to be excluded. However, the manner that this section reads is that any contracted cost could be excluded, such as contracted therapy costs, etc. Can CMS provide clarification of their intent with this section?

The instructions should be expanded for home health agencies with HHA-based hospices to provide that Administrative & General costs are not to be allocated to contracted room and board expenses and contracted inpatient costs included within the reported Hospice cost center (Line 57). This increases the consistency in reported for freestanding hospices and HHA-based hospices.

WORKSHEET F-1 INCOME STATEMENT

Line 1 was broken out into three categories of gross patient revenue – Medicare, Medicaid and Other. However, allowances and discounts are reported in the aggregate. Is there a reason that the two are not consistent? Additional clarification should be made with the reporting of Medicare and Medicaid Managed Care charges. This Worksheet may be misleading in breaking out gross charges by program. Most home health agencies report Medicare revenue at the PPS amount and the Medicaid and Other revenues at the net reimbursement amount. In many cases, no contractual allowances or adjustments are reported.

WORKSHEET F-2 (FUND BALANCE / EQUITY ROLLOVER)

This Worksheet was eliminated from this form set. This Worksheet provides a valuable reconciliation back to the prior year ending balance sheet amount for Fund Balance / Equity. This Worksheet is also used to provide a reconciliation of a chain organization with multiple providers (net income of each provider to the consolidated balance sheet). We recommend that this Worksheet be put back into the cost report forms.

INCONSISTENCY BETWEEN WORKSHEET A AND WORKSHEET O

Since the development of the Worksheet O Series (HHA-based hospice), there has been numerous inconsistencies that require, in some cases, significant effort to appropriately report accurate costs for both the home health agency component and hospice component of operations. The following comments are intended to accomplish similar cost reporting by freestanding hospices and HHA-based hospices. Any form or instructions guidance from CMS is greatly appreciated. Some of these comments overlap with comments previously made herein.

Medical Records – Medical Records costs are reported as part of Administrative & General expenses on Worksheet A; however, a separate cost center is provided on Worksheet O, Line 11.

Option 1 - If the combined providers have a common Medical Records component, we are assuming that all the costs of Medical Records are reported on Worksheet A, Line 4 (Administrative & General, now Line 6). A portion of these costs could be reclassified to the Hospice (Line 57) on Worksheet A. This would facilitate reporting Medical Records costs on Worksheet O.

Option 2 would be to include Medical Records costs on Worksheet A, Line 6 and let these costs be allocated to Hospice through the Worksheet B and Worksheet B-1 cost allocation process. The allocated costs would end up on Worksheet O as an Administrative & General cost.

Any guidance from CMS is greatly appreciated.

Nursing Administration – Nursing administration costs are report as part of Administrative & General expenses on Worksheet A; however, a separate cost center is provided on Worksheet O. This presents a similar issue as presented above with Medical Records.

Other General Service Costs – Worksheet A now provides a cost center, “Other General Service Costs”. This cost center may be intended to address certain of these general service costs; however, instructions refer to a Table 5 in §4790. This was not available for review at the time of the preparation of these comments.

Overallocation of Costs to Hospice – Many techniques for complying with the requirements of the O Series worksheets can cause an overallocation of costs to the HHA-based hospice. For example, if Medical Records costs are split between the HHA and the Hospice component, Administrative & General expenses would be allocated to the Medical Records costs reported for the hospice component but would not be allocated to the HHA component of Medical Records costs. They are part of the Administrative and General expenses being allocated.

LEVEL 1 EDITS

Level 1 edits were not available at the time that these comments were developed. Are Level 1 edits being modified for information reported on the Series O worksheets to be consistent with the Level 1 edits required for freestanding hospice providers? Will any updated Level 1 edits for the revised Home Health Agency Cost Report be available for review prior to the issuance of the final version of the CMS 1728-19? The ability to review proposed Level 1 edits would greatly enhance the ability to respond to the proposed changes to the cost report. It is noteworthy that the inconsistencies between Worksheet A and Worksheet O of the cost report impedes the ability to establish Level 1 edits for home health-based hospices (Worksheet O Series) consistent with the Level 1 edits applicable to the freestanding Hospice Cost & Data Report.

DRUGS CHARGED TO PATIENTS

On the freestanding Hospice cost report form (Form CMS 1984-14), a separate direct care cost center was created for drugs charged to patients (Worksheets A-1 to A-4, line 42.50). This does not appear on the HHA based Hospice cost report form. This would be line 42.50 on Worksheets O-1, O-2, O-3 and O-4. We recommend that this cost center be created on this form to be consistent with the freestanding hospice cost report form.

DME / OXYGEN (WORKSHEET O-3 AND O-4, LINE 38)

These lines are still shaded on the inpatient worksheets but were opened up on the inpatient worksheets of the Hospice freestanding form (Form 1984-14). We recommend that these lines be opened up on Worksheets O-3 and O-4 to be consistent with freestanding Hospice providers.

REPORTING NONREIMBURSABLE COST CENTERS BY HHA-BASED HOSPICE

The Series O Worksheets provide all the nonreimbursable cost centers as reported on the freestanding Hospice Cost Report. In the case of an HHA with an HHA-based hospice, certain of these nonreimbursable cost centers are in direct conflict with the manner in which these costs are reported on Worksheet A. Specifically, we are looking for guidance on the following:

- Fundraising – Can these costs be reported as nonreimbursable on Worksheet A or are they required to flow to Worksheet O?
- Adverting (previously mentioned) – Can these be removed in total on Worksheet A or are these costs, related to hospice, to flow to Worksheet O?
- Patient Monitoring Costs – If patient monitoring activities are conducted for both home health and hospice patients, how are the hospice-related costs to be handled on Worksheet A? Would any patient monitoring costs that make their way to Worksheet O be nonreimbursable on Worksheet O?
- Thrift Store – If a home health agency with an HHA-based hospice operates a Thrift Store, can the Thrift store be reported as a nonreimbursable cost on Worksheet A or are the cost required to flow to Worksheet O? If they are reported as a nonreimbursable cost center on Worksheet A, separate from the hospice, on Worksheet A, the costs associated with the Thrift Store would not flow to Worksheet O.

CONSISTENCY BETWEEN THE GENERAL SERVICE COST CENTERS ON WORKSHEET A TO THOSE REPORTED ON WORKSHEET O

For many HHAs with HHA-based hospices, the cost reporting for certain General Service Costs (those which differ on Worksheet A from Worksheet O) has been difficult and requires sophistication in handling cost reclassifications and allocations. This is especially true when certain costs, i.e. Nursing Administration, Medical Records, Volunteer Coordination, and Physician Administrative Services are reported in Administrative & General expenses on Worksheet A but separately reported on Worksheet O. Reporting these costs as Administrative & General expenses on Worksheet A causes these expenses to be allocated to other cost centers (Worksheets B and B-1) on the basis of accumulated costs. These same expenses, if allocated on Worksheet O-6, are allocated on the basis of patient days, nursing hours, or volunteer hours.

Currently, the manner in which these cost centers are handled as they are transitioned from Worksheet A to Worksheet O are solely at the discretion of the respective home health agency. They cause potentially significant differences in any comparison of cost per-LOC between HHA-based hospices and freestanding hospices. The only approach that would fully address this inconsistency would be establishing General Service Cost Centers on Worksheet A that are more consistent with the General Service Cost Centers on Worksheet O. Barring such an approach, the enhancement of instructions is necessary to improve the consistency of the HHA-based hospice filing with the filing by freestanding hospices.

In conclusion, we appreciate the efforts by CMS on revising the Medicare cost report forms for home health agencies. The home health industry is in a state of many changes. We appreciate the efforts put forth to obtain reliable and accurate data. We look forward to working with CMS on further cost report initiatives.

Respectfully Submitted,

VonLehman & Company Inc.

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

DCM/rao