Responses to Comments Received for Form CMS 1728-19

1	One commenter asked if there was a benefit to reporting CBSA codes on proposed Worksheet S-3, Part III?	CMS appreciates the commenter's question regarding the reporting of CBSA codes on proposed Worksheet S-3, Part III. While this information is not used elsewhere in the cost report, the information is used by other stakeholders, such as CMS' Office of the Actuary.
2	One commenter suggested that CMS define minimal edit specifications for "Other" cost center descriptions found in the General Service, Reimbursable Service and Non-reimbursable Service cost center categories on Worksheet A and Worksheet A-8. This effort would ensure that standard cost center descriptions are not modified while requiring some modification to the "Other" descriptions.	CMS agrees with the commenter's suggestion to define minimal edit specifications for "Other" cost center descriptions on Worksheet A and Worksheet A-8 and have modified the forms and instructions accordingly.
3	One commenter noted that the pre-printed statistical basis for the allocation of Movable Equipment on Worksheet B-1 is Dollar Value, the instructions also allow for a basis of square feet of area occupied.	CMS thanks the commenter for their observation that the proposed form CMS-1728-19 instructions allow Square Feet or Dollar Value as the basis for Column 2, Movable Equipment. While the statistical basis of Dollar Value is the recommended basis of allocating Movable Equipment, if a more accurate result is obtained by allocating costs on an alternative allocation basis (e.g., square feet), the provider may have obtained prior approval or may request approval to use an alternative basis in accordance with CMS Pub. 15-1, chapter 23, §2313. We've modified the cost reporting instructions accordingly.
4	One commenter questioned CMS' need to collect the outpatient Physical Therapy Visits on Worksheet C, Part III. The PS&R does not identify visits by service practitioner type and would not accurately reflect the data needed.	CMS appreciates the commenter's concern and agrees. Worksheet C, Part III was a carry-over from a previous iteration and has been removed as this information is no longer necessary.
5	One commenter indicated that Primary Payer Amounts currently reported on Worksheet D, Part I, Line 9 should be moved to Worksheet D, Part II as they relate to vaccine and HHA PPS services.	CMS agrees with the commenter and has moved Line 9 of Worksheet D, Part I to Line 21 of Worksheet D, Part II.
6	One commenter questioned the instruction for Worksheet D, Part II, Line 31, Other Adjustment (enter an adjustment resulting	CMS agrees with the commenter's concern and has modified the instructions accordingly.

	from changing the recording of vacation pay from cash basis to accrual basis).	
7	One commenter identified a reference to Part B in the column heading on Worksheet D-1.	CMS thanks the commenter for their observation and has removed the reference to Part B from the worksheet accordingly.
8	Several commenters felt the effective date for the revised HHA cost report forms should be delayed until six months after the finalization of the proposed forms and instructions to allow providers time to make changes to their accounting and billing records. The commenters believed the modifications may include changes to the recording of expenses for nursing, physical therapy and occupational therapy, in addition to billing system updates to generate new visit statistics. These commenters also believe the delayed effective date will allow software vendors enough time to make appropriate changes to generate the new census statistics needed for the cost report.	CMS appreciates the commenters' input on the effective date of the proposed form CMS-1728-19 for the HHA cost report. We believe the changes necessary for providers and vendors are less significant than what is described by the commenters. The majority of the changes were removing obsolete worksheets. The changes to the cost report that require recording expenses for nursing, PT and OT were actually effectuated on the bill based on Change Request 9736 dated November 10, 2016 with an implementation date of January 3, 2017. The cost report is being modified to collect this data; however, CMS will delay the effective date six months or for cost reporting periods beginning on or after July 1, 2019 and ending on or after June 30, 2020.
9	A few commenters believe the required signature on Worksheet S, Part II should be broadened from "Chief Financial Officer or Administrator" of the Provider to include any "Authorized Official" as identified in the Medicare enrollment record, specifically as noted in Section 6 of the CMS Form 855A. They believe this change will accommodate smaller agencies that may not have individuals with the title of "Chief Financial Officer". The commenters expressed that other individuals such as the Director of Finance, an owner, or someone with management responsibility of the agency should have the ability to sign the cost report.	CMS appreciates the commenters' suggestion to broaden the HHA's signature capability beyond the chief financial officer or administrator on Worksheet S, Part II. The regulation at 42 CFR 413.24(f)(4)(iv) requires the certification statement be signed by the facility's administrator or chief financial officer. We understand the commenters' concern about possibly not having an employee designated as the chief financial officer, however, each HHA should have an administrator whose job is to control the operations of the business, organization, or facility.
10	Some commenters were pleased that CMS has provided a mechanism for reporting multiple Home Offices on Worksheet S-2 and were hopeful the change would be applied to cost reports for other provider types.	CMS appreciates the commenters' views regarding the mechanism on Worksheet S-2, part I, which allows providers to report multiple Home Offices and is considering adapting this reporting for all provider types.
11	A few commenters felt there is no standardized form for applying for a Home Office since the CMS Form 855A is not required and would like CMS, or the MACs, to provide an application of a new Home Office Provider Number. They believe this	CMS acknowledges the commenters' concern regarding the current application process for a new home office provider number. This comment is outside of the scope of this PRA, however, we will forward the comment to the appropriate division for consideration.

	application would alleviate current insufficient instruction on MAC's websites as well as variances in responses from MACs to written requests for Home Office Provider Numbers.	
12	Some commenters requested that CMS provide clarification between the requirement for formal home office provider number and reporting a transaction from a related party as both transactions are required to be submitted on Worksheet A-8-1.	CMS appreciates the commenters' request for clarification regarding the reporting of related party transactions on Worksheet A-8-1, specifically when a formal home office provider number is needed. A formal home office provider number is needed when there is a chain organization. A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by "one organization". Chain organizations may take a variety of structures and may have a variety of types of components; however, all chains have two basic elements: healthcare facilities and a central organizing body. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. Most chain Home offices are separate and distinct headquarters. The home office is usually physically and organizationally separate and easily identifiable from the facilities it serves. Most home offices provide healthcare related functions to or on behalf of the chain providers. These functions may include central management and policy direction; financial arrangements and overall financial control; centralized services such as accounting, billing, purchasing, laundry, payroll, cost report preparation, etc. Related party costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, facilities, and supplies to the provider. A transaction may occur between a related organization and the provider but does not warrant a home office. For instance Mr. B owns a 60 percent interest in the provider organization and a 55 percent interest in a laundry service supplying the provider. The provider and the supplying organization are considered related by common ownership since Mr. B possesses significant ownership in both organizations. The cost incurred by the provider must be reduced to costs but a home office cost statement is not

		necessary. The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself.
13	Several commenters observed the break out of "Medicaid" from "Other" patients on Worksheet S-3, Part I for visits and patient statistics. In the previous version of the HHA cost report, some preparers interpreted the Medicare census totals in Columns 1 and 2 were only the Traditional Medicare services that would be billed to the MAC. The commenters think CMS should modify the instructions to clearly indicate how Medicare Advantage, Medicaid, Out-of-State, and Medicaid Managed Care census statistics are to be reported.	CMS appreciates the commenters' observation of the break out of "Medicaid" from "Other" patients on Worksheet S-3, Part I and for their recommendation for clarification on how Medicare Advantage, Medicaid, Out-of-State, and Medicaid Managed Care statistics should be reported. We have clarified the instructions for columns 5 and 6 which should also clarify the intention of columns 1 through 4. In addition, for Medicare purposes we define Medicare HHA visits as described in 42 CFR 409.48. These visits are visits covered under Medicare Part A and Part B.
14	Some commenters feel that unless CMS revises Worksheet S-3, Part IV, data reported for 60-day episodes would be comingled with 30-day period per the Patient Driven Groupings Model (PDGM) effective for cost reporting periods ending in 2020. They wondered if CMS will provide two (2) separate Worksheet S-3, Part IVs for 2020 or would some other reporting change be made to accommodate two separate episodic periods.	CMS appreciates the commenters' concern over potential co-mingling of data on Worksheet S-3, Part IV for 60-day episodes and 30-day periods per the Patient Driven Groupings Model effective for cost reporting periods ending after January 1, 2020. CMS does not intend on splitting this information in the cost report. The claims data with dates of service will be used to differentiate the varying number of days per episode/period.
15	Several commenters recognized that Worksheet S-3, Part IV does not include the same visit statistic breakout as is required on both Worksheet S-3, Part I and Worksheet C. These variances include statistics for Licensed Practical Nurse, Physical Therapy Assistant, and Certified Occupational Therapy Assistant which are not included on Worksheet S-3, Part IV. They noted that if the worksheets were made consistent, additional PS&R information would be needed to generate the necessary charges for these disciplines. One commenter noted the statistical breakout on these worksheets should be consistent.	CMS appreciates the commenter's concern that Worksheet S-3, Part IV does not have the same visit statistic breakout as is required on both Worksheet S-3, Part I and Worksheet C. In reviewing Worksheet S-3, Part IV we incorrectly labeled lines 1 and 2. We will modify the lines to read Skilled Nursing Care-visits and Skilled Nursing Care-charges. The visits from Worksheet S-3, Part I are transferred to Worksheet C, Part I, column 3, lines 1 through 9 and will be used to determine the average cost per visit for each discipline. Visits are not being split on Worksheet S-3, Part IV as PPS payments are made under their respective category regardless of staffing level.
16	Some commenters noticed that the categories of direct care employees and independent contractors on the proposed Worksheet S-3, Part V differed from those reported on both proposed Worksheet S-3, Part II and Worksheet A, and that Medical Social Services	CMS appreciates the commenters' concern that the occupational categories are different on the proposed Worksheet S-3, Part V compared to proposed Worksheet S-3, Part II and Worksheet A. We modified the direct patient care staff on proposed Worksheet S-3, Part V to mirror the

	is not separately listed on the proposed Worksheet S-3, Part V.	direct patient care staff on proposed Worksheet S-3, Part II; however, Worksheet A reflects line labels in accordance with billing requirements. Proposed Worksheet S-3, Part II collects administrative FTEs as well as direct patient care FTEs.
17	A few commenters felt that requiring total paid hours in Column 4 of proposed Worksheet S-3, Part V may be difficult for home health providers to report since payment for direct care personnel on a per visit method is common in this industry for such disciplines as contracted therapies and nurses. They requested a response from CMS regarding what HHAs should use as an equivalent in the absence of actual time records. They noted that prior to PPS on October 1, 2000, agencies were allowed to use the Adjusted Hourly Salary Equivalency Amount (AHSEA) which was 1.0 hour per visit as a proxy in the absence of actual time records.	CMS recognizes the commenters' concern about reporting total paid hours on proposed Worksheet S-3, Part V. CMS believes home health agencies should be able to provide the hours required on proposed Worksheet S-3, Part V from their internal records for each occupational category listed, or for contracted services from invoices identifying time spent for contract labor.
18	A few commenters felt the HHA cost report needs to address patient monitoring equipment costs incurred that may be subject to acceptable equipment capitalization requirements and specific depreciation policies of the provider. They believe CMS should provide instruction for equipment that needs to be capitalized and whether the depreciation can be directly charged to the Remote Patient Monitoring cost center.	CMS thanks the commenters for their concern over patient monitoring equipment costs that may be subject to capitalization and depreciation. We refer the commenters to PRM 15-1, chapter 1 for the proper treatment of major movable equipment. In addition, per the regulation at 42 CFR 409.46(e), if remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs.
19	Some commenters believe they should be able to select an alternative basis in the first and subsequent years for the allocation of Remote Patient Monitoring costs instead of using "Time Spent" since these costs have not been previously included as a General Service cost.	CMS appreciates the commenters' request for an alternative basis for the allocation of Remote Patient Monitoring costs. We believe Time Spent is the most accurate basis, however, if a more accurate result is obtained by allocating costs on an alternative allocation basis (e.g., square feet), the provider may have obtained prior approval or may request approval to use an alternative basis in accordance with CMS Pub. 15-1, chapter 23, §2313.
20	A few commenters opined on the meaning of the allocation basis "Time Spent" for Remote Patient Monitoring. They wondered if it related to the time registered nurses, licensed	CMS appreciates the commenters' request for clarification on the meaning of the allocation basis "Time Spent" for Remote Patient Monitoring. Time spent should be properly

	practical nurses, etc., spend installing the in-home system, as well as the time spent monitoring and transmitting information to physicians and/or others. They believe that CMS should define the allocation basis of "Time Spent" in the instructions or final rule to ensure consistent reporting by home health agencies.	accounted for as noted in the regulation at 42 CFR 409.46(e): "when remote patient monitoring is used by the HHA to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only under the provision of a skilled service. A visit to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on remote patient monitoring equipment is not allowable."
21	Some commenters observed that Telehealth services are not part of the home health benefit and are segregated in the revised Home Health Agency Cost Report on proposed Worksheet A, Line 30 with the cost report instructions stating "Telehealth services are outside the scope of the Medicare home health benefit and home health PPS". The commenters want to know why these costs are reported under the HHA Reimbursable Services on proposed Worksheet A, Line 30 instead of being reported as a Nonreimbursable service below Line 39?	CMS appreciates the commenters' observation that Telehealth services are not part of the home health benefit and acknowledges their concern over the reporting of Telehealth costs under the HHA Reimbursable Services on proposed Worksheet A, Line 30 of the cost report rather than being reported as an HHA Non-reimbursable Service below Line 39. CMS will revise the proposed cost reporting forms and instructions to report telehealth services to a non-reimbursable cost center on Line 47.
22	A few commenters requested an explanation of the value of Worksheet A-7 and how this information is used by CMS. They stated if there is no use of the data provided on Worksheet A-7, the revised cost report would be an appropriate time to remove the worksheet.	CMS appreciates the commenters' request for an explanation of the value of Worksheet A-7. This worksheet was a carry-over from the 1728-94 version, however it is no longer used by CMS and will be removed from the forms and instructions.
23	A few commenters believe the reporting of advertising costs on Worksheet A-8 are inconsistent with the handling of advertising costs on Worksheet O for those home health agencies that operate an HHA-based hospice. The commenters also felt the handling of advertising and marketing activities by an HHA with an HHA-based hospice are inconsistent with how a free-standing hospice handles these same costs.	CMS thanks the commenters for their observation. CMS will add Line 48 – Advertising to Worksheet A. However, for both HHA and HHA-based Hospice, in accordance with CMS Pub. 15-1, Chapter 23, §2328, where the costs (direct and allowable share of general service cost) attributable to any non-allowable cost center are so insignificant as to not warrant establishment of a non-reimbursable cost center these costs may be adjusted on Worksheet A-8, Line 11 and/or Worksheet O, Column 6 accordingly.
24	Some commenters expressed concern over situations when a Home Health Agency with a HHA-based hospice both benefit from the administrative activities of a Volunteer Service Coordination program. They included a suggestion for CMS to include a General	CMS appreciates the commenters' concern over potentially shared Volunteer Service Coordination cost between the HHA and the HHA-based hospice. In accordance with 42 CFR 418.78 Volunteer Services are an integral part of the hospice Conditions of Participation and as

	Service cost center on Worksheet A to accommodate situations such as these.	such are reported on Worksheet A, line 57. If the HHA also receives services from the volunteer services coordinator the HHA should reclassify the cost associated with the HHA from the hospice, Worksheet A, line 57, to the HHA.
25	A few commenters are requesting clarification of Section 4714 of the cost report instructions regarding what contracted costs are to be excluded from total cost for purposes of determining the basis of allocation of the Administrative and General costs. Some commenters felt 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 on Line 57 as this increases the consistency in reporting for free-standing hospices and HHA-based hospices.	CMS appreciate the commenters' request for clarification of Section 4714 of the cost report instructions regarding what contracted costs are to be excluded from total cost for purposes of determining the basis of allocation of the Administrative and General costs, however; the instructions for Section 4714 are instructing providers to properly apportion A&G cost when an HHA contracts for services and the contract identifies the A&G cost applicable to those services, the entire contract cost should not be included as a statistical basis for allocating A&G cost. We will modify the instructions to specifically include the verbiage "HHA or HHA-based hospice" for clarification.
26	A few commenters expressed concern that reporting gross patient revenue on Worksheet F-1, Line 1 by program may be misleading as the reporting of allowances and discounts is in aggregate.	CMS appreciates the commenters' concern over the breakout of gross patient revenue on Worksheet F-1, Line 1 while reporting allowances and discounts in the aggregate. We will modify the worksheet to capture allowances and discounts by program as well for consistency. In addition, we will include in the instructions that both Medicare and Medicaid are columns used for title XVIII and title XIX and that any HMO services for either should be reported in Other.
27	Some commenters expressed concern over the removal of Worksheet F-2 as they felt it provided a reconciliation for a chain organization with multiple providers. The commenters recommended incorporating the worksheet back into the cost report.	CMS appreciates the commenters' concern over the removal of Worksheet F-2, however, the form has been deemed obsolete for cost reporting purposes.

28	Several commenters were concerned that since the development of the Worksheet O series, there are numerous inconsistencies requiring significant effort to correctly report accurate costs for both the HHA component and HHA-based hospice component of operations. The commenters' referenced costs for Medical Records and Nursing Administration, as well as Worksheet A's Other General Service cost center, as examples of the inconsistencies for reporting cost between the two components. Additionally, the commenters felt that many techniques for complying with the requirements of the Worksheet O series can cause an over-allocation of costs to the HHA-based hospice.	CMS appreciates the commenters' concern over what they consider a lack of consistency between the General Service cost centers on Worksheet A of the HHA and Worksheet O of the HHA-based hospice. We agree that the inconsistency in cost centers may cause challenges in allocation; therefore, we've added Line 7, Nursing Administration and Line 8, Medical Records to Worksheet A. In addition, we've revised the instructions for Line 9 to report Other General Service Cost not reported on Lines 1 – 8. All subsequent worksheets were modified accordingly.
29	Several commenters opined on why there is no cost center for drugs charged to patients on the HHA-based hospice cost report forms as there is on the freestanding Hospice cost report.	CMS appreciates the commenters' concern about the lack of a cost center for drugs charged to patients on the HHA-based hospice cost report forms. We agree this line should be on the HHA-based Hospice Worksheets. CMS will update the forms and instructions accordingly.
30	A few commenters would like CMS to open the DME/Oxygen, Line 38 on the inpatient Worksheets O-3 and O-4 to be consistent with freestanding Hospice providers.	CMS appreciates the commenters' observation about the accessibility of Line 38, Durable Medical Equipment/Oxygen on the inpatient Worksheets O-3 and O-4 of the revised HHA cost report. We agree that Line 38 should not be shaded on Worksheets O-3 and O-4 and CMS will update the forms and instructions accordingly.
31	Several commenters expressed concern that while the Worksheet O series provides all the nonreimbursable cost centers as reported on the freestanding Hospice cost report. They felt these cost centers are in conflict with how the costs are reported on Worksheet A of the HHA cost report with an HHA-based hospice.	CMS appreciates the commenters' concern over the non-reimbursable cost centers on the Worksheet O series in the HHA-based hospice cost report, such as, Fundraising, Advertising, Patient Monitoring Costs, and Thrift Store. Not all of these costs would be applicable or incurred at the HHA. However, if the HHA-based Hospice operates a Thrift Store, the cost would be reported on Worksheet A Line 57, Hospice and then detailed on Worksheet O, Line 69. If costs for Advertising or Fundraising are unique to the HHA-based hospice it is treated the same as Thrift Store, however if those costs are shared between the HHA and HHA-based Hospice, all cost associated with these cost centers can be reported on W/S A, Lines 48 and 49 and the portion applicable to the HHA-based hospice will

		be reclassified to line 57 and detailed on Worksheet O, Lines 62 (Fundraising) and 67 (Advertising). Patient monitoring costs for the HHA-based Hospice must be reported separately on Worksheet A, Line 57 and detailed on Worksheet O Line 68. Remote patient monitoring costs related to the HHA are specific to the HHA and are reported on Worksheet A, Line 5 in accordance with 42 CFR §409.46(e).
32	Some commenters expressed concerns over the lack of consistency between the General Service cost centers on Worksheet A of the HHA and Worksheet O of the HHA-based hospice on the Form CMS-1728-19.	CMS appreciates the commenters' concern over what they consider a lack of consistency between the General Service cost centers Worksheet A of the HHA and Worksheet O of the HHA-based hospice. Since direct patient care does not occur at the location of the Home Health Agency, there is a difference in how the cost centers are handled on Worksheet A for the HHA verses Worksheet O of the HHA-based hospice. CMS believes the manner in which Worksheet A and Worksheet O are to be completed is in accordance with all regulatory language pertaining to a Home Health Agency that operates an HHA-based Hospice.