NATIONAL ASSOCIATION OF Community Health Centers

Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Federal, State and Public Affairs
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

February 17, 2015

Ms. Julie Stankivic
Health Insurance Specialist
Division of Cost Reporting
Chronic Care Policy Group
Center for Medicare
C5-04-07
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted to via www.regulations.gov and to Julie.Stankivic@cms.hhs.gov

RE: CMS-224-14 - Federally Qualified Health Center Cost Report Form

Dear Ms. Stankivic,

The National Association of Community Health Centers, Inc. (NACHC) is pleased to provide comments on the above-referenced Medicare Cost Report Form for Federally Qualified Health Centers (FQHCs). NACHC is the national membership organization for health centers that have been approved by the Health Resources and Services Administration (HRSA) as meeting all program requirements established under Section 330 of the Public Health Service Act. As Section 330 Health Centers encompass over 90 percent of all FQHCs nationally, NACHC represents the vast majority of organizations who complete the Medicare FQHC Cost Report. For more information on health centers, please see the Attachment.

These comments are structured as follows:

A. An overview of the input that we sought and NACHC's goals in commenting on these documents
B. An explanation of our primary concern, namely that proposed changes to the underlying methodology for calculating a FQHC's cost-per-visit will create future "apples to oranges" comparisons
C. Specific comments on Worksheets
D. Specific comments on the Instructions
E. Comment on giving FQHCs advance notice to implement changes

A. Input Sought and Goals of our Review

In preparing these comments, we have solicited input from accountants who have decades of experience in preparing the current Medicare Cost Report (Form CMS-222-92) for hundreds of FQHCs. Our goals have been to:

- Ensure consistency in how FQHCs' total cost per visit is calculated between the current and revised versions of the Cost Report (Forms CMS-222--92 and CMS-224-14, respectively.)
- Increase clarity and reduce areas of potential confusion.
- Identify areas where FQHCs may be unable to obtain the information requested, or where the need for the requested information is unclear.
- Identify relevant information that has not yet been made available for public comment.
- Ensure that FQHCs are given adequate notice to adjust to the new Cost Reporting requirements.

B. Primary Concern – Changes in Underlying Methodology for Calculating Cost-per-Visit Will Create Future "Apples to Oranges" Comparisons

Based on this review, NACHC is very concerned that the proposed revisions to the Cost Report will make several significant changes to the manner in which FQHCs' costs are calculated. This **will result in an FQHC's cost per visit, as determined by the Cost Report, being significantly different depending on which version of the Cost Report format is used**. Some of the proposed changes to the new format would result in costs being higher than they would be under the current format, while other would result in costs being lower. In either case, any future evaluations and adjustments based on FQHC costs – as reported under the Cost Report -- would be based on an "apples to oranges" comparison.

For example, the current Cost Report format counts most pharmacy costs as a component of "Cost Other Than FQHC," which results in these costs (including allocable overhead costs) being excluded from the calculation of a FQHC's total/adjusted cost per visit. However, the revised Cost Report counts these costs under "General Service Cost Centers," resulting in them being included in a FQHC's cost per visit. This change could cause a FQHC's cost per visit (as calculated under the revised Cost Report) to increase significantly, when there have been no real changes in their costs. According to data submitted to HRSA, Health Centers' costs for pharmacy services were almost $600 million in 2013, so the impact of this change would be substantial across the program. The opposite situation – a decrease in costs due only to changes in the Cost Report format – will result from changes in how medical supplies and medical staff transportation costs are reported

This "apples to oranges" outcome is problematic for two reasons. First, while the Medicare FQHC PPS established in Section 10501 of the Affordable Care Act changed the manner in which FQHCs are reimbursed relative to their costs, it did not change the way in which their

costs are calculated. Therefore, these proposed changes will significantly alter FQHC payments in ways that were not intended by Congress.

Second, as you are aware, the current base PPS payment rate of $158.85 was determined using costs as calculated under the current Cost Report. Future analyses of FQHC costs will be based on a comparison of this rate (adjusted by the appropriate Geographic Adjustment Factor and MEI or other inflation adjustor) to costs as calculated under the new Cost Report format. However, the proposed format changes will make it extremely difficult to identify real changes in costs; rather, any changes in the cost-per-visit will reflect both real changes in the FQHC's underlying cost structure, as well as changes due to the new reporting requirements. Due to the lack of clarity about what part of the change was actually due to FQHC activities, it would be inappropriate to draw any conclusions or take any actions based on the apparent changes in cost-per-visit.

For these reasons, it is NACHC's view that the revised Cost Report format must adhere to the same underlying principles of cost measurement as the current format; this consistency is necessary both to be consistent with Congressional intent and to allow for the accurate measurement of changes in FQHC costs over time. This does not mean that changes cannot or should not be made to the Cost Report format, but rather that these changes should not significantly alter how the final calculation of cost-per-visit is determined.

For ease in review, we have structured our comments in the order in which the Worksheets appear in the proposed Cost Report format. Our comments on potential changes to the underlying methodology for measuring cost are addressed under Worksheets A and B. Our other comments, including comments on the Instructions, focus on the other goals outlined above: increasing clarity; reducing potential confusion; identifying areas where information may be unavailable or where the need is unclear; pointing out information for which public comment has yet to be solicited; and ensuring that FQHCs have adequate notice to adjust to the new format.

C. Specific Comments on Proposed Worksheets

Worksheet S, Part I

- Under the heading of "Cost Report Status," line 4 asks the FQHC to indicate whether the Cost Report submitted is a full Cost Report or a low Medicare utilization Cost Report. Given that the current Medicare Cost Report form (form CMS-222-92) also provides an option for a "no Medicare utilization Cost Report," it would seem appropriate for the new Medicare Cost Report form to be modified to allow for this additional option as well.

Worksheet S, Part II

- In the body of the "Certification by Officer or Administrator or Provider(s)", a reference is made to the "Balance Sheet and Statement of Revenues and Expenses…". Given that

Worksheet F-1 is only the Statement of Revenues and Expenses, the reference to "Balance Sheet" should be eliminated from the provider certification statement.

Worksheet S, Part III

- Given that the FQHC is the only provider type reported in the Cost Report, we recommend that the words "…for the element of the above complex indicated" be eliminated from the "Settlement Summary" descriptive language (there will not be multiple elements reported).

Worksheet S-1, Part I

- On line 8, a FQHC filing a consolidated Cost Report is asked to provide both the date the FQHC requested approval to file a consolidated Cost Report and the date the contractor approved the FQHC's request to file a consolidated Cost Report. Given that many FQHCs (and contractors) may not have such information readily available due to the passage of time and the changes that have occurred with contractor jurisdiction since inception of the Medicare FQHC benefit effective October 1, 1991, we recommend that the aforementioned information request be eliminated or modified to seek information regarding only FQHC subunits (sites) that are approved to participate in the Medicare program on or after the effective date of form CMS-224-14. We believe that CMS should be able to rely on past contractor audits of Medicare FQHC Cost Reports to establish the validity of consolidated Cost Report submissions for Cost Reporting periods ended/ending on or before August 31, 2015.

Worksheet S-1, Part II

- For FQHC consolidated Cost Report participants (subunits/sites), information requested from lines 5 through 14 is duplicative given that this information is also requested on Worksheet S-1, Part I for the primary FQHC. The nature of the information requested requires responses regarding federal grant funds, medical malpractice and interns and residents issues; such issues are organization issues versus FQHC site specific issues. Accordingly, and in the interest of administrative simplification, we recommend that the foregoing lines be eliminated from Worksheet S-1, Part II.

Worksheet S-3, Part I

- Information requested includes medical, mental health and interns and residents visits for Title V and Title XIX beneficiaries. As this information is not necessary to inform future decisions regarding the Medicare FQHC Prospective Payment System (PPS), we recommend that this worksheet be streamlined to collect such information for Title XVIII and in Total only; such visits information would then be consistent with information currently collected on form CMS-222-92 and would relieve additional administrative burden on FQHC staff associated with establishing tracking and reporting systems for Title V and Title XIX visits information.

In addition, the draft Cost Report instructions do not address whether Medicare Advantage Plan (Medicare managed care) visits are to be included within Title XVIII visits reported on this worksheet. For completion of form CMS-222-92, only Medicare Part A medical and mental health visits are reported on Worksheet C, Part II – accordingly, we would recommend a consistent treatment for completion of form CMS-224-14 (revise the draft Cost Report instructions to explicitly exclude Medicare Advantage Plan visits from the reporting of Title XVIII visits).

Worksheet S-3, Part II

- Information requested on lines 2 and 3 for contract labor and benefits costs seems redundant (physician and physician services under agreement). We recommend eliminating line 3.

  In addition, the draft Cost Report instructions for completion of Column 1 reference "top level management services". Please eliminate this reference to avoid confusion – the worksheet does not include any such lines for information reporting.

Worksheet S-3, Part III

- Information requested on lines 15 and 16 for FQHC employee data seems redundant (physician and physician services under agreement). We recommend eliminating line 16.

Worksheet A

- Given that implementation of the Medicare FQHC PPS did not change the nature of Medicare cost finding for FQHCs, we believe it is important and necessary to maintain consistency from form CMS-222-92 to form CMS-224-14 regarding calculation of the FQHC's total (adjusted) cost per visit. Based on our review of draft form CMS-224-14, we believe substantive changes are proposed to Worksheet A that will result in potentially significant inconsistencies in the calculation of the FQHC's total cost per visit; and, to the extent such information is used to inform potential future changes to the Medicare FQHC PPS rate, any such inconsistencies are presumably unacceptable and detract from the integrity of the new payment system. We will address each specific item in the remainder of our comments concerning this worksheet.

- The draft Cost Report instructions for line 2 (Capital Related Costs – Moveable Equipment), indicate that moveable equipment depreciation is to be reported as a component of this general service cost center. Given that form CMS-222-92 reports depreciation of medical equipment within the cost of FQHC services, excluding overhead (in other words, as a direct cost within the category of "Other Health Care Costs"), we recommend that medical equipment depreciation be reported within the "Direct Care Cost Centers" on form CMS-224-14. This could be accomplished via the

establishment of an additional line within this section of form CMS-224-14 (perhaps an additional line labeled "Other Direct Care Costs (specify)" would be appropriate). We believe that FQHCs could simply report such costs within line 2 and make a cost reclassification entry on Worksheet A-1 to reclassify such costs from the general service line to the new direct care cost center line.

- Under the heading of "General Service Cost Centers" we recommend combining lines 5 and 6 (Plant Operation and Maintenance and Janitorial). Given that aggregate general service costs will be apportioned via the use of an aggregate unit cost multiplier (versus a step-down of general service cost centers based on specified allocation statistics unique to each general service cost center), we believe it will enhance administrative simplification if the foregoing lines are combined.

- Under the heading of "General Service Cost Centers" we recommend that the draft Cost Report instructions for line 7 (Medical Records) be revised to include reference to a FQHC's costs of implementation and maintenance of electronic health records systems. As electronic health records impact the type, intensity, duration and/or amount of services provided by FQHCs, we recommend that such costs be recognized as a component of the "Direct Care Cost Centers" on form CMS-224-14 (via a reclassification entry on Worksheet A-1 similar to the process described above with respect to the proper cost classification/recognition for medical equipment depreciation; again, through utilization of a new line to be created within the "Direct Care Cost Centers" section of form CMS-224-14 – "Other Direct Care Costs (specify)").

- Under the heading of "General Service Cost Centers," lines 9, 10 and 11 are inconsistent with the reporting of such costs on form CMS-222-92.

  Pharmacy costs, excluding the cost of drugs and biologicals that are not usually self-administered and Medicare covered preventive injectable drugs (influenza and pneumococcal), are reported as a component of "Cost Other Than FQHC" on form CMS-222-92; accordingly, this treatment results in any such pharmacy costs, including allocable overhead costs, being excluded from the calculation of a FQHC's total/adjusted cost per visit.

  Medical supplies and medical staff transportation costs are reported as a direct cost within the category of "Other Health Care Costs" on form CMS-222-92.

  In order to preserve the integrity of the Medicare cost finding process for FQHCs, we recommend that lines 9, 10 and 11 be removed from the "General Service Cost Centers" classification of form CMS-224-14; pharmacy costs should be reported within the category of "Other FQHC services" while medical supplies and medical staff transportation costs should be recognized as a component of the "Direct Care Cost Centers" (again, through utilization of a new line to be created within this section of the Cost Report – "Other Direct Care Costs (specify)").

Given that implementation of the Medicare PPS clarified that venipuncture services are included in the FQHC's PPS per-diem payment, we recommend that the draft Cost Report instructions be revised to indicate that any such costs should be recognized as a component of the "Direct Care Cost Centers" on form CMS-224-14.

- Under the heading of "Direct Care Cost Centers", visiting nursing services are not included. Given that visiting nursing services meeting certain requirements can be considered a FQHC visit, we recommend that a Cost Report line item be included within this category of costs for the reporting of any such visiting nursing services.

- Line 36 of Worksheet A provides for the reporting of costs of "Other Allied Health Personnel". In reviewing the draft Cost Report instructions, the description for this line item is vague. Accordingly, we recommend that CMS provide some examples of such personnel normally employed/contracted by FQHCs as a part of the final Cost Report instructions (patient centered medical home care coordinators and support personnel, case managers, etc.).

Worksheet B, Part 1

- As mentioned in our comments regarding Worksheet A, visiting nursing services are not included. Given that visiting nursing services meeting certain requirements can be considered a FQHC visit, we recommend that a Cost Report line item be included within this worksheet for the reporting of any such visiting nursing services cost and visits.

- As also mentioned in our comments regarding Worksheet A, implementation of the Medicare FQHC PPS did not change the nature of Medicare cost finding for FQHCs. Accordingly, we believe it is important and necessary to maintain consistency from form CMS-222-92 to form CMS-224-14 regarding calculation of the FQHC's total (adjusted) cost per visit. Based on our review of draft form CMS-224-14, we believe substantive changes are proposed to Worksheet B, Part I that will result in potentially significant inconsistencies in the calculation of the FQHC's total cost per visit; and, to the extent such information is used to inform potential future changes to the Medicare FQHC PPS rate, any such inconsistencies are presumably unacceptable and detract from the integrity of the new payment system.

  Specifically, columns 4, 6 and 7 of Worksheet B, Part I request information for visits by FQHC practitioner (total visits, medical visits and mental health visits). In reviewing the draft Cost Report instructions, it appears that CMS is seeking to collect visits information for FQHC medical and mental health visits furnished by practitioners, including health care staff and physicians under agreement. Chapter 13 of the Medicare Benefit Policy Manual defines a FQHC visit as a medically necessary medical or mental health visit, or a qualified preventive health visit that is provided face-to-face (one-on-one) between a patient and a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, clinical social worker, visiting nurse (RN or LPN under certain conditions), and qualified practitioners of outpatient DSMT and MNT (when the FQHC

meets the relevant requirements for provision of these services). Given the foregoing, we recommend that the Cost Report instructions and form CMS-224-14 be revised so that FQHCs are required to provide visit information for only qualified practitioners in a manner consistent with visit information reported on form CMS-222-92. We believe this can be accomplished by restricting (blocking) input of information on certain lines of columns 4, 6 and 7 for which the reporting of visits information would be inconsistent with past CMS requirements regarding completion of form CMS-222-92 (lines 5, 6, 10, 12, 13 and 14; and, as previously discussed, a new line should be added to this worksheet for reporting visiting nursing services).

- Columns 8 and 9 seek reporting of Medicare medical and mental health visits by practitioner. While FQHCs track total visits by qualified practitioner, FQHCs do not generally track Medicare visits by qualified practitioner. For completion of form CMS-222-92, FQHCs report total visits by qualified practitioner on Worksheet B, Part I and are required to report Medicare medical and mental health visits in total on lines 11 and 13 of Worksheet C, Part II (the reporting of Medicare visits by qualified practitioner is not required; in fact, FQHCs generally complete the information reported on Worksheet C, Part II using the Medicare PS&R – the PS&R does not provide a segregation of Medicare medical and mental health visits by qualified practitioner). As this expanded reporting requirement will create a burden for FQHCs from a visit tracking perspective, we recommend that the requirement to report Medicare medical and mental health visits by practitioner be eliminated.

- As noted in our comments regarding Worksheet A, we believe it is necessary to add an additional line to Worksheet B, Part 1 in order to preserve the integrity of the Medicare calculation of total (adjusted) cost per visit between forms CMS-222-92 and CMS-224-14. As a reminder, this additional line is necessary to allow for the capture of FQHC direct service costs that are not specifically assignable to a qualified practitioner line (perhaps using a line titled “Other Direct Care Costs (specify)”). Costs reported on this line would receive an allocation of general service cost in column 2 and would be included within total costs in column 3 for purposes of calculating total cost per visit on Line 17 of column 5.

Worksheet B, Part II

- Allowable GME costs reported on form CMS-222-92 include an allocable portion of FQHC total overhead costs based on the ratio of interns and residents visits to total qualified practitioner visits. From reading the draft Cost Report instructions for completion of Worksheet A, line 47 we believe that CMS is proposing to change the reporting of allowable GME overhead costs (the instructions indicate that Line 47 is to include overhead costs directly assigned to the interns and residents program, excluding all overhead included in the general service cost centers paid under the FQHC PPS). Given that total Cost Reported on Worksheet B, Part II, column 1 carries forward from Worksheet A, column 7, line 47, we believe that such reporting is inconsistent with past CMS Cost Reporting requirements. Accordingly, we

recommend that Worksheet B, Part II be modified to include allocable overhead costs in a manner consistent with form CMS-222-92.

Worksheet E

- Lines 4 and 18 require reporting of Medicare Advantage Plan supplemental payments (the draft Cost Report instructions for Line 4 state to enter the amount of such supplemental payments from the PS&R – such payment information is not currently included on the PS&R). Given that there is not a Medicare settlement impact of reporting such payment information, we recommend that line 4 be eliminated and the instructions for completion of line 18 be clarified to also exclude such payment information. We believe this will reduce confusion for FQHCs when completing form CMS-224-14.

Worksheet F-1

- Given that Worksheet S-2 requires FQHCs to provide financial data and reports, we believe the additional requirement to complete Worksheet F-1 is repetitive and, therefore, should be eliminated. Elimination of this proposed worksheet will relieve additional administrative burden that would be placed on FQHC administrative personnel.

D. Specific Comments on Proposed Instructions

In addition to our comments referencing certain draft Cost Report instructions earlier in this letter, we have the following additional comments:

Worksheet S-2, Lines 11 and 12

- The draft Cost Report instructions reference a crosswalk between revenue codes, departments and charges on the PS&R to cost center groupings on the Cost Report. Given that form CMS-224-14 does not request the reporting of detailed FQHC charge information, we recommend that these references be eliminated (to reduce confusion and provide clarity of information to be reported).

Worksheet A – General

- Section 4408 of the draft Cost Report instructions references a description of cost center coding and table of cost center codes included in Section 4495, table 5. We are unable to review and comment on this information as it was not provided by CMS in the draft documents posted for public review and comment; accordingly, we request that CMS make this information available for public review and comment and provide an additional comment period.

Worksheet A, Lines 23, 26 and 29

- The draft Cost Report instructions for line 23 include reporting costs of "nurse practitioners providing physician services" on line 23; line 26 references reporting costs of "nursing care provided by nurse practitioners"; and, line 29 references reporting costs of "nursing care provided by certified nurse midwives".

  In order to reduce confusion and provide absolute clarity of reporting, we recommend that line 23 be reserved for the reporting of costs of physician services only; line 26 be reserved for the reporting of costs of nurse practitioners only; and, line 29 be reserved for the reporting of costs of certified nurse midwives only. Given that physicians, nurse practitioners and certified nurse midwives are all qualified practitioners, the reporting of all costs associated with each practitioner type should be segregated for Cost Reporting purposes.

Worksheet A, Line 61

- The draft Cost Report instructions reference venipuncture and indicate that any such costs are to be included in the pharmacy cost center. Given our prior comments regarding Worksheet A reporting of the pharmacy cost center, we recommend that clarification is made that the cost of venipuncture is included in an appropriate direct care cost center.

Worksheet B, Part III

- The draft Cost Report instructions indicate to enter total hours in column 3, by adding columns 1 and 2. Given that columns 1 and 2 include FTE information rather than hours information, we believe the instructions should be revised to indicate that total FTEs should be entered in column 3.

E. Implementing the new format prospectively, rather than retrospectively

- NACHC is concerned that some FQHC may have difficulty in preparing their Cost Report data according to the requirements of the new format on a retroactive basis. Therefore, NACHC recommends that this new format become effective on a prospective, rather than retrospective, basis. Under this approach, FQHCs would not be required to use the new format until the Cost Reporting Period that starts on or after the day that the final version of the new format is published.

* * *

Thank you for the opportunity to comment on the draft Medicare FQHC Cost Report and Instructions. NACHC staff, along with accountants who have worked for decades assisting FQHCs with their Medicare Cost Reports, would welcome all opportunities to follow up with you about these comments. To initiate these discussions, please contact Ms. Colleen Meiman, NACHC's Director of Regulatory Affairs, at 301-296-0158 or cmeiman@nachc.org.

Sincerely,

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers

cc: Corinne Axelrod
Health Insurance Specialist
Division of Ambulatory Services
Hospital and Ambulatory Policy Group
Center for Medicare, CMS

Jim Macrae
Associate Administrator
Bureau of Primary Health Care
Health Resources and Services Administration

John Rigg
Director
Office of Policy Analysis
Health Resources and Services Administration

Attachment: Overview of Section 330 Health Centers

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve ***over 22 million patients***, including nearly seven million children and more than a quarter million veterans.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation.) A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a designated medically underserved area or a medically underserved population. Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are below the Federal Poverty Level (FPL)
- Charge persons whose incomes are between 100% and 200% FPL based on a sliding fee scale
- ***Be governed by a board of directors, of whom a majority of members must be users of the health center.***

Most Section 330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of caring to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2013, on average, the insurance status of Health Center patients is as follows:

- 41% are Medicaid recipients
- 35% are uninsured
- 14% are privately insured
- 8% are Medicare recipients.

No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed care to uninsured and medically underserved people.