NATIONAL ASSOCIATION OF Community Health Centers

September 3, 2015

By Email: *OIRA_submission@omb.eop.gov*

Office of Management and Budget (OMB)
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

RE: CMS-224-14 - Federally Qualified Health Center Cost Report Form – Concerns re: Content and Adherence to Paperwork Reduction Act Regulations

The National Association of Community Health Centers, Inc. (NACHC) is pleased to have a second opportunity to provide input on the proposed changes to the Medicare Cost Report Format (CRF) for Federally Qualified Health Centers (FQHCs). NACHC is the national membership organization that represents the vast majority of FQHCs.

NACHC wishes to comment on both the content of the proposed changes to the FQHC CRF, and CMS' process for seeking and responding to public input on the document. We begin with a summary of our comments, and then discuss each one in detail.

SUMMARY OF COMMENTS:

Process:

Paperwork Reduction Act requirements at 5 CFR 1320.8(d)(1) require agencies to "consult with members of the public" about proposed changes to PRA-related documents, and to provide them with information to evaluate the proposal in terms of the need for the data and administrative burden. Unfortunately, despite these requirements and numerous requests, CMS has failed to:

- provide an opportunity for consultation with the public;
- explain the need for, or the practical utility of, the significant changes which it is proposing to the FQHC CRF; or
- explain its rationale for rejecting the majority of comments received from the public.

For these reasons, NACHC is again requesting that, in accordance with PRA requirements, CMS provide an opportunity for dialogue with affected members of the public about the

need for and utility of its proposed changes, and its rationale in rejecting public recommendations. This dialogue should include, but does not need to be limited to, NACHC and accounting firms with extensive experience in FQHC Medicare Cost Reports.

Content: We have grouped our concerns into three categories, based on priority.

Priority "A"

- **Highest Priority** – CMS has proposed significant changes to methodology for calculating and FQHC's cost-per-visit. This will create future "apples to oranges" comparisons which could significantly affect FQHC payment under both Medicare and Medicaid. CMS has failed to provide any rationale for making these significant changes, and NACHC is unable to see how they are either "necessary for the proper performance of the functions of the agency" or "have practical utility." Therefore, we request that CMS retain the same methodology for calculating cost-per-visit as was used to determine the baseline per-visit rate under the new Medicare FQHC Prospective Payment System. We also repeat our request for a dialogue with CMS officials so that we can understand their rationale for proposing these changes
- Delete request for information that many FQHCs will not have and may lead to a "fatal error" when filing Cost Reports.
- Provide missing information for public review.

Priority "B"

- Eliminate the new requirement to provide visit data for Title V and Title XIX patients, as this data is not "necessary for the proper performance of the functions of the agency" and will have no "practical utility" for Medicare purposes
- Eliminate new reporting requirements around Medicare visits by practitioner, as this data is not "necessary for the proper performance of the functions of the agency" and will have no "practical utility" for Medicare purposes
- Retain current allocation of GME costs, or else explain rationale for proposed change
- Align information collected on visiting nurses across the various forms.
- Avoid penalizing FQHCs for delays in releasing this revised CRF by giving all FQHCs at least 150 days following the official publication of the revised CRF to submit their cost reports, regardless of when their Cost Reporting Period closed.

Priority "C"

- Eliminate duplicative requests for data in three sections of the Cost Report
- Retain option for "No Medicare Utilization Cost Report" as this will impact FQHCs whose state Medicaid payment relies on Medicare Cost Report
- Delete reference to forms or lines that do not exist

CMS PROCESS FOR SEEKING PUBLIC INPUT, AS REQUIRED UNDER THE PAPERWORK REDUCTION ACT

It is our understanding that revisions to the Medicare Cost Report Format (CRF) for FQHCs are subject to the Paperwork Reduction Act (PRA) and the regulations that implement it, as promulgated at 5 CFR 1320. The process and purpose for seeking public input on non-regulatory documents subject to the PRA is outlined at Section 1320.8(d)(1), as follows (emphasis added):

> **"(1)** Before an agency submits a collection of information to OMB for approval…, the agency shall provide 60-day notice in the *Federal Register,* ***and otherwise consult with members of the public*** and affected agencies concerning each proposed collection of information, to solicit comment to:
>
> **"(i)** *Evaluate whether the proposed collection of information is necessary* for the proper performance of the functions of the agency, including whether the information will have practical utility; …
>
> "(iii) *Enhance the quality, utility, and clarity* of the information to be collected; and
>
> "(iv) *Minimize the burden* of the collection of information on those who are to respond…."

This full text of this section is included in Attachment A, for your reference.

This language makes it clear that simply publishing a notice in the *Federal* Register is not sufficient to meet regulatory requirements for public input. Rather, there is a two-part requirements –to publish a FRN "**and** otherwise consult with members of the public." ***Based on this requirement to consult with the public, NACHC expected to have an opportunity for dialogue with CMS staff about the proposed changes, particularly given the significant concerns that we raised in our previous comments, which involve many of the issues outlined in Section 1320.8(d)(1) (e.g., whether the collection of specific data is necessary for program purposes, ways to reduce administrative burden.)*** NACHC, as well as CPAs with over 20 years' experience assisting FQHCs to complete their Medicare Cost Reports, have requested such a dialogue on numerous occasions, and offered to do it either over the phone or in person at CMS headquarters, or via email. We have received no response to any of these requests. Also, CMS staff have provided no written explanation (via the Federal Register or otherwise) of why they are making the specific changes they have proposed, or why they are not making the majority of the changes we recommended. This lack of information forces us to guess why CMS is adding specific requirements, which contradicts one of the key purposes of the PRA process, as outlined in 1320.8(d)(1)(i) (to allow the public to "evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency.")

We have considered the possibility that CMS may have specific rules around PRA publications that would preclude such dialogue. However, our experiences with other parts of CMS on PRA issues have been very different. For example, other CMS staff proactively reached out to affected entities to ensure that they are aware of the publication. (With the FQHC CRF, no effort was made to inform affected parties either time this document was

available for public comment.) We have also had phone calls and email discussions with other CMS staff explaining our concerns and their reasons for the proposed changes, both during and after the comment period. These processes resulted in a mutual understanding between CMS and NACHC about the need for specific information, the burden associated with providing it, and how the information would be used. As a result, the final documents successfully met the agency's needs while minimizing administrative burden on providers.

As discussed in detail below, both NACHC and some of our partner CPAs submitted extensive comments in February on the initial draft CRF. (See Attachment B for these comments.) The CRF version published in August addressed a few of our concerns raised in our February comments, and we appreciate CMS' efforts. However, it fails to address our most important concerns, or to provide any explanation for CMS' decisions. For these reasons, ***NACHC is again requesting that, in accordance with 5 CFR Section 1320.8(d)(1), CMS "otherwise consult with members of the public" by providing an opportunity for dialogue with affected members of the public about its proposed changes.*** This opportunity can be either verbal or in writing, although we think that a verbal dialogue would be more efficient. We would be happy to meet at a time of CMS' choosing.

PROPOSED CHANGES TO COST REPORT FORMAT

As discussed above, NACHC appreciates CMS' accepting some of the recommendations included in our, and our partner CPAs', comments submitted in February. However, we are concerned that the majority of our comments were not accepted, including the highest priority ones. As noted above, we have received no information about why CMS is proposing these changes, or not accepting our comments, and therefore are unable to "evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility" (5 CFR Section 1320.8(d)(1)(i)). Given this lack of information about the need for these changes, and the significant issues that they will raise for FQHCs, our concerns remain unchanged.

Our original comments listed our requests by section of the CRF. This time, we are reorganizing them by priority level (A, B, and C) to make it easier for CMS and OMB to focus on our highest priority areas. We are also indicating how CMS' failure to explain its proposals or rationale for not accepting ours violates the PRA regulatory requirements outlined above.

Priority "A" Comments and Concerns

A1. **Highest Priority – CMS has proposed significant changes to methodology for calculating and FQHC's cost-per-visit. This will create future "apples to oranges" comparisons which could significantly affect FQHC payment under both Medicare and Medicaid. In addition, NACHC does not think these changes are "necessary for the proper performance of the functions of the agency" or "have practical utility", and CMS has failed to provide any rationale for making them. Therefore, NACHC recommends that CMS retain the same methodology for calculating cost per visit as was used to calculate the baseline per-visit rate when the new Medicare FQHC Prospective Payment System was recently implemented.**

As stated previously, 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.

In contrast, 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. In total, we are uncertain whether these proposed changes will cause a typical FQHC's cost-per-visit to increase or decrease relative to current calculations, but we are certain that it change.

This "apples to oranges" outcome is problematic for four reasons:

1. The current base PPS payment rate of $158.85 was determined using costs as calculated under the current Cost Report. **We expect that 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 CRF. 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.

2. Many states use Medicare cost reports as a key element for calculating FQHCs' rates and updates under Medicaid. Therefore, **even if Medicare does not plan to make payment changes based on the new Medicare CRF, many state Medicaid programs will.** Given that roughly 47% of FQHC patients are on Medicaid, changes to Medicare's methodology for calculating cost-per-visit could have financial ramifications for FQHCs far beyond their Medicare revenues.

3. 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 costs in ways that were **not intended by Congress.**

4. **If CMS wanted to change the way in which Medicare cost-per-visit is calculated for FQHCs, the logical time to do so would have been when the baseline FQHC PPS rate was calculated.** That would have ensured that future comparisons to the baseline would be apples-to-apples comparisons. In contrast, it is methodologically unsound, and misleading, to set a baseline amount using one methodology and then make future comparisons to the baseline amount using a different methodology.

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 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. The following comments address the specific lines and requirements in the proposed CRF that need to be adjusted in order to ensure a consistent methodology is used to calculate cost-per-visit.

A1 - Comments on Worksheet A

- 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 the current CRF 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 the current CRF; 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;
  - pharmacy costs should be reported within the category of "Other FQHC services"
  - 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." (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.)

A1 – Comments on Worksheet B

- As noted in our comments on 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 the current and new CRF. 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.

A2. Deleting request for information that many FQHCs will not have and may lead to a "fatal error" when filing Cost Reports

On Worksheet S-1, Part I, line 8 instructs FQHCs filing a consolidated Cost Report to provide both the date they requested to file a consolidated Report and the date the contractor approved the request. Many FQHCs requested to file consolidated cost reports over 20 years ago, soon after the inception of the Medicare FQHC benefit on October 1, 1991. Due to the passage of time, changes in staff, and the significant advancement of IT systems since that time, many health centers no longer have these specific dates available.

As a result, many FQHCs will be forced to leave this line blank. NACHC is particularly concerned that this could result in a "fatal error" when the FQHC submits the report electronically, meaning that the system will refuse to accept the report. This will cause the FQHC to be unable to submit its Cost Report on time, which will lead to an immediate cessation in all Medicare payments. Therefore, FQHCs will need to choose between entering incorrect data and losing all Medicare payment.

NACHC therefore requests that CMS delete the request for the dates that the FQHC both requested and received approval to file a consolidated Cost Report. If CMS insists on maintaining this line, NACHC requests that leaving these cells blank not qualify as a fatal error that leads to an immediate halt to Medicare reimbursement. If CMS is concerned that FQHCs may be filing consolidated reports without appropriate authorization, it could instruct the MACs and Legacy FI to address this issue in a manner that does not force FQHCs

to choose between entering inaccurate data and losing their Medicare payments. For example, we expect that CMS could rely on past contractor audits of Medicare FQHC Cost Reports to establish the validity of consolidated Cost Report submissions for Cost Reporting periods ending on or before August 31, 2015.

A3. Provide missing information for public review under Paperwork Reductions Act
With regards to Worksheet A, our previous comments stated:

> "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."

Unfortunately, this information was not provided for public review as part of this second PRA review period. **NACHC therefore repeats its request that CMS release the description of the cost center coding and table of cost center codes included in Section 4495, table 5 for public review, or else provide an explanation for why the PRA requirements do not apply to this information.**

Priority "B" Comments and Concerns

- **Eliminate new requirement to provide visit data for Title V and Title XIX patients, as this data is not "necessary for the proper performance of the functions of the agency" and will have no "practical utility" for Medicare purposes** - *Worksheet S-3, Part I*
  This Worksheet requires data on medical, mental health and interns and residents visits for Title V and Title XIX beneficiaries. We do not see how this information is necessary to inform future decisions regarding the Medicare FQHC Prospective Payment System (PPS,) nor what practical utility it would have for Medicare Administrative Contractors. In addition, this data is not required on the current CRF, and most FQHC do not collect it in this way, so this new requirement would add administrative burden on FQHC staff to establish tracking and reporting systems for Title V and Title XIX visits information. NACHC therefore recommend that this worksheet be streamlined to collect such information for Title XVIII and in Total only, as is requested on the current CRF.

- **Eliminate new reporting requirements around Medicare visits by practitioner, as this data is not "necessary for the proper performance of the functions of the agency" and will have no "practical utility" for Medicare purposes** - *Worksheet B, Part 1*
  Columns 8 and 9 in Part 1 of Worksheet B request data on Medicare medical and mental health ***visits by practitioner***. This is a new reporting requirement which will place a burden on FQHCs, and it is unclear what purpose it will serve for CMS. Specifically, while FQHCs track total visits (including Medicare and all other patients) by qualified practitioner, they do not generally break this data down further into Medicare versus non-Medicare patients. The current Cost Report does not require this break-down –

rather, it requires FQHCs to report *total visits by qualified practitioner* on Worksheet B, Part I and *total Medicare medical and mental health visits* in total on lines 11 and 13 of Worksheet C, Part II. However, the reporting of Medicare ***visits by qualified practitioner is not currently required***; in fact, FQHCs generally complete the information reported on Worksheet C, Part II using the Medicare PS&R – and even that report 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, as we see no "practical utility" for CMS to collect this data, we recommend that the requirement to report Medicare medical and mental health visits by practitioner be eliminated.**

- **Retain current allocation of GME costs, or else explain rationale for proposed change -** *Worksheet B, Part II*
  Allowable GME costs on the current Cost Report form 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. CMS has provided no information on why it is proposing this change. Accordingly**, we recommend that the allocation of allowable GME costs, as reported on Worksheet B, Part II, remain consistent with the current Cost Report. If this is not possible, we request that CMS explain its rationale for changing the allocation of GME costs.**

- **Align information collected on visiting nurses -** *Worksheet S3*. Information requested on lines 5 and 6 of Part II and lines 17 and 18 of Part III should be updated to state "Visiting Registered Nurse" and "Visiting Licensed Practical Nurse". This will align the collection of information for Worksheet S-3 Parts II and III with Worksheet A (CMS made this change on Worksheet A in response to our earlier comments but apparently overlooked this change on Worksheet S-3, Part II and Part III).

- **Avoid penalizing FQHCs for delays in releasing this revised CRF by giving all FQHCs at least 150 days following the official publication of the revised CRF to submit their cost reports, regardless of when their Cost Reporting Period ended.**
  Given that FQHCs will be required to use the new CRF for cost reporting periods beginning on or after October 1, 2014, we believe it is important for CMS to specify that the due date will be the ***later of*** the last day of the fifth month following the end of either:
  - the FQHC's cost reporting period or

- the date that the revised CRF (form CMS-224-14) is issued and available for use by FQHCs.

We believe this clarification is important for established FQHCs whose cost reporting periods end on or after September 30, 2015, in the event the new format is not issued and available for use by FQHCs by that date.

In addition, and perhaps most importantly, we are concerned about new FQHCs who have enrolled since the Medicare FQHC PPS implementation began on October 1, 2014, but whose cost reporting period ends prior to September 30, 2015. (For example, a health center who added a new FQHC site in January 2015 but whose cost reporting period ends on June 30, 2015 would have a separate cost reporting period for the new FQHC site that runs from January-June. Starting in July, the new site would be included in a consolidated report with the other FQHC sites in its organization.) For these sites, the "150 day clock" to submit their Cost Report is already ticking. Since failure to submit a completed Cost Report by the deadline can result in an immediate halt in all Medicare payments, these FQHCs will be unfairly penalized if their deadlines are not delayed.

Priority "C" Comments and Concerns

- **Eliminate three duplicative requests for data in various sections of the Cost Report**
  - 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 will create a significant administrative burden on FQHC staff without an added benefit to the Medicare program. Therefore, NACHC recommends that CMS eliminate Worksheet F-1 as it is duplicative.
  - In Part II of Worksheet S-1, , the information requested from lines 5 through 14 is duplicative for FQHCs that file consolidated Cost Reports, 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, in the interest of administrative simplification, we recommend that lines 5 through 14 be eliminated from Worksheet S-1, Part II.
  - On Worksheet S-3, Part II, the 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.

- **Retain option for "No Medicare Utilization Cost Report" as this will impact FQHCs whose state Medicaid payment relies on Medicare Cost Report-** *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. The current Cost Report Form also gives the option of a "No Medicare utilization Cost Report." This option is important for FQHCs in states that require them to submit a Medicare Cost Report in order to qualify for Medicaid payment, even if they do not have

Medicare patients. Therefore, NACHC recommends that CMS retain the option for a "No Medicare Utilization Cost Report."

- **Delete reference to forms or lines that do not exist**
  - *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-3, Part II* – The 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.

* * *

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 202-296-0158 or cmeiman@nachc.org.
Sincerely,

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

cc: Julie Stankivic
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Attachment A: *5 CFR Section 1320.8(d)*
Paperwork Reduction Act requirements for issues that do not require formal rulemaking

(d)

(1) Before an agency submits a collection of information to OMB for approval, and except as provided in paragraphs (d)(3) and (d)(4) of this section, the agency shall provide 60-day notice in the *Federal Register,* and otherwise consult with members of the public and affected agencies concerning each proposed collection of information, to solicit comment to:

- **(i)** Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- **(ii)** Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- **(iii)** Enhance the quality, utility, and clarity of the information to be collected; and
- **(iv)** Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Attachment B – NACHC Comments on January 2015 PRA Version of Medicare FQHC Cost Report Format

NATIONAL ASSOCIATION OF Community Health Centers

February 17, 2015

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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-22414, 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 CMS222-92; 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 CMS222-92, 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-22414. 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

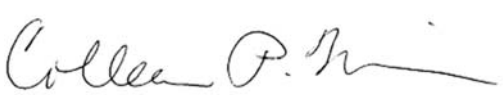
- The draft Cost Report instructions indicate to enter total hours in column 3, by adding columns 1 and 2. Given that columns 1 and 2 include FTE information rather than hours information, we believe the instructions should be revised to indicate that total FTEs should be entered in column 3.

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 202-296-0158 or cmeiman@nachc.org.
Sincerely,



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