COMMENT/RESPONSE FOR CMS-224-14

We received several comments on the proposed Federally Qualified Health Center Cost Report (FQHC), form CMS-224-14. Comments were either general in nature or very specific requests for clarification, changes, and additions to the various worksheets throughout the proposed cost report and the related instructions. We will address the general comments first.

I. General Comments

COMMENT: Two commenters were concerned that some FQHCs may not be able to prepare their cost report in the revised format on a retroactive basis. Therefore, the commenters request that the form CMS-224-14 be effective on a prospective, versus a retrospective basis.

RESPONSE: The Centers for Medicare & Medicaid Services (CMS) acknowledges the commenters' concerns regarding the effective date of the new FQHC prospective payment system (PPS) cost report; proposed form CMS-224-14. The change in payment system from cost based reimbursement to PPS reimbursement prevents CMS from delaying the use of the new cost report for any cost report beginning on or after October 1, 2014. No substantial changes were made to the proposed Worksheet A cost centers and most of the proposed cost centers are currently captured or recorded on form CMS-222-92. The type of visit and the practitioner who performed a visit should be readily available, since the FQHC is required to furnish this information on the claim submitted to CMS for reimbursement under the FQHC PPS.

COMMENT: Two commenters were concerned that the calculation of the cost per visit on the proposed form CMS-224-14 does not include the costs of the FQHC in a similar manner as were included in the cost per visit on the form CMS-222-92, which would not allow a comparison of costs under the all-inclusive rate system (AIR) and costs under the FQHC PPS. As examples, the

commenters noted that costs will appear to increase if pharmacy costs are moved from "Costs Other Than FQHC" to "General Services Cost Centers", and costs will appear to decrease as a result of where medical supplies and medical staff transportation costs are reported.

RESPONSE: We understand the commenters' concerns regarding the regrouping of the "pharmacy," "medical supplies," and "medical staff transportation" cost centers in the proposed form CMS-224-14 compared to the form CMS-222-92. The proposed revisions to form CMS-224-14 are designed to improve the clarity and accuracy of the data, while making as few changes as possible to minimize confusion and recordkeeping requirements. For example, we proposed that pharmacy costs be included under "general service" cost centers because these costs apply to the FQHC as a whole and are treated as overhead costs under the Medicare program, this same rationale is applied to costs associated with medical supplies and staff transportation costs. This change will ensure proper allocation of all overhead costs to the direct care cost centers, resulting in a more precise cost per visit. The costs associated with medical supplies are split between the general service costs and the medical supply costs that are cost reimbursed as part of the administration of a pneumococcal and/or influenza vaccines, thereby capturing all medical supply costs associated with operating the FQHC.

While we understand the concerns of the commenters in desiring to compare multi-year data, we believe that the new payment system requires some adjustments in how costs are reported, and that these changes will provide higher quality cost reporting data.

COMMENT: Two commenters believe that the Medicare FQHC PPS established in section 10501 of the Affordable Care Act, P.L. 111-148, changed the manner in which FQHCs are reimbursed relative to their costs but did not change the way in which their costs are calculated. Therefore, they believe that the proposed changes will significantly alter FQHC payments in

ways that were not intended by Congress, and that future analyses, and possible policy decisions, will be jeopardized by the inability to compare the cost data.

RESPONSE: CMS appreciates the concerns expressed by the commenters. Section 10501 of the Affordable Care Act required the development of a prospective payment system (PPS) that included a process for appropriately describing the services furnished by FQHCs, and established payment rates based on descriptions of such services, without application of the productivity standards that were required under the AIR system.

In accordance with these requirements, beginning on October 1, 2014, payment to FQHCs is based on the lesser of the national encounter-based FQHC PPS rate, or the FQHC's total charges, for primary health services and qualified preventive health services furnished to Medicare beneficiaries, with some adjustments. The national encounter-based rate will be adjusted in calendar year 2016 by the Medicare Economic Index (MEI), and subsequently by either the MEI or a FQHC market basket. Therefore, changes to the cost report will not alter the FQHC PPS rate. The cost report will be used for payment of the costs of Graduate Medical Education, bad debt, and influenza and pneumococcal vaccines and their administration. Payment for these services will not be affected by changes in the cost report groupings.

II. Comments Pertaining to Worksheets and Instructions

The following comments are specific to select proposed worksheets included in the proposed form CMS-224-14 and include specific requests for clarification, changes and additions to the proposed worksheets and the related instructions. Our responses will address each proposed worksheet and all comments pertaining to that proposed worksheet in a single response.

COMMENT: Two commenters requested that a check off box for a "no Medicare utilization cost report" be added to the proposed Worksheet S, Part I.

RESPONSE: We appreciate the commenters' suggestion; however, we do not believe it is necessary to include a check off box for a "no utilization Medicare cost report" because CMS Pub. 15-2, Chapter 1, §110(A) instructs providers to submit a written statement to the Medicare Administrative Contractor (the contractor) in lieu of a full cost report, where there is no Medicare utilization.

COMMENT: Two commenters suggested that the words "balance sheet" be removed from the certification statement included on proposed Worksheet S, Part II.

RESPONSE: We appreciate the commenters' suggestion to remove the term "balance sheet" from the certification statement, however, we are unable to modify the certification statement because the language has been adopted through notice and comment rulemaking (see 42 CFR 413.24(f)(4)(iv)).

COMMENT: Two commenters suggested that only one FQHC could be reported on proposed Worksheet S, Part III, therefore the language "… for the element of the above complex indicated" should be removed.

RESPONSE: We agree with the commenters' suggestion and have removed the language from the worksheet.

COMMENT: A few commenters made various requests for clarification, additions, and deletions to proposed Worksheet S-1, Part I. These included: deletion of the date the FQHC requested and was granted approval to file a consolidated cost report, except for sites approved following the adoption of the form CMS-224-14; clarification of whether or not an FQHC can elect to file consolidated contemporaneously with the filing of its cost report; addition of the

number assigned to a home office by CMS, if applicable; and clarification as to whether or not question 19 relates to "moonlighting" interns and residents.

RESPONSE: CMS acknowledges the commenters' concerns and agrees that the inclusion of the date the FQHC requests and is granted approval to file a consolidated cost report (in accordance with Chapter 9, section 30.8 of the Medicare Claims Processing Manual, CMS Pub. 100-04) will only apply to sites approved following the adoption of the proposed form CMS-224-14. FQHCs that use the proposed form CMS-224-14 and elect to file a consolidated cost report that was approved prior to the adoption of proposed form CMS-224-14 will not be required to furnish the date the FQHC requested and was granted approval to file a consolidated cost report. A contractor cannot accept or approve a request to file a consolidated cost report at the time an FQHC files its cost report. An FQHC must make a request in advance of the reporting period for which the consolidated cost report is to be used in accordance with the manual provision.

We agree that an FQHC that is part of a chain organization may choose to file a home office cost statement. Therefore, we will add a question to the proposed Worksheet S-1, Part I, including a box for the home office CMS certification number (CCN), to collect this information.

The questions that have been added to the proposed Worksheet S-1, Part I, involving interns and residents are general in nature. Therefore, we will address the commenters' concerns regarding the proper reporting of moonlighting interns and residents in our response to the comments on the proposed Worksheet A below.

COMMENT: Two commenters requested that we eliminate the reporting of site specific information relating to funding type, medical malpractice and interns and residents from the

proposed Worksheet S-1, Part II because they consider these to be organization, not site specific issues.

RESPONSE: CMS appreciates the commenters' suggestions that site specific information relating to funding types, medical malpractice, and intern and residents be eliminated from the proposed Worksheet S-1, Part II, however, this site specific information is needed by CMS to ensure proper development of the FQHC market basket as required by section 10501 of the ACA and to provide estimates of total facility and Medicare margins that will be used in future payment update activities.

The data derived from the proposed questions about interns and residents ensure appropriate payments are made to the FQHC and that there are no duplicate payments pertaining to intern and resident costs paid by the Medicare program and also by grants funded by the Health Care Resources and Services Administration (HRSA).

COMMENT: A few commenters made various requests for clarification, additions and deletions to proposed Worksheet S-2. Two commenters requested that the instructions for lines 11 and 12 of the proposed Worksheet S-2 be modified to eliminate the references to charges since the proposed cost report does not require the reporting of detailed FQHC charges; one commenter asked whether FQHCs are required to file a separate proposed Worksheet S-2 and answer each question for each CMS CCN included in a consolidated cost report; one commenter requested clarification of the instructions for allowable graduate medical education (GME) costs, specifically the reporting of costs for HRSA funded GME training, and programs that would be considered nonallowable under the Medicare program; and one commenter asked that CMS clarify the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements that would apply to protected health information or individually identifiable health information

(PHI/IIHI), on the bad debt listing included as Exhibit 1, included in the instructions to question 8.

RESPONSE: CMS thanks the commenters for recognizing that the proposed form CMS-224-14 does not collect data on charges. The calculation of the Medicare cost per visit for a medical visit and a mental health visit requires the total cost and the total visit count for each direct service cost center. Consequently, total charges and Medicare charges are not required to be captured in the proposed form CMS-224-14. We have reviewed the existing requirement in light of the changes to the FQHC PPS and have determined that a crosswalk is still necessary in order to ensure proper payments; however, the crosswalk has been modified to match revenue codes with visits.

We are clarifying that only the primary FQHC responds to the questions set forth on the proposed Worksheet S-2 when filing a consolidated cost report. Questions relating to a change of ownership and/or certification/decertification of an FQHC included in a consolidated cost report are included on the proposed Worksheet S-1, Part II, line 1, columns 2, 4, 5 and 6 for each FQHC CCN included in the consolidated cost report.

We will address the commenters concerns about HRSA funded GME programs in our response to the comments on the proposed Worksheet A.

We thank the commenter for expressing their concern with the privacy of the information reported as part of Exhibit 1, known more commonly as the bad debt listing. The listing is a suggested format for providing information relevant to payment for Medicare bad debt and is not part of the electronic cost report. This Exhibit 1 takes the place of the Exhibit 5, formerly included in the form CMS-339. The Exhibit 1 is not part of the electronic cost report and continues to be a separate data collection. To the degree the information included on Exhibit 1,

the bad debt listing, constitutes commercial or financial information that is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

COMMENT: A few commenters made various requests for clarification, additions and deletions to the proposed Worksheet S-3, Part I. Two commenters requested that we eliminate collection of visit data by medical, mental health and interns and resident visits for Title V and XIX recipients and clarify whether Medicare Advantage (MA) visits are to be included in the visits reported on this worksheet. One commenter requested that we clarify whether medical and mental health visits include visits by interns and residents and also clarify whether interns and residents in non-approved GME programs or HRSA funded programs are reported on lines 5 and 6.

RESPONSE: We thank the commenters for their suggestions. CMS is sensitive to the burden associated with the record keeping requirements that FQHCs are required to maintain to complete the proposed form CMS-224-14. However, we have determined that we are unable to remove the requirement to report visits by program for two reasons. First, CMS requires the identification of the visits by program to properly isolate the Medicare visits for purposes of calculating allowable GME and second, this breakdown is also necessary to provide estimates of total facility and Medicare margins that may be used in future payment update activities.

We are clarifying that MA visits are to be included in the total visits for all patients reported in column 4 on the proposed Worksheet S-3, Part I. The reporting of medical and mental health visits in column 2 is limited to visits of beneficiaries receiving their Medicare benefits under the fee for service program.

We are also clarifying that medical and mental health visits performed by interns and residents who are funded by a Teaching Health Center (THC) or Primary Care Residency Expansion (PCRE) grant from HRSA must be excluded from proposed Worksheet S-3, Part I, lines 5 and 6. Instead, the visits performed by an intern and/or resident funded by a THC or PCRE grant from HRSA will be reported on proposed Worksheet S-1, Part I, lines 25 and 26 and Worksheet S-1, Part II, lines 13 and 14.

COMMENT: A few commenters requested that we merge the labor and benefit costs associated with physician services under agreement included on proposed Worksheet S-3, Part II, line 3, with physician services on line 2; and, that we merge the FTE counts for physician services under agreement on line 16 with physician services on line 15 on proposed Worksheet S-3, Part III. Two commenters requested that we remove the words "top level management services" from the related instructions to proposed Worksheet S-3, Parts II and III.

RESPONSE: CMS acknowledges the commenters' concerns and agrees that it is not necessary to separately identify physicians under agreement on the proposed Worksheet S-3, Parts II and III; therefore, we have removed the "physicians under agreement" line from the proposed Worksheet S-3, Parts II and III. However, we have maintained the physicians under agreement cost center on the proposed Worksheet A and the proposed Worksheet B, as these costs must be separately identified in order to properly calculate the payment for pneumococcal and influenza vaccines paid on a reasonable cost basis.

We appreciate and acknowledge the commenters request to remove the words "top level management services" from the proposed instructions. We agree with commenters request and have removed the phrase "top level management services" from the proposed instructions.

COMMENT: A few commenters made various requests for clarifications, additions and deletions to the proposed Worksheet A form and the instructions. Two commenters were concerned with the consistency and interpretation of the cost data found on the Worksheet A included in the existing form CMS-222-92 cost report and the proposed Worksheet A included in the proposed form CMS-224-14 cost report, as the data from the Worksheet A reported on the form CMS-222-92 was used to establish the base payment rates under the FQHC PPS. These commenters specifically requested that we move the proposed "capital-related moveable equipment" cost center to direct costs; combine the proposed "plant operation and maintenance" and "janitorial" cost centers; clarify that the cost of implementation and maintenance of electronic health records systems is to be reported in the proposed "medical records" cost center; move the proposed "pharmacy" cost center to other FQHC services; move the proposed medical staff transportation and medical supply costs to direct costs; clarify that venipuncture costs should be included as a direct care cost; add visiting nurse services as a separate cost center under direct care costs; provide examples of other allied health personnel in the instructions for line 36; and reserve line 23 for the sole reporting of physician services. One commenter asked that we clarify, in the instructions for the proposed Worksheet A, the definition of allowable and nonallowable GME costs and address if the costs for approved training under the HRSA PCRE or THC grants should be reported on line 47, "allowable GME costs", and address where moonlighting interns and residents are reported.

RESPONSE: CMS appreciates the commenters' suggestions and is sensitive to their concerns relative to how payment rates may or may not be affected by the changes to the proposed Worksheet A included in the proposed form CMS-224-14.

CMS does not believe that a revised sequence/order of the cost centers contained on the proposed Worksheet A included in the proposed form CMS-224-14, will have a material effect on payment rates. The proposed sequence/order of the cost centers ensure that cost centers previously reported on the form CMS 222-92 under the headings "other health care costs", "facility overhead-facility costs", and "facility overhead-administrative costs" are grouped according to 42 CFR 413.24(d)(1) and are also consistent with other cost reports applicable to other types of providers under the program.

We have rearranged the cost centers for capital-related moveable equipment, medical staff transportation and medical supply costs to the proposed "general service" cost centers because they are overhead costs that apply to the FQHC as a whole and are not directly related to care provided to an individual beneficiary. This modification will ensure our ability to develop a unit cost multiplier to be applied on the proposed Worksheet B, Part I to properly include these costs in the calculation of the Medicare cost per visit.

We appreciate the commenters' suggestion for reporting costs associated with electronic health records; however, the costs associated with electronic health records must not be included in the "medical records" cost center. We are clarifying the proposed definition for capital-related movable equipment included in the proposed Worksheet A cost reporting instructions, that the costs associated with capital related movable equipment, such as depreciation, lease and rental, insurance, taxes, and hardware/software updates attributable to electronic health records systems, must be reported in the proposed "capital-related movable equipment" cost center.

We are sensitive to the burden associated with the record keeping requirements that FQHCs are subject to when completing their cost report and we appreciate the suggestion to merge the proposed cost centers "plant operation and maintenance" and "janitorial" into a single

cost center. The function of these cost centers separately ensures appropriate reporting of specific costs associated with operating the FQHC. The proposed cost center "plant operation and maintenance" contains costs associated with the physical plant and equipment used to operate the FQHC while the proposed "janitorial" cost center accounts separately for costs associated with everyday cleaning activities within the FQHC. Therefore, we do not believe it would be appropriate to merge these two cost centers into a single cost center.

We agree with the commenters' suggestion to separately identify the costs associated with nurses who provide visiting nurse services. Accordingly, we have revised the cost center description and proposed instructions for proposed lines 27 and 28 on the proposed Worksheet A by adding "visiting" to "registered nurse" and "licensed practical nurse". The revised lines will include only those direct care costs associated with a registered nurse (RN) or licensed practical nurse (LPN) who provides visiting nurse services in accordance with the Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 13, §180. A similar change has been made to the proposed Worksheet B, Part I, lines 5 and 6. Costs associated with RNs or LPNs who provide services incident to a physician, physician's assistant, nurse practitioner, certified nurse midwife, clinical psychologist, or clinical social worker (see CMS Pub. 100-02, Chapter 13, §§110, 120, and 140) must be reported on proposed Worksheet A, line 36, which we have renamed "nursing and other allied health personnel." The proposed instructions for line 36 have also been revised to reflect this change.

Commenters also requested clarification on the proper reporting of venipuncture costs on the proposed form CMS-224-14. The medical supplies associated with the venipuncture procedure, or those used during a home visit, are reported in the proposed "medical supplies" cost center.

Commenters requested an example of "other allied health personnel". A medical assistant is an example of "other allied health personnel". We have added this example to the cost reporting instructions.

We appreciate and agree with the commenters' suggestion to remove the cost associated with a nurse practitioner performing physician services from the proposed "physician services" cost center. We have added this language instead to the description of the proposed cost center for "nurse practitioner services". This change ensures that all nurse practitioner costs will be reported in a single cost center.

We appreciate the request for clarification regarding the proper reporting of intern and resident costs involving HRSA grants and moonlighting residents. An FQHC must include all allowable direct costs, including those direct costs associated with an intern and/or resident funded by a THC and/or PCRE grant from HRSA in the proposed "allowable GME" cost center on line 47, only if the program meets the requirements set forth in 42 CFR 405.2468(f). Direct costs associated with an intern/resident who is funded by a THC and/or PCRE grant included in line 47, must be reclassified to line 78, the proposed "nonallowable GME costs" cost center. This reclassification is necessary to ensure that payment is not made twice for the same services; CMS will not reimburse the FQHC for the direct costs of GME funded by a grant from HRSA. We will add this clarification to our instructions for lines 47 and 78 of the proposed Worksheet A to ensure proper completion of the cost report. Costs associated with intern and resident programs that do not meet the requirements set forth in 42 CFR 405.2468(f), are reported in the "nonallowable GME costs" cost center.

A "moonlighting" resident or fellow is a postgraduate medical trainee who is practicing independently, outside the scope of his/her residency training program and would be treated as a

physician within the scope of the privileges granted by the FQHC. This cost is neither an allowable GME cost, nor a nonallowable GME cost. These costs are reported as physician service costs included under the proposed direct care cost centers.

COMMENT: Two commenters requested that we publish the description of cost center coding and table of cost center codes for notice and comment prior to adoption.

RESPONSE: CMS acknowledges the commenters' concerns surrounding the ability to provide comments on the cost center coding and table of cost center codes that are part of the electronic reporting specifications that will be used to operationalize the proposed form CMS-224-14 in an electronic or automated format. However, the electronic reporting specifications are not developed until the proposed cost report is final. While CMS is sensitive to the request to provide for notice and comment prior to their adoption, CMS believes that the electronic specifications are not subject to notice and comment rulemaking, because they are not related to the burden associated with the recordkeeping and data gathering requirements required by FQHCs to comply with filing the proposed form CMS-224-14.

COMMENT: Two commenters made various requests for clarification, additions and deletions to the proposed Worksheet B, Part I and the instructions. Two commenters requested that we add a cost center for 'visiting nurses' to the proposed worksheet; suggested that CMS limit the collection of visit data to that previously reported on the form CMS-222-92; and add a line for 'other-direct care' costs. One commenter requested that we clarify if intern and resident visits are included by practitioner type on this proposed worksheet.

RESPONSE: CMS acknowledges and appreciates the suggestions submitted by the commenters and we understand the commenters' concerns with the record keeping burden and data gathering associated with completion of the proposed Worksheet B, Part I. With the advent

of a new payment system, CMS is seeking to obtain a more accurate account of the costs associated with the types of visits that are covered in an FQHC and the actual cost of such visits attributable to Medicare beneficiaries. The types of practitioners included in the proposed Worksheet B, Part I, as revised, are all permitted to provide and bill for a visit to a beneficiary in an FQHC, very much like the existing Worksheet B, Part I that is included in the form CMS-222-92. In addition, because this data is readily available to the FQHC for inclusion in the proposed Worksheet B, Part I, we do not believe there will be an increase in burden.

In addition, in order to properly determine the costs associated with all overhead services applicable to a visit, we have added a column for other direct costs that will be calculated by taking the sum of the costs associated with the proposed cost centers titled "nursing and other allied health personnel," "laboratory technicians," "physical therapist," and "occupational therapist" and multiplying those costs by the ratio of visit count by practitioner to total visits. We believe this change to the proposed Worksheet B, Part I addresses the commenters' concerns regarding those direct care costs that are associated with the cost per visit.

We also want to clarify that all visits performed by interns and residents would be included in the total visits by practitioner, column 2, on the proposed Worksheet B, Part I by practitioner type. That is, if the intern or resident is providing services under the direction of a teaching physician, the visit would be included as a physician visit. Only those title XVIII visits from the proposed Worksheet S-3, Part I, column 2 will be used in the calculations in columns 9 and 10 of proposed Worksheet B, Part I for determination of the Medicare cost per visit.

COMMENT: Two commenters believe that CMS has changed the reporting of allowable GME overhead costs.

RESPONSE: CMS appreciates the commenters' observation regarding the change involving the proper payment of overhead costs associated with intern and resident programs. We did remove an erroneous adjustment that was included in the form CMS-222-92 to properly reflect the payment policy on overhead costs associated with GME provided in an FQHC as set forth in 42 CFR 405.2468(f). An FQHC may claim direct overhead costs associated with operating an approved program in its costs related to allowable GME. However, payment for all overhead costs included in the proposed "general service" cost centers is excluded because it is already reimbursed as part of the payment received by the FQHC under the FQHC PPS.

COMMENT: Two commenters requested that CMS revise the instruction in proposed Worksheet S-3, Part III to refer to total FTEs in column 3.

RESPONSE: CMS thanks the commenters for their suggestion, and has revised the proposed cost reporting instruction accordingly.

COMMENT: Two commenters requested that we remove the reporting of MA Plan supplemental payments from the proposed Worksheet E because the Provider Statistical and Reimbursement (PS&R) report does not include this information.

RESPONSE: We acknowledge the commenters' request; however, we have confirmed that the MA Plan supplemental payments are reported in the PS&R, report type 778. We further note that we have modified the instructions and this data will be reported for informational purposes only.

COMMENT: Two commenters believe the data collected on the proposed Worksheet F-1 is repetitive of the data included on proposed Worksheet S-2 and therefore should be eliminated.

RESPONSE: CMS acknowledges the commenters' concerns; however, the financial statements submitted as part of the filing of the cost report pursuant to the proposed instructions for the

proposed Worksheet S-2 are not part of the provider's electronic cost report file. In order to reduce administrative burden we specifically limited the data to be collected on proposed Worksheet F-1 to a high level summary of the revenues and expenses of the FQHC. The purpose of the data collection on the proposed Worksheet F-1 is to provide estimates of total facility and Medicare margins that will be used in future payment update activities and discussions with the Medicare Payment Advisory Commission (MedPAC) to ensure the accuracy of payments to FQHCs.