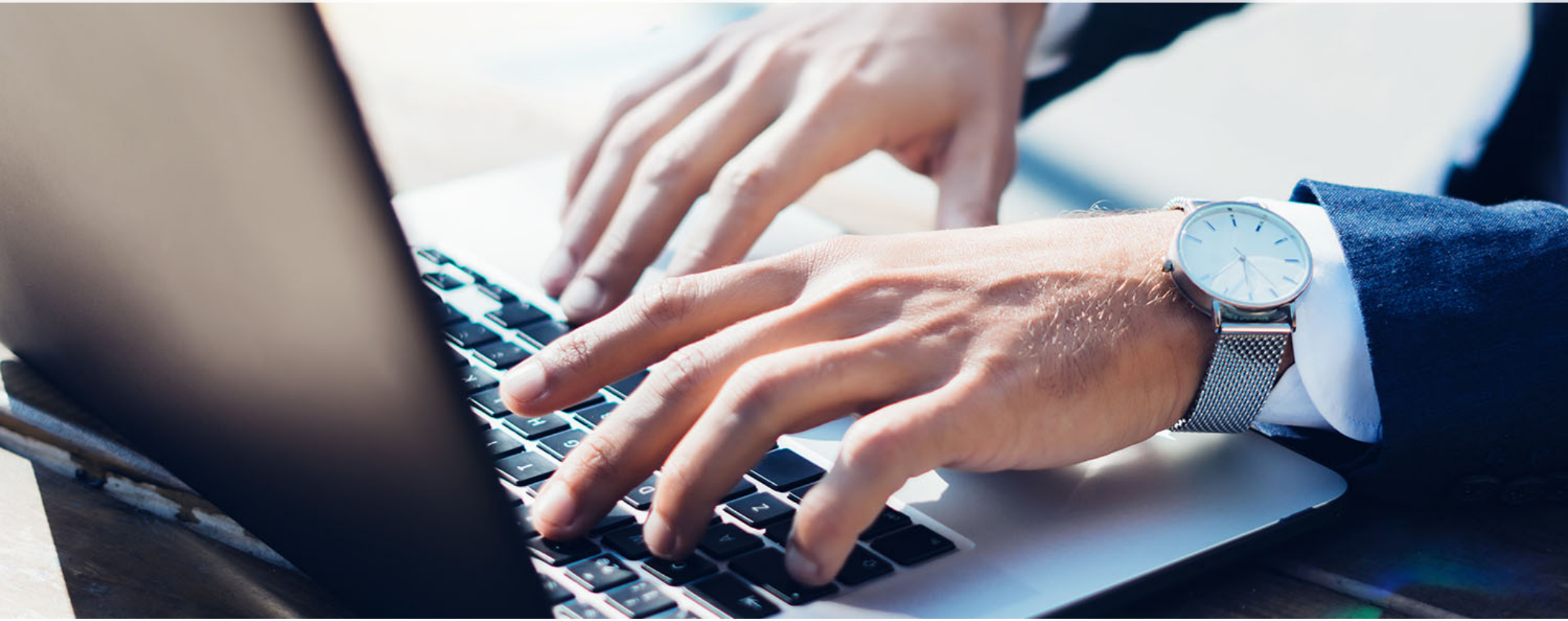
Health Financial Systems

HFS MCR and Software Update

Eric Swanson, Luke DiSabato & Becky Dolin

November 2, 2023



Overview

Agenda

- HFS Tech Update
- Extensions
- MCR Form Updates
- Amending cost reports
- Electronic Signature in HFS
- MCReF changes (CMS Exhibit Templates)
- HFS New Report Wizard
- IRIS Update
- Questions

About HFS

- Small Company in Elk Grove, CA.
- 42 years experience making MCR software.
- HFS makes Medicare Cost Reporting software for Hospitals, Skilled Nursing Facilities, Home Health Agencies, CMHC, RHC, FQHC, ESRD, Hospice, Home Office and OPO.
- SaFE Website, HCRIS Website, IRIS Database software and ProPapers
- Specialized Reporting for – CA, NY, MA and VA

MCRIF32 Development

- **So far this year we have issued:**
  - MCRIF32 Updates – 5- Transmittals 18 - 20
  - MCRIF32 Patches – 12
  - IRIS Updates - 8

    HCRIS Data – 3
  - WI PUF (7/24/2023)

Health Financial Systems

HFS Systems and Features

	Auditor	Management Reports	Data Extractor	EC/PI Import/Export	PS&R	AAI	API Excel	SaFE	Electronic Signing
2552-10	X	X	X	X	X	X	X	X	X
2540-10	X	X	X	X	X	X	X	X	X
1728-20	X	X	X	X	X	X	X	X	X
222-17	X	X	X	X	X	X	X	X	X
224-14	X	X	X	X	X	X	X	X	X
265-11	X	X	X	X	X	X	X	X	X
1984-14	X	X	X	X	X	X	X	X	X
2088-17	X	X	X	X	X	X	X	X	X
216-94	X	X	X	X	X	X	X	X	X
287-22	X	X	X	X		X	X	X	X

HFS Development

- MCRIF32 Upgrade to latest development software
- MCRIF32 Print Upgrades
- Server Upgrades
- HCRIS Upgrade

Development

One Drive/Network Drive Issues

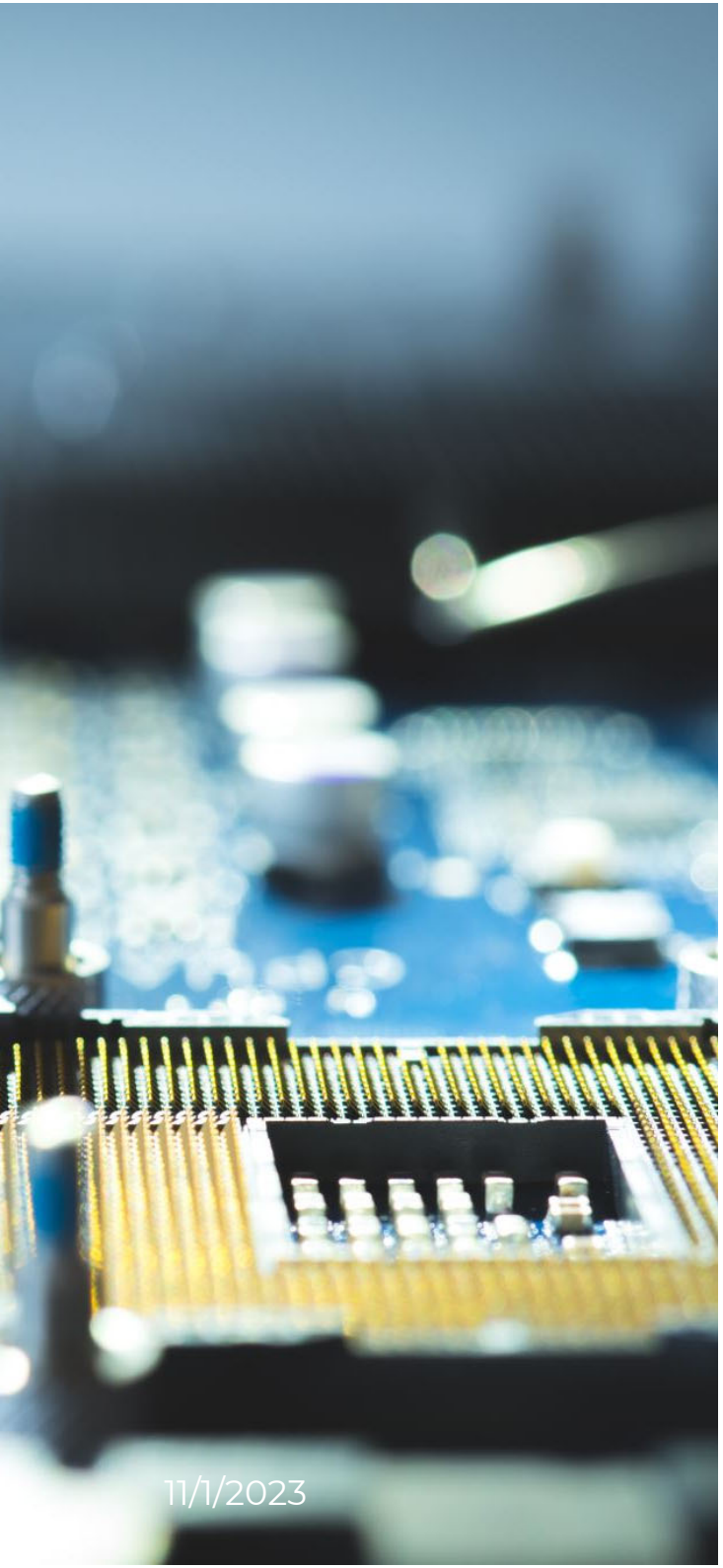
Continuing to work on issues with processing in these environments

Please continue to let us know about issues.

Work around to move files to hard drive – feasible?

Web Based Development

- **SaFE**
  - Processed and Stored about 44,000 submissions.
  - 20,394 were electronically signed
- **HCRIS**
  - 1,500,000 MCR reports
  - Upgrade in 2023
- **Partnership Developing MCR Workpaper Product**



Application Programming Interface

Computer Programs Talking to Each Other

- **Read**
- **Write**
- **Auditor**
- **Printing**
- **ECR Import**

Batch Processing

Batch Print

Batch Import

Batch Data Extractor

Batch AAI

HFS wanted to undergo a formal assessment and obtain a report we could share with clients that would confirm our security posture. HFS chose HITRUST.

HFS has been HITRUST certified for four years.

HFS will no longer seek HITRUST certification.

HFS will pursue a SOC 2 audit/report.

Training and Support

- Continued WebEx Training on HFS software features – 10 Sessions – Offered twice per year.
- Transmittal Updates
- Guest Speakers
- Individual Meetings/Training/Presentations
- Suggestions

Switching to On24

Pros

In browser testing for CPE

Automated CPE Certificates

Browser Only – No Downloads necessary

Recorded Webinars that Qualify for CPE

Cons

No more calling in

2024 HFS User Meeting

October 10 – 11, 2024

Sheraton Grand – Seattle, WA

Extensions

- **While no current extension for after 12/31/2020 cost reports:**
  - 42 CFR 413.24(f)(2)(ii)
    - (ii) Extensions of the due date for filing a cost report may be granted by the contractor only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

Background T-18

- Community Health Access and Rural Transformation (CHART) model
- Supporting Documentation Requirements (Exhibits)
- FY 2023 IPPS final rule GME Changes (Hershey changes)
- Sections 126, 127, 131 of the CAA 2021
- Allogeneic Stem Cell vs Chimeric Antigen Receptor T-Cells
- Sequestration Changes.

Background

- **Supporting Documentation Requirements (Exhibits)**
- **FFY 2019 IPPS Final Rule Supporting documents:**
  - Teaching hospitals--For teaching hospitals, the Intern and Resident Information System (IRIS) data.
  - Bad debt--Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming Medicare bad debt reimbursement, a detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.
  - DSH eligible hospitals--Effective for cost reporting periods beginning on or after October 1, 2018, for hospitals claiming a disproportionate share hospital payment adjustment, a detailed listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's cost report. If the hospital submits an amended cost report that changes its Medicaid eligible days, the hospital must submit an amended listing or an addendum to the original listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's amended cost report.
  - Charity care and uninsured discounts--Effective for cost reporting periods beginning on or after October 1, 2018, for DSH eligible hospitals reporting charity care and/or uninsured discounts, a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH eligible hospital's cost report.
  - Home Office
    - Same fiscal year end. Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with the same fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report.
    - Differing fiscal year end. Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with a different fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report.

- **Supporting Documentation Requirements (Exhibits)**
  - CR11644 requires documentation +/-3% for cost reports submitted on or after 12/31/2020.
  - T-18 (Effective Cost Reporting Periods Beginning on or After October 1, 2022.
    - Medicare bad debt by beneficiary Exhibit 2A.
    - Exhibit 3A, Medicaid Eligible Days.
    - Exhibit 3B, listing of Charity Care Charges, to report charity care charges by patient.
    - Exhibit 3C, listing of Total Bad Debts. To report total bad debts by patient.

https://www.cms.gov/medicare/audits-compliance/part-a-cost-report-audit/electronic-cost-report-exhibit-templates

- **Supporting Documentation Requirements Teaching hospitals--IRIS.**
  - FFY 2022 IPPS FR August 13, 2021, Federal Register
  - CR12724 Mandates use of XML and begins tracing to the cost report for periods beginning October 1, 2022.

- Home Office
  - The Home Office Cost Statement, Form CMS-287-22 Transmittal 1 was published by CMS, on October 28, 2022. Transmittal 1 is effective for cost reporting periods beginning on or after October 1, 2022.
    - Will provide for electronic submission and MAC storage

- **Worksheet S-2, Part II, line 12 Bad Debts and supporting documentation**

Line 12--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts *that* are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89 for the criteria for an allowable *Medicare* bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit *listings supporting the bad debts claimed in the cost report. Effective for cost reporting periods beginning on or after October 1, 2018, a cost report will be rejected when submitted without listings that correspond to the amount of bad debt claimed (42 CFR 413.24(f)(5)). Exhibit 2 (for cost reporting periods beginning prior to October 1, 2022) and Exhibit 2A (for cost reporting periods beginning on or after October 1, 2022) present the information required to support the bad debt claimed. (See exhibits and instructions presented at the end of §4004.2.) If applicable, submit separate exhibits for each provider number in a hospital health care complex.*

Background

- **FY 2023 IPPS final rule GME Changes (Hershey changes)**
  - Implemented a revised DGME payment methodology that eliminates penalties for hospitals that train residents and fellows and operate over their full-time equivalent caps, according to the report.
    - Effective for CR Periods beginning on or after 10/1/2001
    - “Not a basis for reopening final settled NPRs.”
    - T-18 implements for CR periods beginning on or after 10/1/2022

Form Changes – Worksheet S-2, Part I

- **Line 68 added to implement DGME changes prior to 10/1/2022.**

	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)	1	
68	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		68

- **Replaces HFS line 109 on Worksheet E-4 but can be used by providers for cost reporting periods beginning before the October 1, 2022. Must obtain permission from MAC to use this line prior to 10/1/2022. Line not applicable for cost reporting periods beginning on or after 10/1/2022 since E-4 changes will be implemented.**

Background

- **Sections 126, 127, 131 of the CAA 2021**
  - Section 126 of the CAA, 2021, makes available an additional 1,000 Graduate Medical Education (GME) full-time equivalent (FTE) resident cap slots, phased in at a rate of no more than 200 slots per year, beginning in fiscal year 2023.
  - Section 127 made several changes affecting urban and rural hospitals that train residents in Rural Training Programs, formerly known as Rural Training Tracks.
  - Section 131 of the CAA created new opportunities for some teaching hospitals with disadvantageous PRAs and/or FTE caps to potentially get the opportunity to reset some numbers (during the time frame of December 27, 2020 to December 26, 2025).

Form Changes – Worksheet S-2, Part I

- **No cost reimbursement for DGME effective for cost reporting periods beginning on or after 12/27/2020**

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? *For cost reporting periods beginning prior to December 27, 2020, e*nter "Y" for yes or "N" for no in column 1. *For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions.* For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior year or penultimate year, and *you are* impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				56
57	*For cost reporting periods beginning prior to December 27, 2020, i*f line 56, *column 1,* is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst. E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. *For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.*				57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				59

- **Line 56 - For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), a hospital must enter "Y" for yes and report FTE residents on Worksheet E-4 if the hospital trained at least 1.0 FTE in an approved program(s) in the cost reporting period. Additionally, if the hospital trained less than 1.0 FTE residents in an approved program(s) and this training resulted from the hospital's participation in a Medicare GME affiliation agreement (as defined under 42 CFR 413.75(b)), then the hospital must also enter "Y" for yes and report FTE residents on Worksheet E-4.**
- **Line 57 - For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56, column 1, is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.**

Form Changes – E, Part A

- **Lines added for CAP Adjustments**

	Indirect Medical Education Adjustment Calculation for Hospitals		
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)		5
5.01	*FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)*		*5.01*
6	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6
6.26	*Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)*		*6.26*
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)		7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.		7.01
7.02	*Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)*		*7.02*
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)		8.02
8.21	*The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)*		*8.21*
9	Sum of lines 5 *and 5.01,* plus *line 6, plus lines 6.26 through 6.49*, minus lines 7 and 7.01, *plus or minus line 7.02,* plus/minus line 8, plus lines *8.01 through 8.27* (see instructions)		9

- **Line added for Cellular Therapy Acquisition Costs**

55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)		55
55.01	*Cellular therapy acquisition cost (see instructions)*		*55.01*
56	Cost of physicians' services in a teaching hospital (see instructions)		56

Form Changes

4090 (Cont.) FORM CMS-2552-10 12-22

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET E-4

Check applicable box:	[ ] Title V	[ ] Hospital	[ ] CAH-Based IPF
	[ ] Title XVIII	[ ] PARHM Demonstration	[ ] CAH-Based IRF
	[ ] Title XIX	*[ ] CHART Model*	

COMPUTATION OF TOTAL DIRECT GME AMOUNT

1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996		1
1.01	*FTE cap adjustment under §131 of the CAA 2021 (see instructions)*		*1.01*
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)		2
2.26	*Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)*		*2.26*
3	Amount of reduction to Direct GME cap under §422 of MMA		3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)		3.01
3.02	*Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)*		*3.02*
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)		4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		4.02
4.21	*The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)*		*4.21*
5	FTE adjusted cap (line 1 plus *and 1.01,* plus line 2 *plus lines 2.26 through 2.49,* minus lines 3 and 3.01, *plus or minus line 3.02,* plus or minus line 4, plus lines *4.01 through 4.27*		5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		6
7	Enter the lesser of line 5 or line 6		7

		Primary Care	Other	Total	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year				8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. *For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.*				9
10	Weighted dental and podiatric resident FTE count for the current year				10
10.01	Unweighted dental and podiatric resident FTE count for the current year				01
11	Total weighted FTE count				11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)				12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instr.)				13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)				14
15	Adjustment for residents in initial years of new programs				15
15.01	Unweighted adjustment for residents in initial years of new programs				01
16	Adjustment for residents displaced by program or hospital closure				16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				01
17	Adjusted rolling average FTE count				17
18	Per resident amount				18
18.01	*Per resident amount under §131 of the CAA 2021*				*01*

- Lines added for individual CAP Adjustments
  - CAA Sect. 131
  - CAA Sect. 127
  - CAA Sect. 126
- Also implements IPPS 2023 FR Changes.

Background

- **Allogeneic Stem Cell vs Chimeric**
  - Stem cell transplantation is a process in which stem cells are harvested from either a patient's (autologous) or donor's (allogeneic) bone marrow or peripheral blood for intravenous infusion. (CMS Pub. 100-04, chapter 3, §90.3).
    - Allogeneic bone marrow transplant effective for cost reporting periods beginning on or after October 1, 2020, the inpatient routine, ancillary, and other costs associated with acquiring allogeneic hematopoietic stem cells for transplantation, including acquisition costs in cases that do not result in transplant due to death of the intended recipient or other causes, and reimbursed under reasonable cost as required under §1886(d)(5)(M) of the Act.
- **Antigen Receptor T-Cells**
  - Effective for cost reporting periods beginning on or after October 1, 2022, enter the hospital costs for procuring, storing, and processing chimeric antigen receptor T-cells (CAR T-cell) for immunotherapy infusion (FDA-approved CAR T-cell immunotherapies only). Costs to be identified for data analysis only.

Instructional Changes – Worksheet A

- **New Lines:**

Line 77--Effective for services rendered on or after January 1, 2017, enter the hospital acquisition costs *for allogeneic (stem cells obtained from a donor other than the recipient) hematopoietic* stem *cell transplants (HSCT)* as defined in *42 CFR 412.113(e), CMS Pub. 100-04, chapter 3, §90.3.1, and* CMS Pub. 100-04, chapter 4, §231.11. *This includes direct costs and costs of services purchased under arrangements and registry fees for national donor registries (42 USC 274k), if applicable. Do not reclassify costs from the routine and ancillary cost centers; rather compute the acquisition costs on Worksheet D-6, Part I, including acquisition costs associated with the acquisition services in cases that do not result in transplant (i.e., due to death of the intended recipient or other causes). Do not include costs for the allogeneic hematopoietic stem cell transplants on this line. Do not include acquisition costs, other than the cost of tissue typing, for recipients on this line.* Do not include *any* costs *related to* autologous *(stem cells obtained from the recipient) hematopoietic stem cell acquisition or* transplants *on this line* (CMS Pub. 100-04, *chapter 3, §90.3.2, and 100-04, chapter 4, §231.10*).

Line 78--Effective for cost reporting periods beginning on or after October 1, 2022, enter the hospital costs for procuring, storing, and processing chimeric antigen receptor T-cells (CAR T-cell) for immunotherapy infusion (FDA-approved CAR T-cell immunotherapies only). This includes the cost of the CAR T-cell manufactured biologic (i.e., the cost paid to the manufacturer). Do not include costs for CAR T-cell immunotherapy transplants or the medication cost of the non-CAR T-cell drugs used for CAR T-cell immunotherapy complications, e.g., cytokine release syndrome, on this line.

Line 102--Effective for cost reporting periods ending on or after January 1, 2022, enter the cost of services furnished by the hospital's Medicare-enrolled opioid treatment program as defined in the Act §1861(jjj) and as described in CMS Pub. 100-02, Medicare Benefit Policy Manual, chapter 17, for the treatment of Opioid Use Disorder.

Form Changes - Worksheet D-6

- **On the Worksheet D-6, the hospital reports the acquisition costs for allogeneic HSCT. The worksheet, effective for cost reporting periods beginning on or after October 1, 2020, calculates the inpatient routine, ancillary, and other costs associated with acquiring allogeneic hematopoietic stem cells for transplantation, including acquisition costs in cases that do not result in transplant due to death of the intended recipient or other causes, and reimbursed under reasonable cost as required under §1886(d)(5)(M) of the Act. Costs for allogeneic hematopoietic stem cell transplants are paid under the IPPS and not included on this worksheet.**

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COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-6, PARTS I & II	
PART I - INPATIENT ROUTINE AND ANCILLARY SERVICES CELLULAR THERAPY ACQUISITION COSTS								
	Inpatient Routine Services Acquisition Costs	Routine Services Acquisition Charges	Per Diem Costs (see instructions)		Inpatient Acquisition Days	Acquisition Costs (col. 2 x col. 3)			
		1	D-1	2	3	4			
1	Adults and Pediatrics		38						1
2	Intensive Care		43						2
3	Coronary Care		44						3
4	Burn Intensive Care Unit		45						4
5	Surgical Intensive Care Unit		46						5
6	Other Special Care (specify)		47						6
7	Total (sum of lines 1 through 6)								7

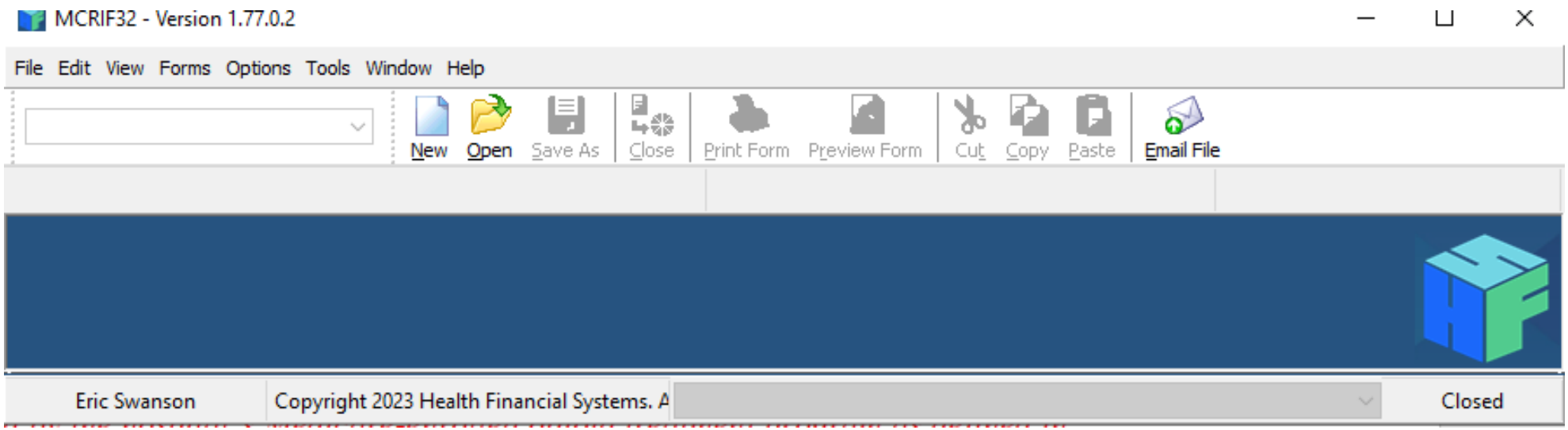
	Ancillary Services Acquisition Costs	Ratio of Cost to Charges (from Wkst. C, Pt. I, col. 9)		Inpatient Ancillary Services Acquistion Charges	Outpatient Ancillary Services Acquistion Charges	Inpatient Ancillary Services Acquistion Cost	Outpatient Ancillary Services Acquistion Cost	
		C	1	2	3	4	5	
8	Operating Room	50						8

Background

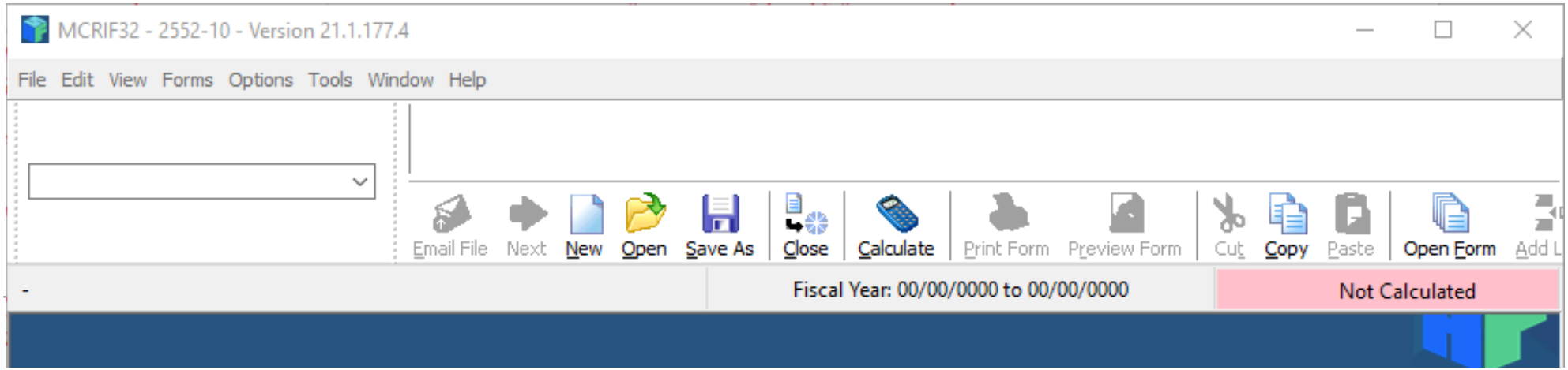
- **Sequestration Changes**
- **Modifications**
  - §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act,
  - §102 of the CAA 2021, §1 of Public Law 117-7,
  - §2 of the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA)
  - Sequestration computed
    - Prior to 5/1/2020 - 2%
    - 5/1/2020 – 3/31/2022 - 0%
    - 4/1/2022 – 6/30/2022 - 1%
    - On or after 7/1/2022 – 2%

- **On December 29, 2022, CMS published Transmittal 18 to Form CMS-2552-10**
  - Effective for cost reporting periods beginning on or after October 1, 2022 (some retroactive changes).
  - T-18 reflects the remaining proposed changes issued in Accordance with the Paperwork Reduction Act (PRA) issued November 10, 2020.
  - HFS was approved for Transmittal 18 on February 22, 2023.
  - HFS updated the Hospital 2552-10 system the week of March 6th, 2023.

- **No File Open (Interface)**



- **CR File Open (Transmittal.Release.Interface.Patch)**



Hospital 2552-10 Transmittal 19

- **CMS issued Transmittal 19 to the 2552-10 on March 24th, 2023. Transmittal 19 has been issued with an effective date of Cost Reporting Periods Beginning on or After January 1, 2023 and implements minor changes including:**
  - The addition of Worksheet E-95 to provide an IPPS and OPPS payment adjustment for domestically made N95 surgical respirators for cost reporting periods beginning on or after January 1, 2023.
  - New Level One edit 10460D for cost reporting periods beginnings on or after October 1, 2020, to ensure charges billed under revenue code 0815 are reported on the Worksheet D-6 and not on the Worksheet D-3, line 77.
  - New Level One edit 10200G to ensure that a description is added for any subscript of Worksheet G-3, lines 24.51 through 24.60 that contains a dollar amount in column 1.
- **The T-19 changes were approved by CMS on April 19, 2023 and HFS updated the Hospital 2552-10 system the week of April 17th, 2023.**

Hospital 2552-10 Transmittal 20

- **CMS issued Transmittal 20 to the 2552-10 on April 21st, 2023. Transmittal 20 has been issued with an effective date of Cost Reporting Periods Beginning on or After April 1, 2023, and implements minor changes including:**
  - Revised instructions to identify and introduce the Rural Emergency Hospital (REH) provider type effective for cost reporting periods beginning on or after January 1, 2023, as established by the Consolidated Appropriations Act, 2021, Division H, Title II, section 125.
  - New Level One edit 12975S for cost reporting periods beginning on or after January 1, 2023, to ensure that REH facilities do not report inpatient days on Worksheet S-3.
  - New Level One edit 12980S for cost reporting periods beginning on or after January 1, 2023, to ensure that REH facilities properly report outpatient visits on Worksheet S-3, line 15.10.
  - Subsequent to the issuance of T-20 CMS clarified that the Public Health Emergency (PHE) ended effective May 11,2023.
- **The T-20 changes were approved by CMS on June 28, 2023, and HFS will update the Hospital 2552-10 system the week of July 3rd, 2023.**

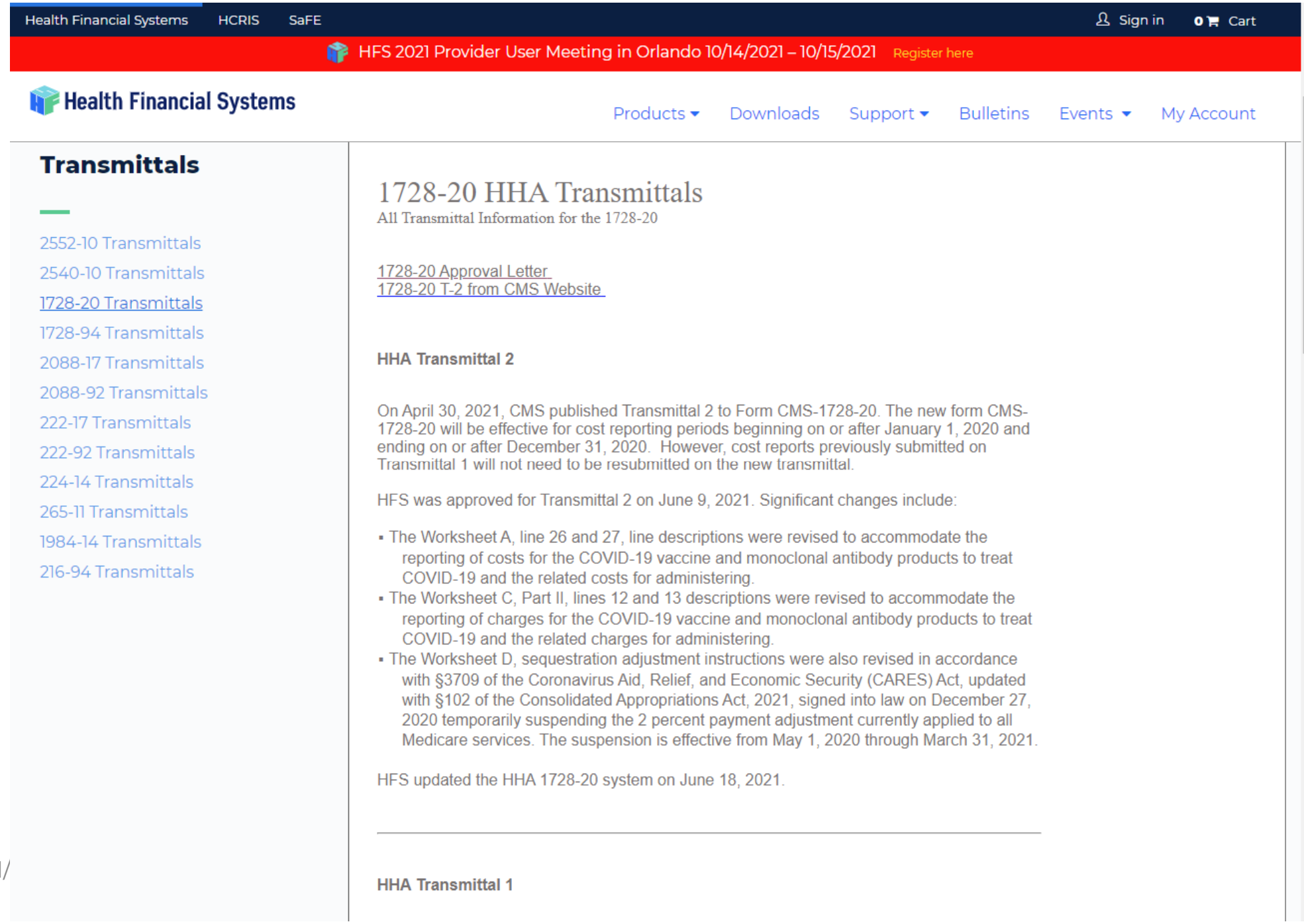
Hospital 2552-10 Transmittal 21

- **CMS issued Transmittal 21 to the 2552-10 on July 28th, 2023. Transmittal 21 has been issued with an effective date of Cost Reporting Periods Beginning on or After August 1, 2023, and implements minor changes including:**
  - The recission of the Community Health Access and Rural Transformation (CHART) model as of March 17, 2023.
  - The addition of edits 14007S, 14008S, 14011S, 14014S, 14016S, and 14021S, to review S-10 data.

The T-21 changes were approved by CMS on August 15, 2023, and HFS will update the Hospital 2552-10 system the week of August 21st, 2023.

Health Financial Systems

Latest Transmittal Updates



Health Financial Systems HCRIS SaFE Sign in 0 Cart

HFS 2021 Provider User Meeting in Orlando 10/14/2021 – 10/15/2021 Register here

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Transmittals

2552-10 Transmittals
2540-10 Transmittals
1728-20 Transmittals
1728-94 Transmittals
2088-17 Transmittals
2088-92 Transmittals
222-17 Transmittals
222-92 Transmittals
224-14 Transmittals
265-11 Transmittals
1984-14 Transmittals
216-94 Transmittals

1728-20 HHA Transmittals

All Transmittal Information for the 1728-20

1728-20 Approval Letter
1728-20 T-2 from CMS Website

HHA Transmittal 2

On April 30, 2021, CMS published Transmittal 2 to Form CMS-1728-20. The new form CMS-1728-20 will be effective for cost reporting periods beginning on or after January 1, 2020 and ending on or after December 31, 2020. However, cost reports previously submitted on Transmittal 1 will not need to be resubmitted on the new transmittal.

HFS was approved for Transmittal 2 on June 9, 2021. Significant changes include:

- The Worksheet A, line 26 and 27, line descriptions were revised to accommodate the reporting of costs for the COVID-19 vaccine and monoclonal antibody products to treat COVID-19 and the related costs for administering.
- The Worksheet C, Part II, lines 12 and 13 descriptions were revised to accommodate the reporting of charges for the COVID-19 vaccine and monoclonal antibody products to treat COVID-19 and the related charges for administering.
- The Worksheet D, sequestration adjustment instructions were also revised in accordance with §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, updated with §102 of the Consolidated Appropriations Act, 2021, signed into law on December 27, 2020 temporarily suspending the 2 percent payment adjustment currently applied to all Medicare services. The suspension is effective from May 1, 2020 through March 31, 2021.

HFS updated the HHA 1728-20 system on June 18, 2021.

HHA Transmittal 1

1728-20 T-4

- CMS Published T-4 to the 1728-20 on March 31, 2023.
- Effective for Cost Reporting Periods Beginning on or After January 1, 2023.

- **Eliminates the use of Worksheet A, Line 47 effective for cost reporting periods beginning on or after 1/1/2023 and modifies instructions to line 5 to incorporate these costs as applicable.**

Line 47 - Telehealth.--Enter the direct costs associated with telehealth. Telecommunication technology is considered remote patient monitoring and not a telehealth service. Telehealth services are subject to limitations under §1834(m) of the Act, namely that the beneficiary must be located in a health professional shortage area (HPSA) or rural area, and that the beneficiary must be physically present at a specific site of service. Telehealth services performed by a physician/practitioner under §1834(m) of the Act are outside the scope of the Medicare home health benefit and home health PPS. *Effective January 1, 2023, this line is no longer used. See instructions for line 5.*

Line 5 - Telecommunication Technology.--Enter allowable administrative costs related to *the use of* telecommunication technology *(other than audio-only telephone calls) in the provision of home health care* as described in 42 CFR 409.46(e). *This can include: r*emote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency*; teletypewriter (TTY) technology; and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician.* If *telecommunications technologies are* used by the home health agency, the costs of *any* equipment, set-up, and service related to *the technology* are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the *technology*, without the provision of a skilled service are not separately billable.

ESRD 265-11 Transmittals 7-9

- **Three Transmittals that all primarily addressed the reporting of salaries relating to the maintenance or renal dialysis equipment:**
  - Transmittal 7 shaded the Worksheet A, Line 6 (capital-related costs of renal dialysis equipment) to exclude salaries (column 2).
  - Transmittal 8 established an effective date of cost reporting periods beginning on or after January 1, 2023, as an effective date to include the salaries and benefits of technicians in the operation of plant or A&G cost center.
  - Transmittal 9 further clarified the line 6 instructions to report the salaries of technicians who maintain dialysis machines, dialysis support equipment and water purification equipment on line 6.01.
  - Transmittal 9 also added Edit 1010A to ensure that Worksheet A, line 6 column 2 is not used for cost reporting periods beginning on or after January 1, 2023.

FQHC 224-14 Transmittal 5

- **Minor clarifications and Updates:**
  - The FQHC, 224-14 system was updated to Transmittal 5 by CMS, on October 28, 2022. Transmittal 5 is effective for cost reporting periods that end on or after October 31, 2022.
  - HFS was approved for Transmittal 5 on November 8, 2022.
    - The primary change in Transmittal 5 was the calculation of Sequestration as follows (Clarification):
      - No Sequestration for the period 5/1/2020 – 3/31/2022
      - 1% Sequestration for the period 4/1/2022 – 6/30/2022
      - 2% Sequestration effective 7/1/2022.
    - The OMB Expiration Date was revised to 8/31/2025
  - HFS updated the RHC 224-14 system the week of November 14, 2022.

Hospice 1984-14 Transmittal 5

- **Minor clarifications and Updates:**
- **On February 25, 2022, CMS published Transmittal 5 to Form CMS-1984-14. The new Transmittal will be effective for cost reporting periods ending on or after February 28, 2022.**
- **HFS was approved for Transmittal 5 on March 9, 2022, and updated the Hospice software the week of March 11, 2022. Significant changes include:**
  - Added non-reimbursable cost center line 72 for Items and services under ASFRA 1997. The Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12) prohibits the use of Federal funds to provide or pay for any health care item or service, or health benefit coverage, for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide. CMS has updated the Provider Reimbursement Manual cost report instructions for hospices to include costs prohibited by the Act as a non-reimbursable cost center.
  - Edit 1050A has been revised for cost reporting periods ending on or after 09-01-2018 to exclude Line 13 “effective March 1, 2020, through the end of the PHE (to be determined)”

Home Office Cost Statement 287-22 Transmittal 1/2

- **Forms redesigned to:**
  - Provide for ECR submission.
  - Provide for electronic signature.
  - Consistency with other cost reports.
  - CMS will provide MACs with a content database similar to but not publicly available like HCRIS.

- **Transmittal 1 is effective for cost reporting periods beginning on or after October 1, 2022, was published 10/28/2022 .**
- **Transmittal 2 with the same effective date was issued April 14, 2023, with minor clarifications.**

RHC/FQHC Vaccine Only

- **Added 4rth Medicare utilization option for vaccine only.**
  - 222-17 T-4 – Effective for CR periods ending on or after 7/31/2023
  - 224-17 T-6 – Effective for CR periods ending on or after 7/31/2023
- **Both published 7/28/2023**

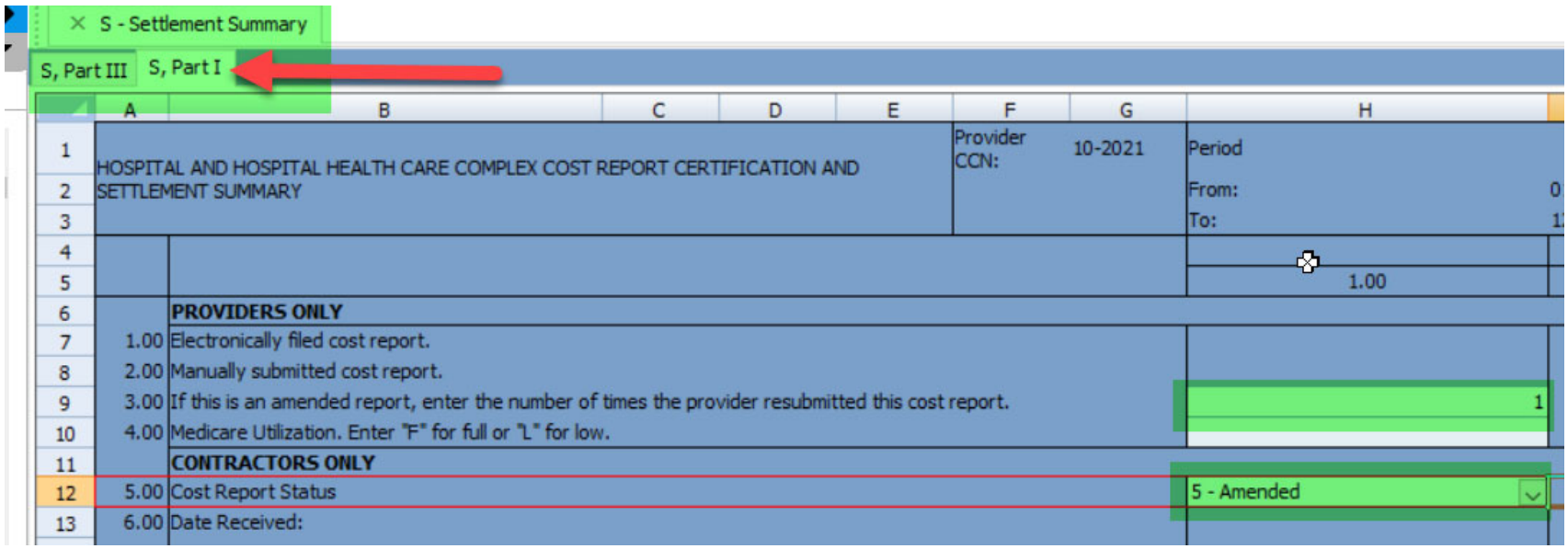
Health Financial Systems

Latest Transmittal Updates

	Type	Latest Transmittal	CMS Issued	HFS Approved	HFS Released	Effective Date
2552-10	Hospital	18/19/20/21	1/10/2022	1/21/2022	1/24/2022	Beginning O/A 4/1/2023
2540-10	SNF	10	6/11/2021	6/25/2021	6/30/2021	Ending O/A 3/31/2021
216-94	OPO	10	8/26/2022	9/9/2022	9/15/2022	Ending O/A 8/31/2022
1728-20	HHA	4	3/31/2023	4/2/2023	4/17/2023	Beginning O/A 1/1/2023
265-11	ESRD	7/8/9	4/28/2023	6/14/2023	6/12/2023	Beginning O/A 1/1/2023
224-14	FQHC	5	10/28/2022	11/8/2022	11/14/2022	Ending O/A 10/31/2022
1984-14	Hospice	5	2/25/2022	3/9/2022	3/11/2022	Ending O/A 2/28/2022
222-17	RHC	4	7/29/2022	8/5/2022	8/8/2022	Ending on or after 7/31/2022
2088-17	CMHC	3	8/26/2022	9/9/2022	9/15/2022	Ending O/A 8/31/2022
287-22	HO	1 / 2	10/28/2022	6/7/2023	6/12/2023	Beginning O/A 10/1/2022

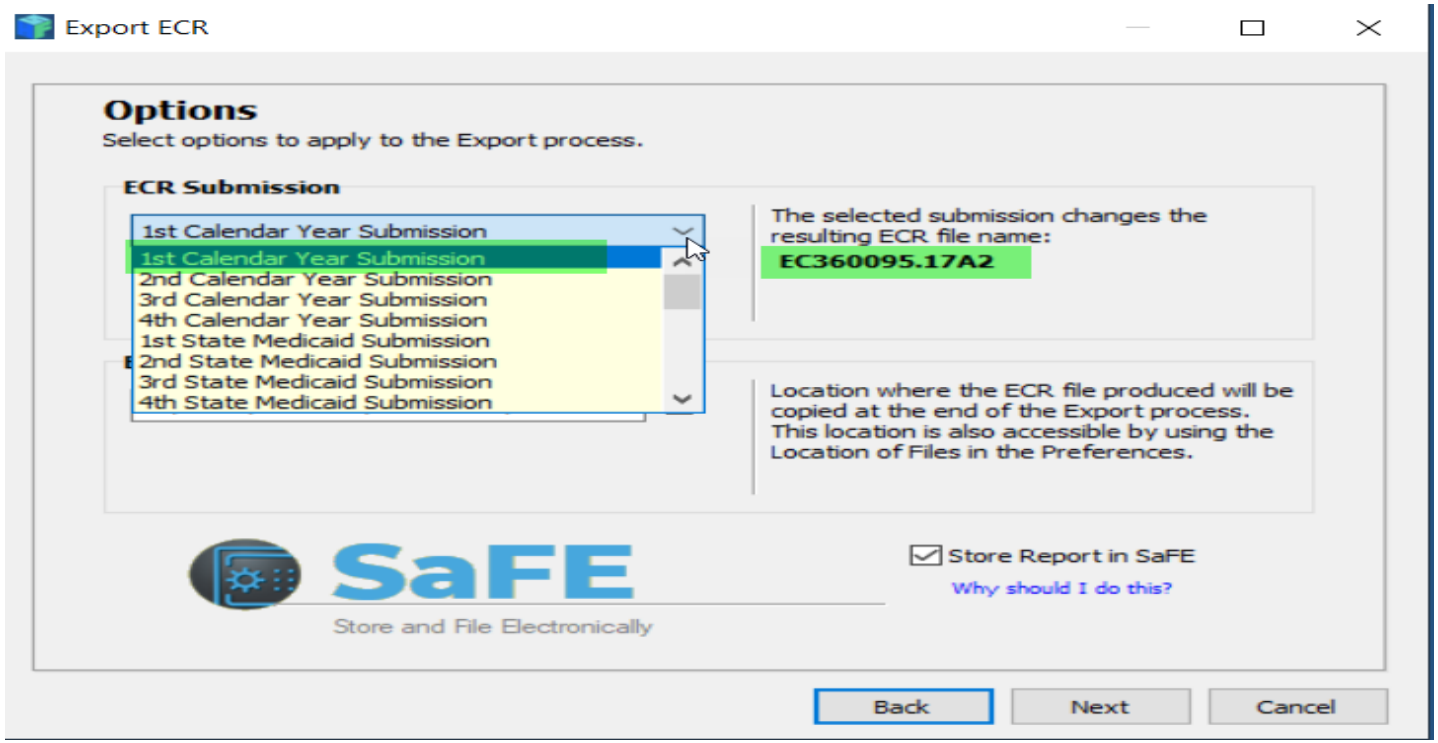
Amended Cost Report Clarification

- **Amended Cost Report Clarification**
  - With the S-10 amended cost reports, we noticed many users were incorrectly identifying the EC file when it is an amended cost report. When you amend a cost report, you open W/S S and select the S Part I tab and then on line 5 you change the mcr code to 5-Amended and change line 3 to 1 for 1st amended.



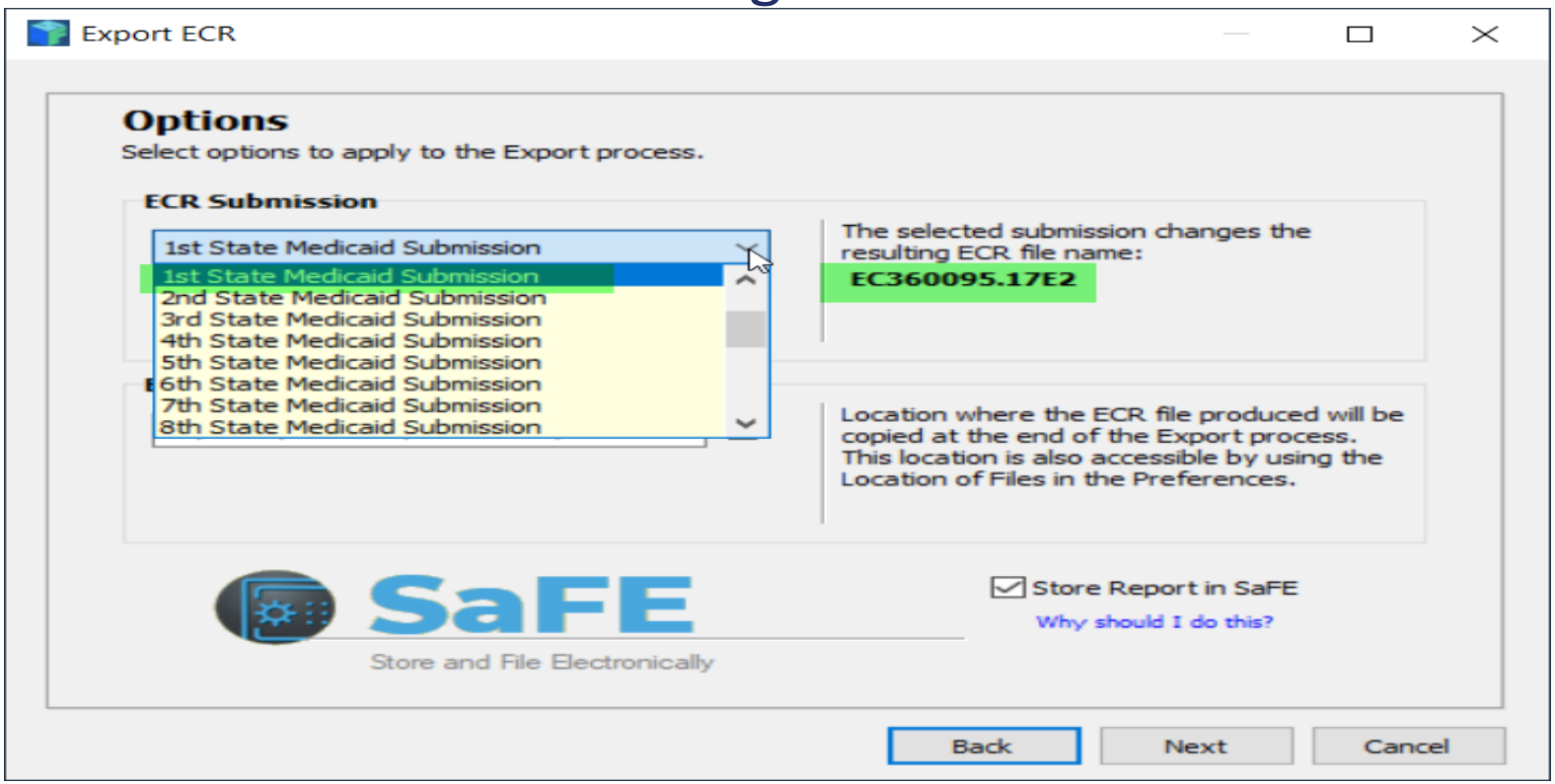
Amended Cost Report Clarification

- **Amended Cost Report Clarification**
  - Then when you do an ECR Export, you keep the EC Option submission still as 1st, only change this if you have 2 cost reports in the same calendar year (like a 6-30 and 12-31 due to CHOW). The EC file extension changes, like below to a 17A2.



Amended Cost Report Clarification

- **Amended Cost Report Clarification**
  - As you can see on the prior slide, we made a change to identify State Medicaid Submissions that users may want to use, in this case it is still an Amended cost report so the 1st XIX is 17E2, 2nd would be 17F2 & we allow for 22nd XIX submission being 17Z2.



- PRA Comment draft published in the September 27, 2023 Federal Register
- Comments must be received by November 27, 2023.
- Draft published at HFS Website:

https://hfssoft.com/news/

Health Financial Systems

Electronic Signature Demos

https://hfssoft.com/productfeatures/Electronic%20Signing%20Feature

Health Financial Systems HCRIS SaFE Welcome EricSwanson (Log Off) 0 Cart

HFS Holiday Hours: Thursday 12/24/2020 - 8:00 ET-12:00 PT; Friday 12/25/2020 - Closed; Thursday 12/31/2020 - 8:00 ET-12:00 PT; Friday 1/1/2021 - Closed

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HFS has incorporated the ability to electronically sign an MCR into the ECR Export process. As CMS updates the form sets and HFS is approved users will be offered this ability in their software. Users are given the option to sign the MCR themselves (if they meet the CMS criteria of CFO or Administrator) or they can give contact information for the signer and the HFS SaFE site will facilitate the signing.

Features

It's easy to use and documented for the preparer and signer at every step.

The HFS shows the complete CMS certification to the statement along with the ability to view the report and any other information the preparer adds to the 'signing package'.

If the signer is not an HFS user they are NOT required to register with our system.

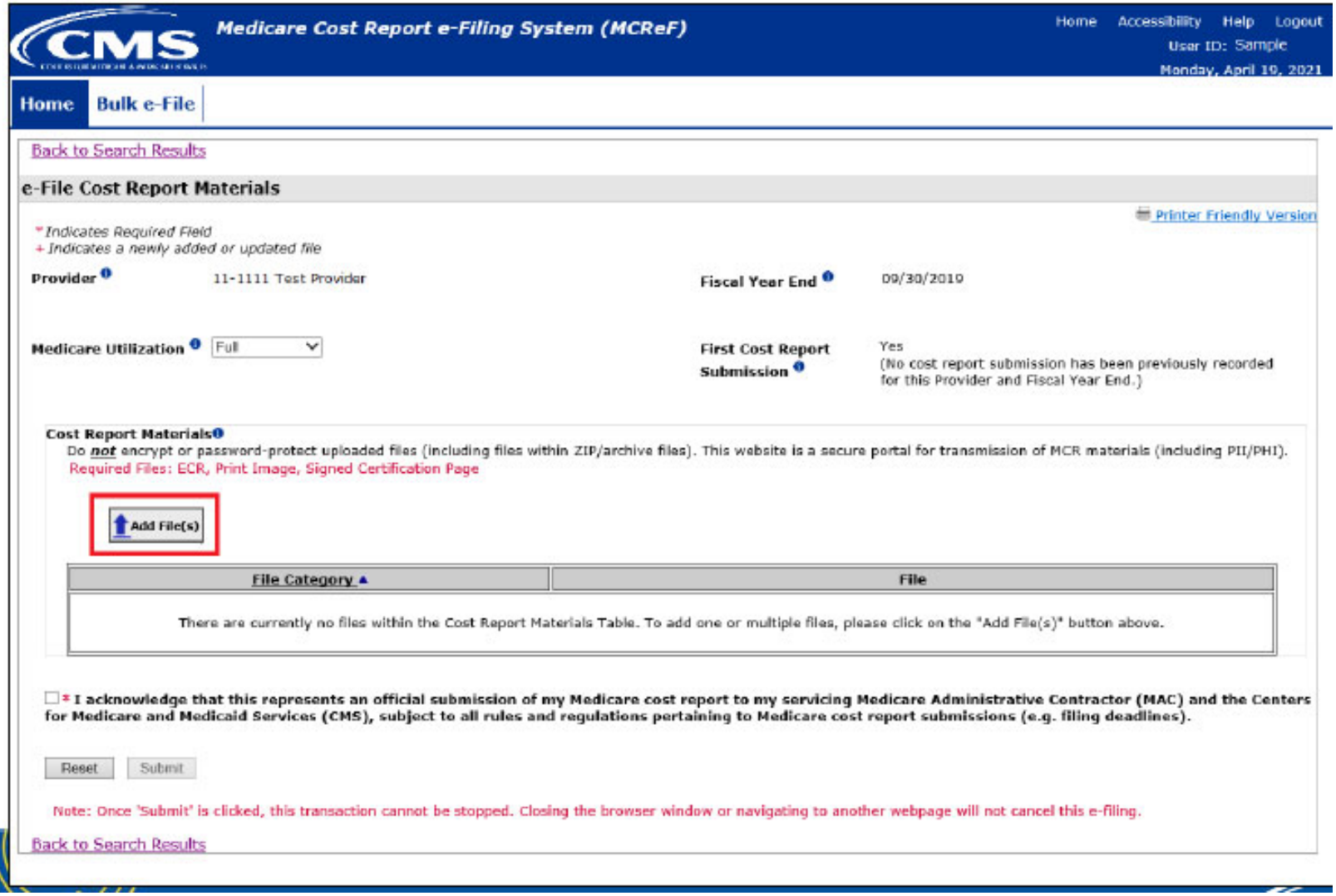
See How to Sign Electronically
- Demo of preparation of submission for CFO signature
- Demo of CFO Signature
- Demo of Self Signature

Electronic Signature Process

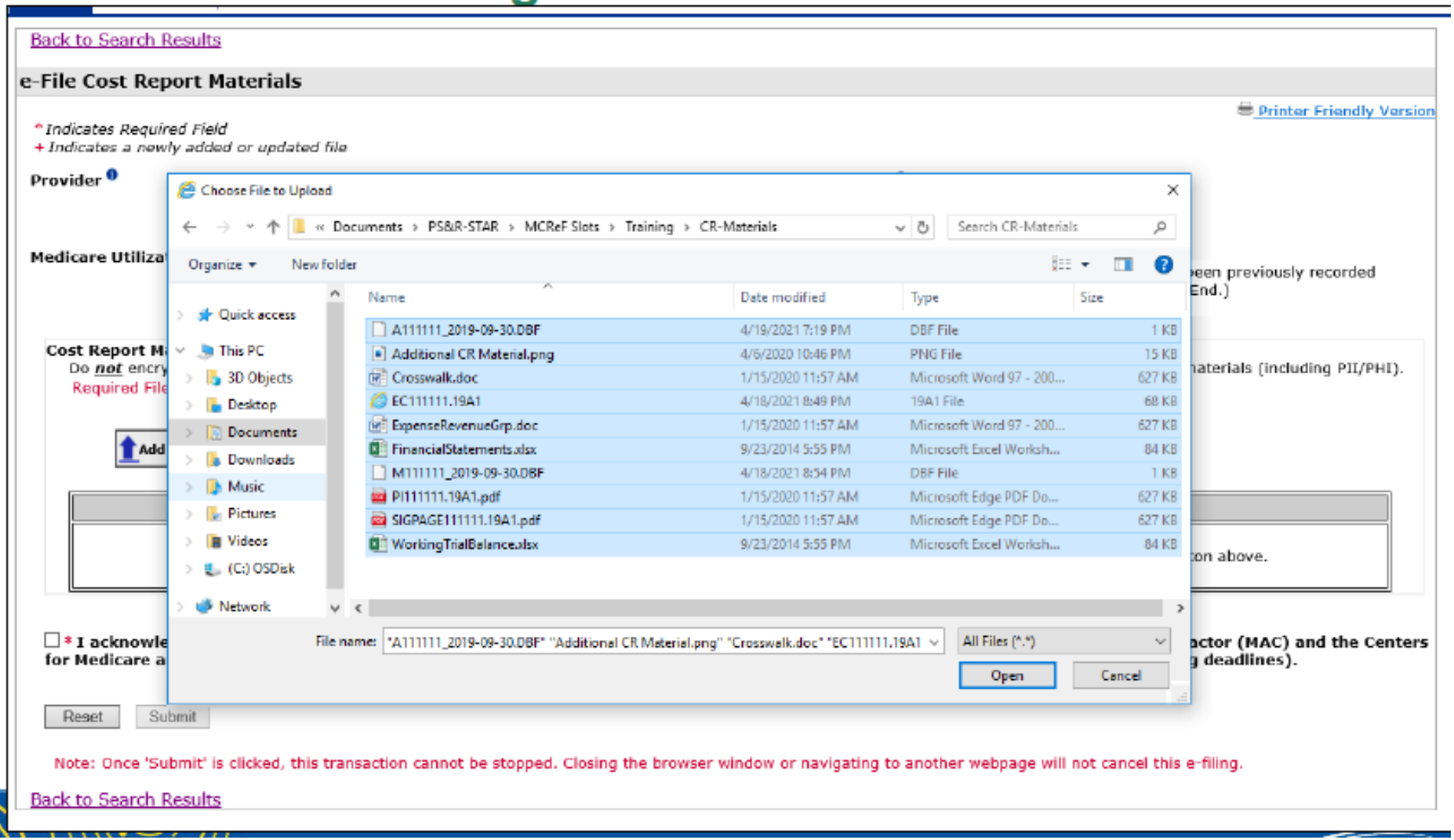
- **Electronic Signature Process begins at ECR export**
- **Three options**
  - “Wet” signature
  - Preparer completes electronic signature
  - Preparer forwards to Administrator/CFO (via email)

- **Other Resources:**
  - MCReF User Manual
    - https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCReF-User-Manual.pdf
    - More information and samples of allowable certification pages.
    - Appendix B has listing of file categories with the naming convention – Begins with …
  - MCReF FAQ
    - https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCReF-FAQ.pdf
  - How to Request MCReF User Role
    - https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/How-to-Request-MCReF-user-role.pdf
  - New MCReF Presentation:
    - https://www.cms.gov/files/document/mcref-medicare-part-cost-report-e-filing-updates-webinar-march-30-2023-presentation.pdf

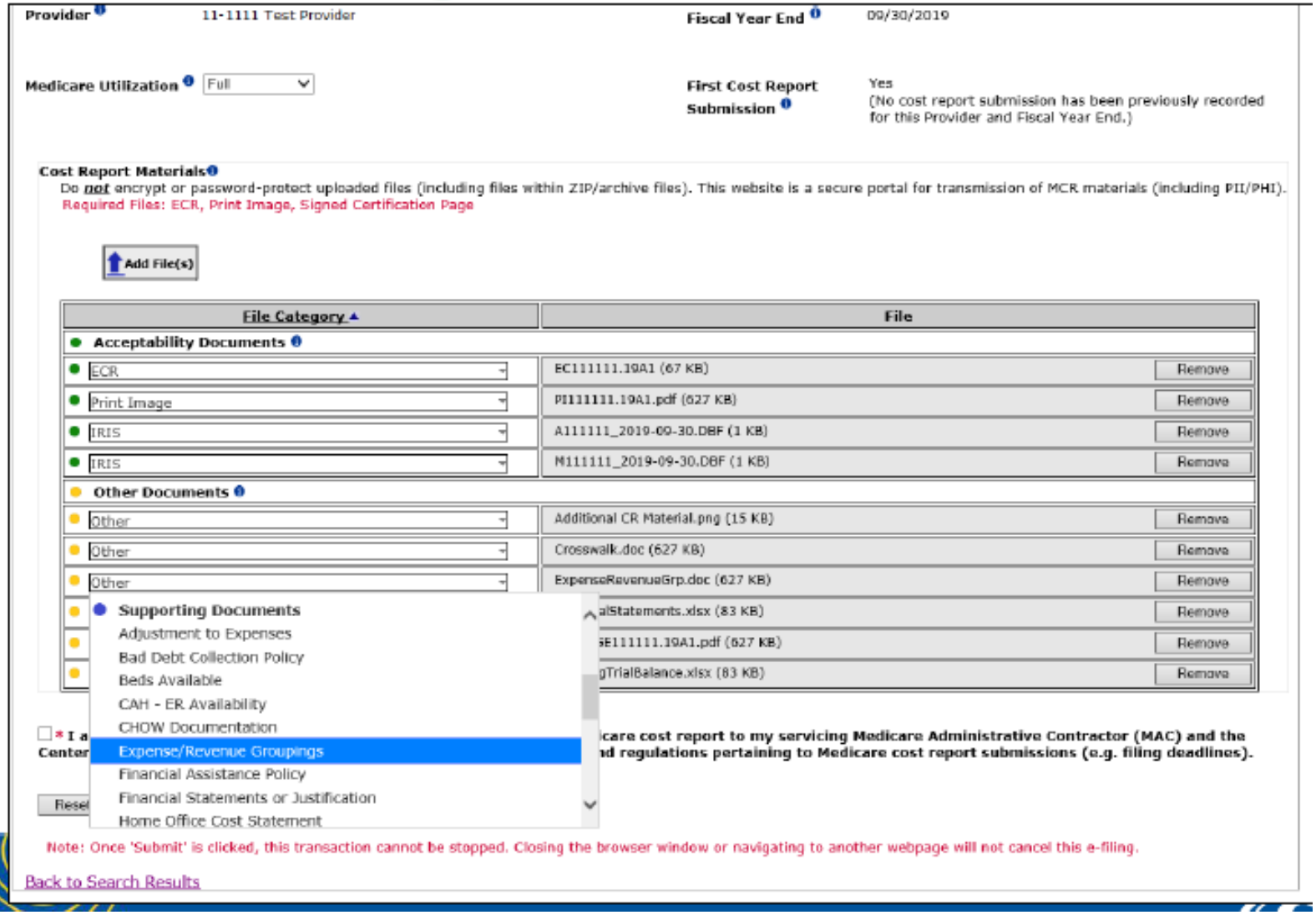
Updated Individual e-Filing Process

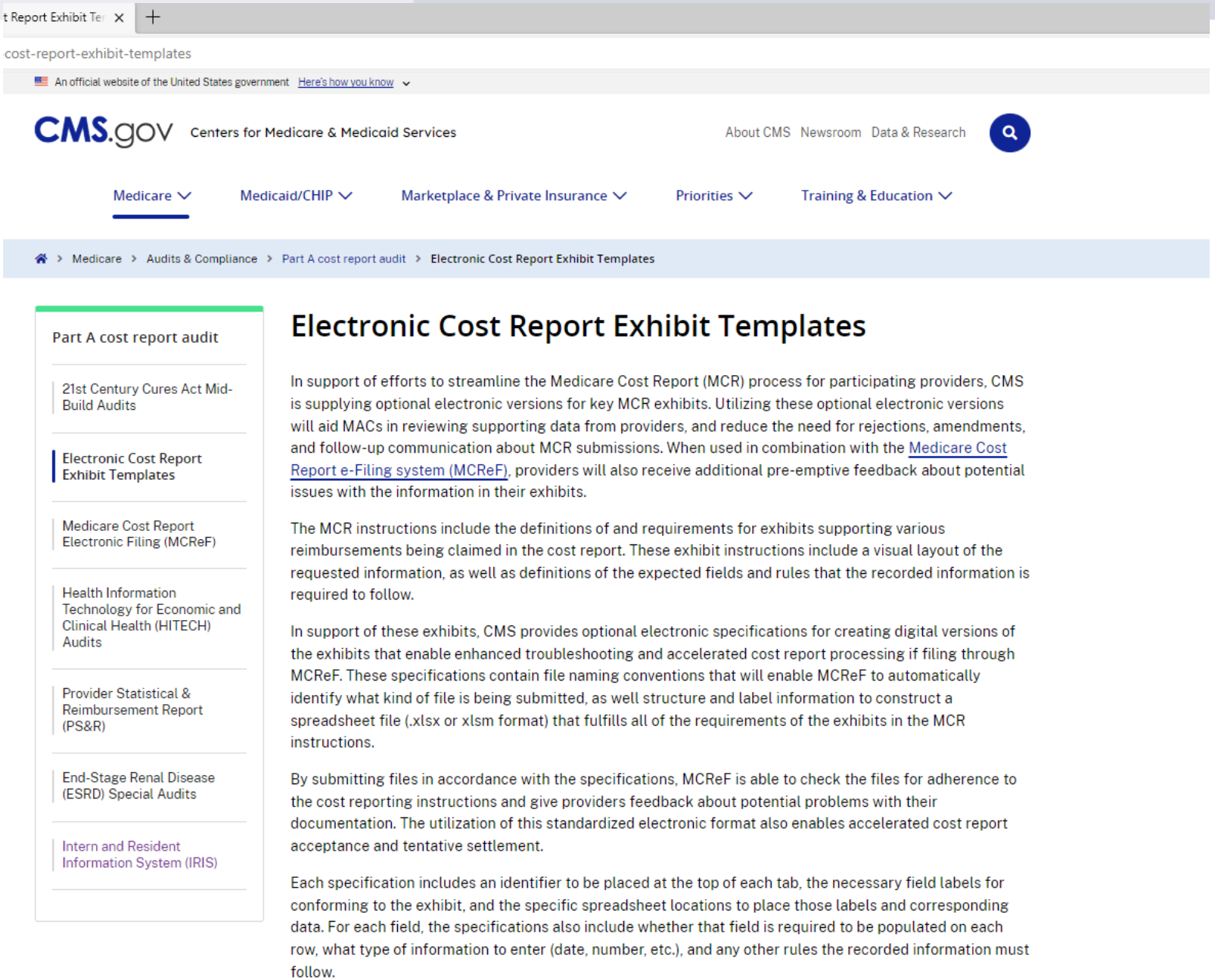


Updated Individual e-Filing Process



Updated Individual e-Filing Process





t Report Exhibit Te ×

cost-report-exhibit-templates

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Medicare Medicaid/CHIP Marketplace & Private Insurance Priorities Training & Education

Medicare > Audits & Compliance > Part A cost report audit > Electronic Cost Report Exhibit Templates

Part A cost report audit

- 21st Century Cures Act Mid-Build Audits
- Electronic Cost Report Exhibit Templates
- Medicare Cost Report Electronic Filing (MCReF)
- Health Information Technology for Economic and Clinical Health (HITECH) Audits
- Provider Statistical & Reimbursement Report (PS&R)
- End-Stage Renal Disease (ESRD) Special Audits
- Intern and Resident Information System (IRIS)

Electronic Cost Report Exhibit Templates

In support of efforts to streamline the Medicare Cost Report (MCR) process for participating providers, CMS is supplying optional electronic versions for key MCR exhibits. Utilizing these optional electronic versions will aid MACs in reviewing supporting data from providers, and reduce the need for rejections, amendments, and follow-up communication about MCR submissions. When used in combination with the Medicare Cost Report e-Filing system (MCReF), providers will also receive additional pre-emptive feedback about potential issues with the information in their exhibits.

The MCR instructions include the definitions of and requirements for exhibits supporting various reimbursements being claimed in the cost report. These exhibit instructions include a visual layout of the requested information, as well as definitions of the expected fields and rules that the recorded information is required to follow.

In support of these exhibits, CMS provides optional electronic specifications for creating digital versions of the exhibits that enable enhanced troubleshooting and accelerated cost report processing if filing through MCReF. These specifications contain file naming conventions that will enable MCReF to automatically identify what kind of file is being submitted, as well structure and label information to construct a spreadsheet file (.xlsx or xlsm format) that fulfills all of the requirements of the exhibits in the MCR instructions.

By submitting files in accordance with the specifications, MCReF is able to check the files for adherence to the cost reporting instructions and give providers feedback about potential problems with their documentation. The utilization of this standardized electronic format also enables accelerated cost report acceptance and tentative settlement.

Each specification includes an identifier to be placed at the top of each tab, the necessary field labels for conforming to the exhibit, and the specific spreadsheet locations to place those labels and corresponding data. For each field, the specifications also include whether that field is required to be populated on each row, what type of information to enter (date, number, etc.), and any other rules the recorded information must follow.

In addition to these optional electronic specifications, CMS has created pre-made templates that are arranged according to the specifications. These are blank spreadsheets with all of the appropriate worksheet identifiers and all of the field labels in the specified locations, ready for data entry.

Medicare Bad Debt Listing

The Medicare Bad Debt Listing specification has three variations, depending on the MCR version the listing is being submitted with.

- A general specification shared across the following MCR versions and exhibits
  - 222-17 – Exhibit 1
  - 2088-17 – Exhibit 1
  - 224-14 – Exhibit 1
  - 265-11 – Exhibit 1
  - 2540-10 – Exhibit 1
- MCR Version 1728-20 – Specifying the layout for Exhibit 1
- MCR Version 2552-10 – Specifying the layout for Exhibit 2A

Medicaid Eligible Days

The Medicaid Eligible Days specification is designed to accommodate the completion of Exhibit 3A of the 2552-10 Medicare Cost Report.

Charity Care Charges

The Charity Care Charges specification is designed to accommodate the completion of Exhibit 3B of the 2552-10 Medicare Cost Report.

Total Bad Debt

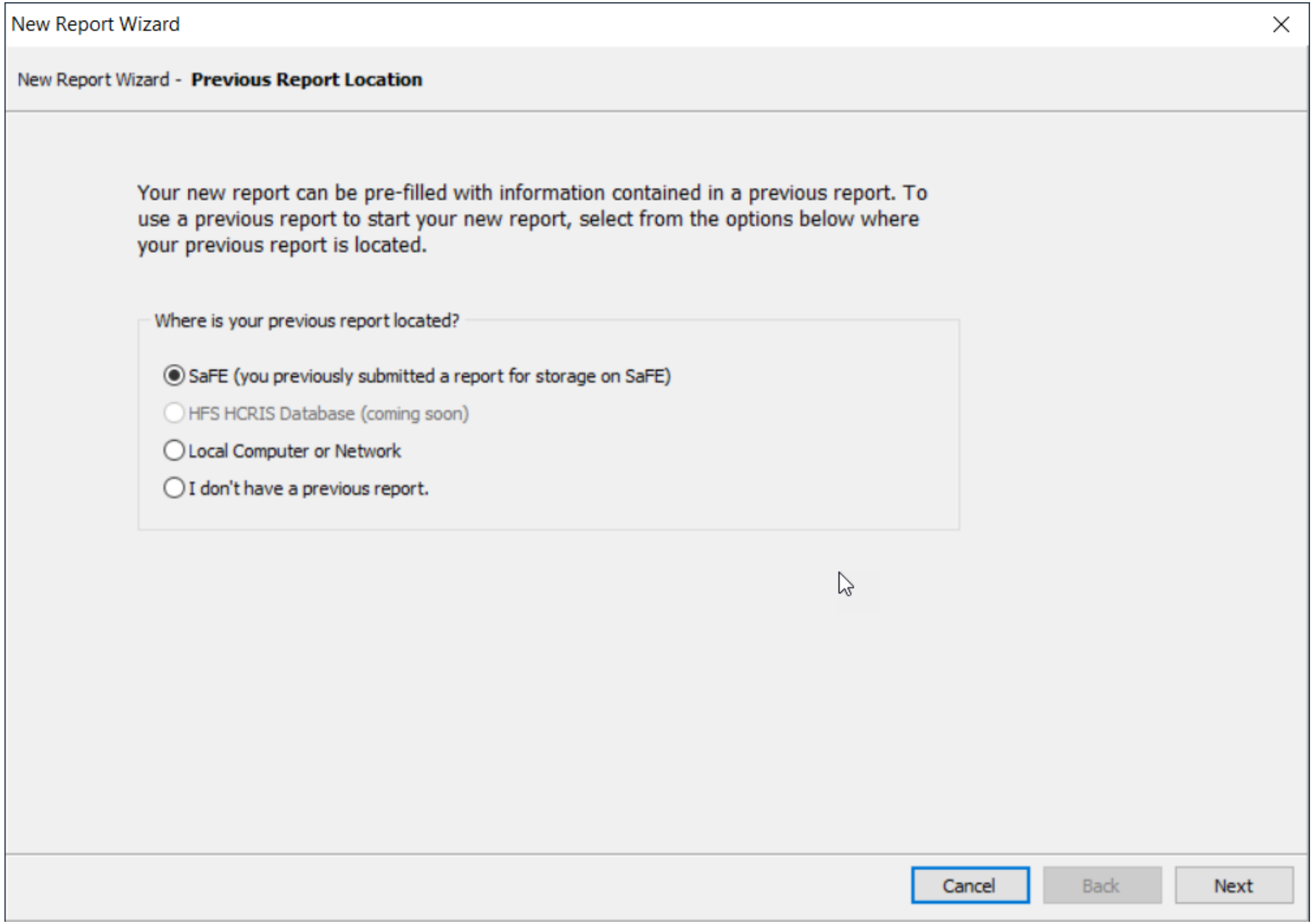
The Total Bad Debt specification is designed to accommodate the completion of Exhibit 3C of the 2552-10 Medicare Cost Report.

- **MCReF Issues**
  - Users uploading .mcrx files as an ECR or PI file
  - STAR edits reviewed as criteria for submission

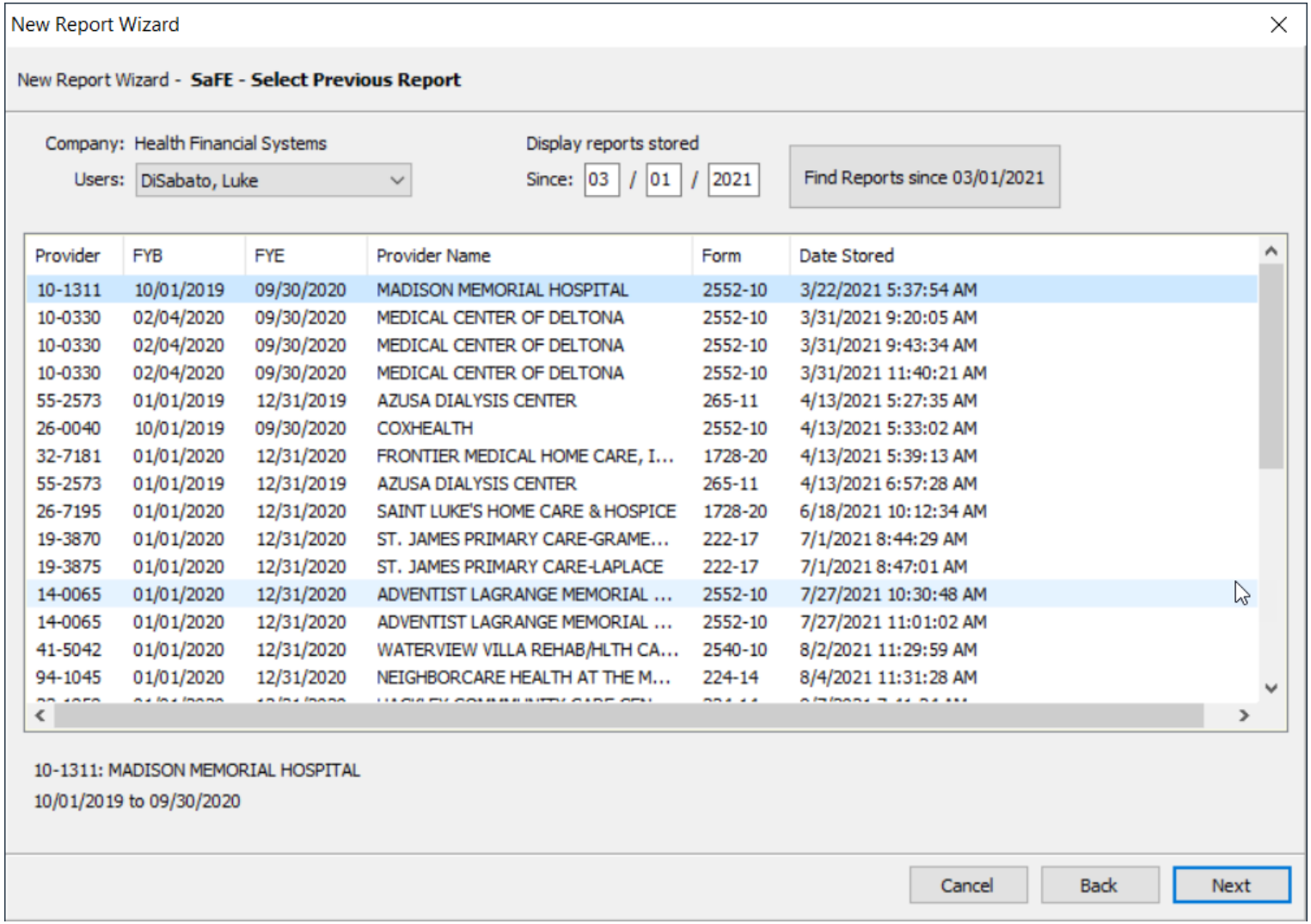
New Report Wizard

- We have added a New Report Wizard with ability for you to pull in information from your PY report. The Template feature is still there but we have expanded this for the user, please look through this and we would love to have feedback on possible additional items.
- This is under File | New Report Wizard.

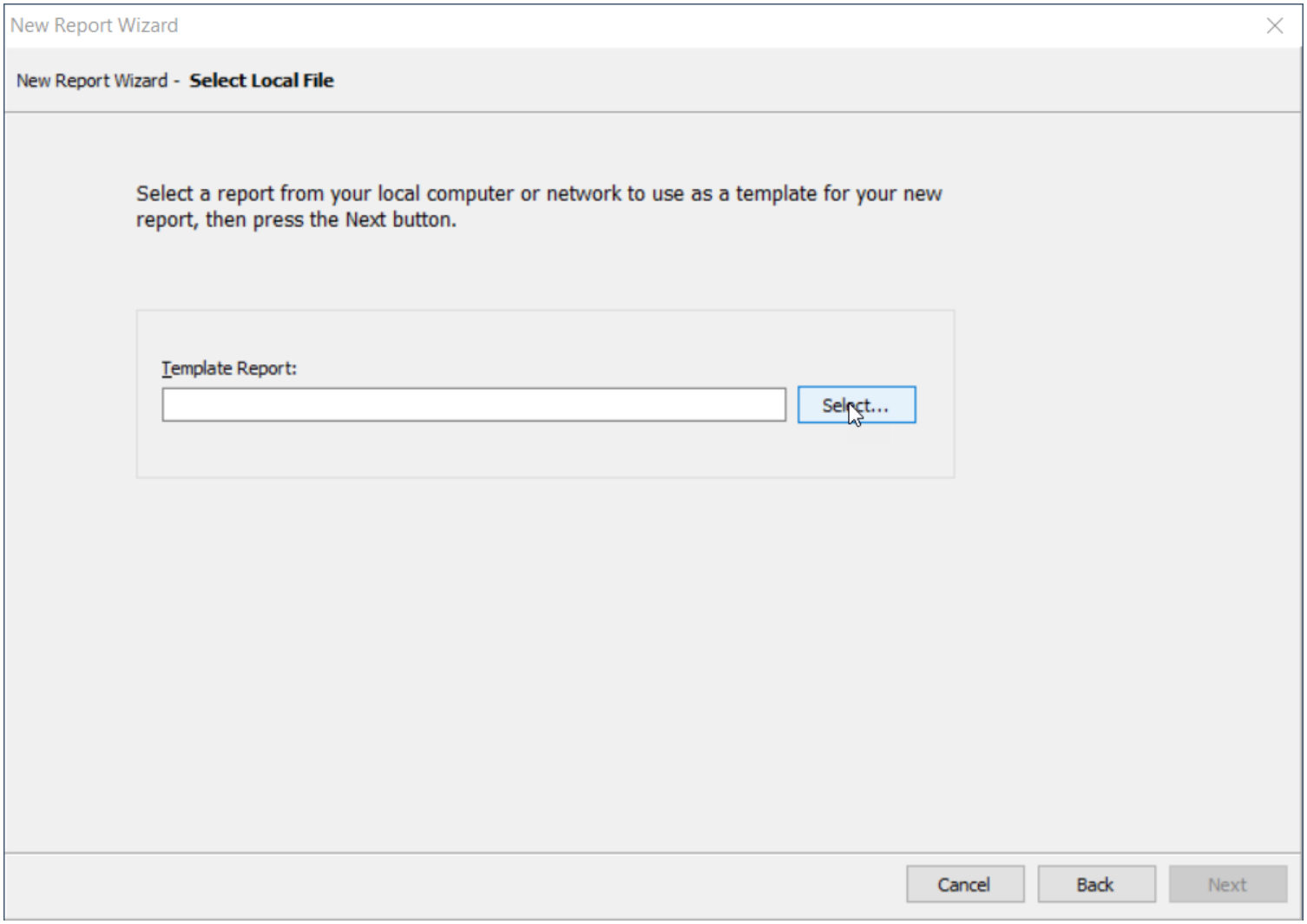
New Report Wizard



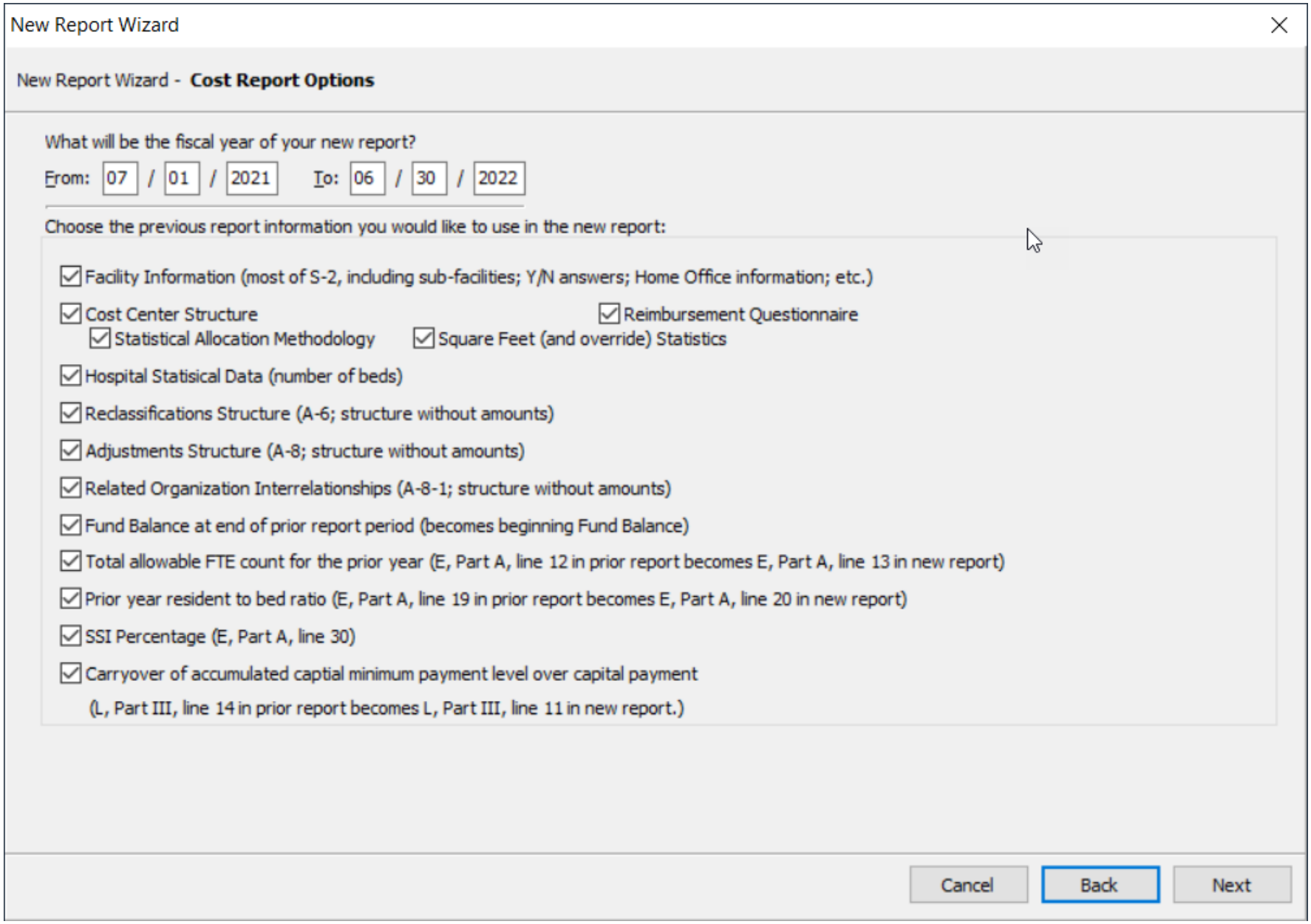
With SaFE, you will need to log in.



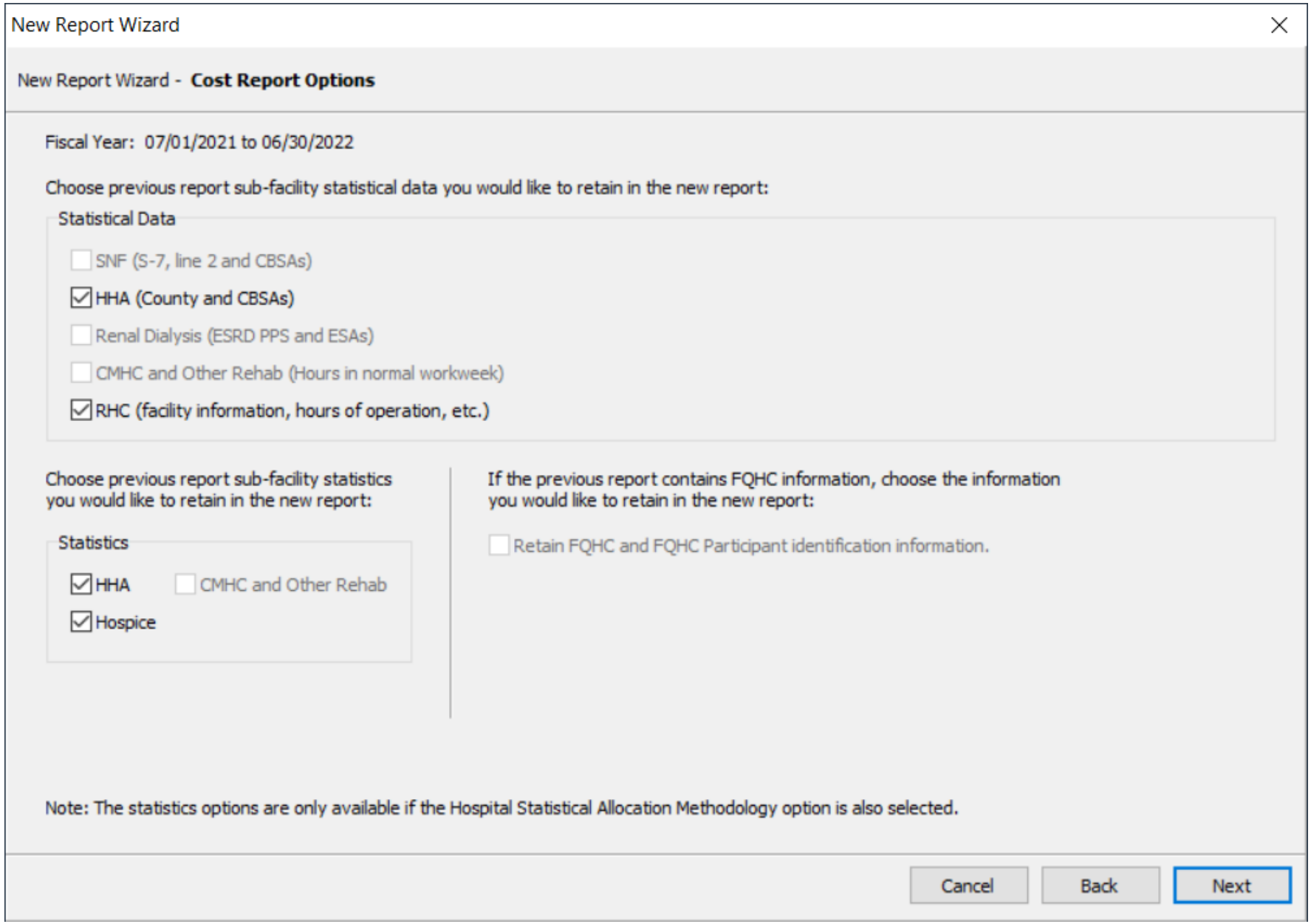
If getting PY file from PC, you will see the following:



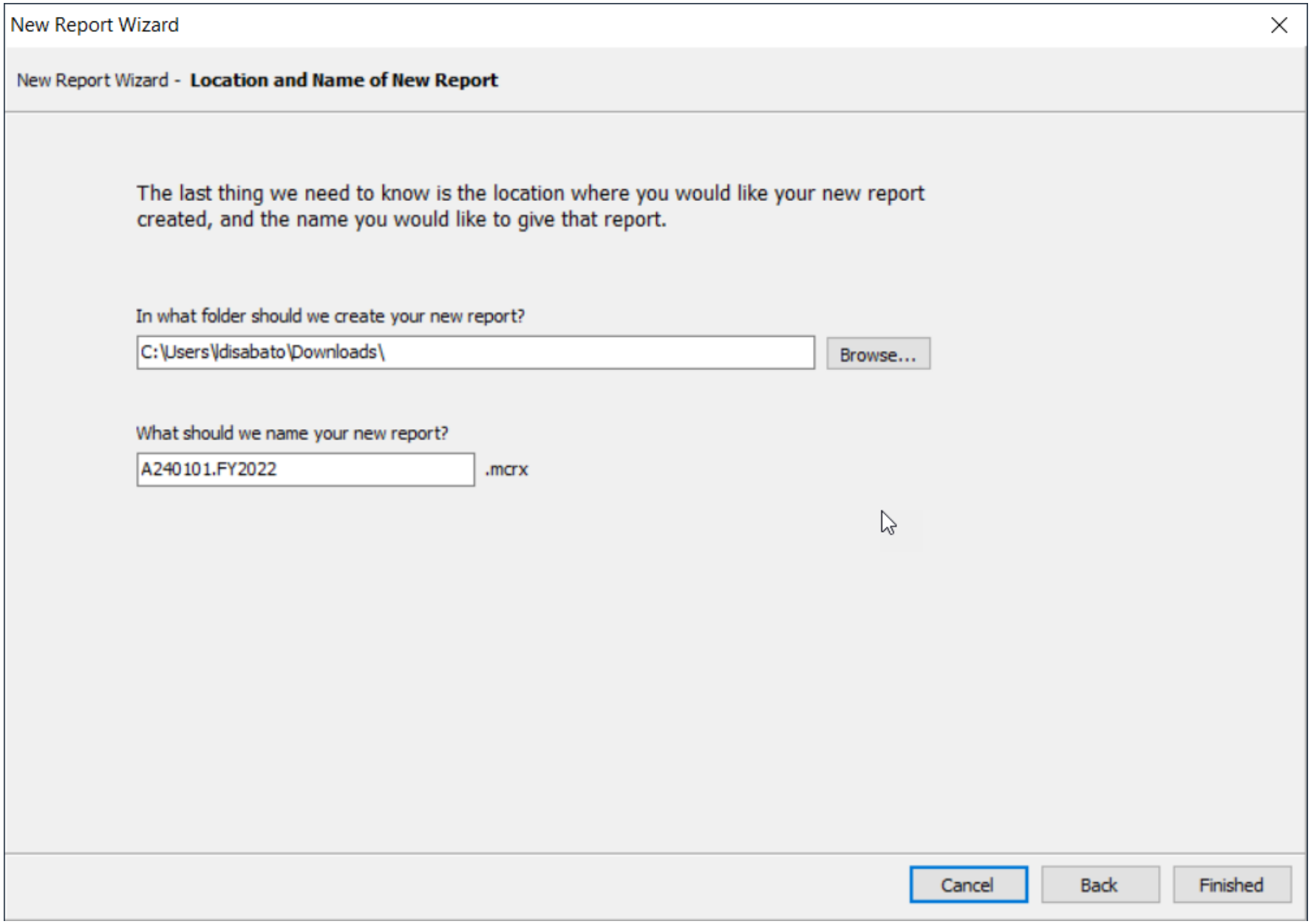
New Report Wizard



New Report Wizard



New Report Wizard



IRIS
Overview

- IME/GME Cost Report Update
- IRIS – Recent CMS Changes and Issues
- New fields being added to IRIS to trace to the Hospital Cost Reports
- HFS IRIS (Intern and Resident Information System) System Highlights
- HFS IRIS Data Entry – template/definitions
- HFS IRIS Audit Report
- Questions

IME/GME Cost Report Update

- CMS has released T18 cost report changes for the GME weighting based on Hershey Medical Center litigation. This was spelled out in the FFY23 IPPS Final Rule. T18 also incorporated changes associated with Sections 126, 127 and 131 of the Consolidated Appropriations Act (CAA), 2021.
- The trigger for the Hershey case is W/S S-2 Pt I line 68 and it will change the computation of W/S E-4 line 9.
- You will also need to revise the PY and Penultimate year mcrx files for E-4 lines 12 & 13 (may need to account for line 15 too).

- Sections 126, 127 and 131 of the Consolidated Appropriations Act (CAA), 2021.
- FTE cap adjustment for section 131 of the CAA 2021 is input on W/S E Pt A line 5.01 and W/S E-4 line 1.01
- The Rural Track Programs in effect under section 127 of the CAA 2021 is input on E Pt A lines 6.26 through 6.49 and E-4 lines 2.26 through 2.49.
- FTE cap slots awarded under section 126 of the CAA 2021 is input on E Pt A lines 8.21 through 8.27 and E-4 lines 4.21 through 4.27.

- The FFY23 IPPS Rule also updated the CY 2020 and 2021 HMO Reduction amounts shown on Worksheet E-4 line 29.01. This also was included in T18.
  - CY 2020 – 3.73%
  - CY 2021 – 3.26%
- The FFY24 IPPS Rule updated the CY 2022 HMO Reduction amount shown on E-4 line 29.01 to 3.27% (8-28-23 federal register page 59058). We are waiting for CMS to update the instructions to implement this change.

- New teaching programs with CR periods on or after 12-27-2020 are no longer able to be paid cost when the program begins after the 1st day of the CR period. You must be reimbursed via W/S E-4 and this is **RETROACTIVE**.

CMS' IRIS Changes

- CMS has moved to an xml file for submission of IRIS with the cost reports rather than the M & A dbf.
- The XML is required for FYB 10-1-2021 so we have it set up to only export with these FYBs.
- The reason for this change is to be able to compute the FTEs from the XML import and trace this to the cost report.

CMS' IRIS Changes

- CMS has added the following new fields to IRIS:
  - Non-IRPS Year One – Simultaneous Match
  - Non-IRPS Year One – Prelim. – Transitional
  - IRF % and IPF % - for time spent at subprovider
  - Non-Provider Site %
  - New Program – True or False
  - Displaced Resident – True or False
  - New Program GME exclusions (NEW)

- CMS' definitions of the new fields:

New Fields

Except for one field being removed (which is addressed in a subsequent section below), the new XML format will contain the same fields as the old DBF format plus the following new fields:

1. Assignment IPF Percentage (Psych): The percentage of the Intern/Resident(IR)'s rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Psych in the 2552-10 Cost Report's Worksheet E-3 Part II.
2. Assignment IRF Percentage (Rehab): The percentage of the IR's rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Rehab in the 2552-10 Cost Report's Worksheet E-3 Part III.
3. Assignment Non-Provider Site Percentage: The percentage of the IR's rotational assignment time that was spent in allowable non-provider site settings. See 2552-10 cost report worksheet S2 Lines 66 & 67.
4. Assignment Displaced Resident (True/False): Indicates whether the IR is an allowable displaced resident for which the hospital may receive a temporary cap adjustment. See 2552-10 worksheet E-4 line 16 (DGME) and worksheet E Part A line 17 (IME). Note that IRIS will track the raw number of displaced resident FTEs while what gets recorded in the cost report is an adjustment whose calculation, among other things, takes into account free cap slots. The displaced resident assignments recorded in IRIS do NOT directly sum to the displaced resident FTEs recorded in the cost report.

- CMS' definitions of the new fields (continued):

5. Assignment New Program (True/False): Indicates whether the resident is in the "initial years of a program that meets the exception to the rolling average rules" as per the cost report instructions. See 2552-10 worksheet E-4 Line 15 (DGME), worksheet E Part A Line 16 (IME), worksheet E-3 Part II Line 7 (Psych), and worksheet E-3 Part III Line 8 (Rehab).
6. Resident Non-IRP Year One Residency: For IRs that either participated in a preliminary/transitional year or a simultaneous match, this records the code for the residency type they were enrolled in during their first year as well as a 'type' value indicating whether it was a preliminary year or a simultaneous match.
7. Creation Software Name: Simple text field for recording the name of the software or vendor used to create the IRIS submission. This is meant to help CMS debug issues with specific files by identifying their source.

Removed Field

The XML format will not include an equivalent of the DBF master file Residency Years Completed (RESYEAR). This field was removed due to being redundant because the same value was already being tracked in a more granular and useful way at the assignment level (ARESYEAR in the assignment file).

- CMS' definitions of the new fields (continued) – the latest addition:

New Program IME Exception	Assignment	imeException	For residents included in New Programs per the field above where the program is not eligible to be counted as a GME New Program, indicates which IME subcategory (IPPS, IPF, or IRF) the program is eligible to count as a New Program for. (Multiple values can be included.) This is generally for providers reclassifying from Urban to Rural or providers with new IPF or IRF teaching programs without a previously established cap. Possible values: "IPPS" "IPF" "IRF"

- Cost Reporting periods beginning on or after 10-1-2021 requires IRIS files to be submitted in XML format rather than the M & A dbf files.
- Beginning with CR periods beginning on or after 10-1-2022, CMS requires the cost report to trace to the computed FTEs from the IRIS file uploaded into CMS' IRIS system.

- CMS did issue CR12724 which instructs the use of XML but also states the tracing to the cost report will be CR beg 10-1-22:

Number	Requirement	Responsibility				
		A/B MAC			DME	
		A	B	HHH	MAC	
12724.1	The MACs shall ensure that the IRIS data for all accepted teaching providers' cost reports with fiscal year beginning on or after October 1, 2021 are filed using the XML IRIS format.	X				
12724.3	The MACs shall reject all cost reports with fiscal year beginning on or after October 1, 2022 that the total unweighted GME and IME FTEs reported on the IRIS do not match the total unweighted GME and IME FTEs reported on the cost report. Note: See attachment B for the Medicare cost report worksheets and line references for the total unweighted GME and IME FTEs.	X				
12724.3.1	The MACs shall allow a variance of two percent between the total GME and IME FTEs reported on IRIS and the as-filed cost reports before rejecting the cost reports.	X				

- Below is Attachment B and the fields to be compared at acceptance.

Attachment B

Total Unweighted GME FTEs– IPPS Teaching Providers

- Worksheet E-4 Line 6: Unweighted resident FTE count for allopathic and osteopathic programs for the current year.
- Worksheet E-4 Line 10.01, Column 2: Unweighted dental and podiatric resident FTE count for the current year.
- Worksheet E-4 Line 15.01 Columns 1 & 2: Unweighted adjustment for residents in initial years of new programs.
- Worksheet E-4 Line 16.01 Columns 1 & 2: Unweighted adjustment for residents displayed by program or hospital closure.

Total Unweighted IME FTEs

- Worksheet E Part A line 10: FTE count for allopathic and osteopathic programs in the current year from your records.
- Worksheet E Part A line 11: FTE count for residents in dental and podiatric programs.
- Worksheet E Part A line 16: Adjustment for residents in initial years of the program.
- Worksheet E Part A line 17: Adjustment for residents displaced by program or hospital closure.
- Worksheet E-3 Part II line 6 (Inpatient Psychiatry Facility): Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program".
- Worksheet E-3 Part II line 7 (Inpatient Psychiatry Facility): Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program".
- Worksheet E-3 Part III line 7 (Inpatient Rehabilitation Facility): Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program".
- Worksheet E-3 Part III line 8 (Inpatient Rehabilitation Facility): Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program".

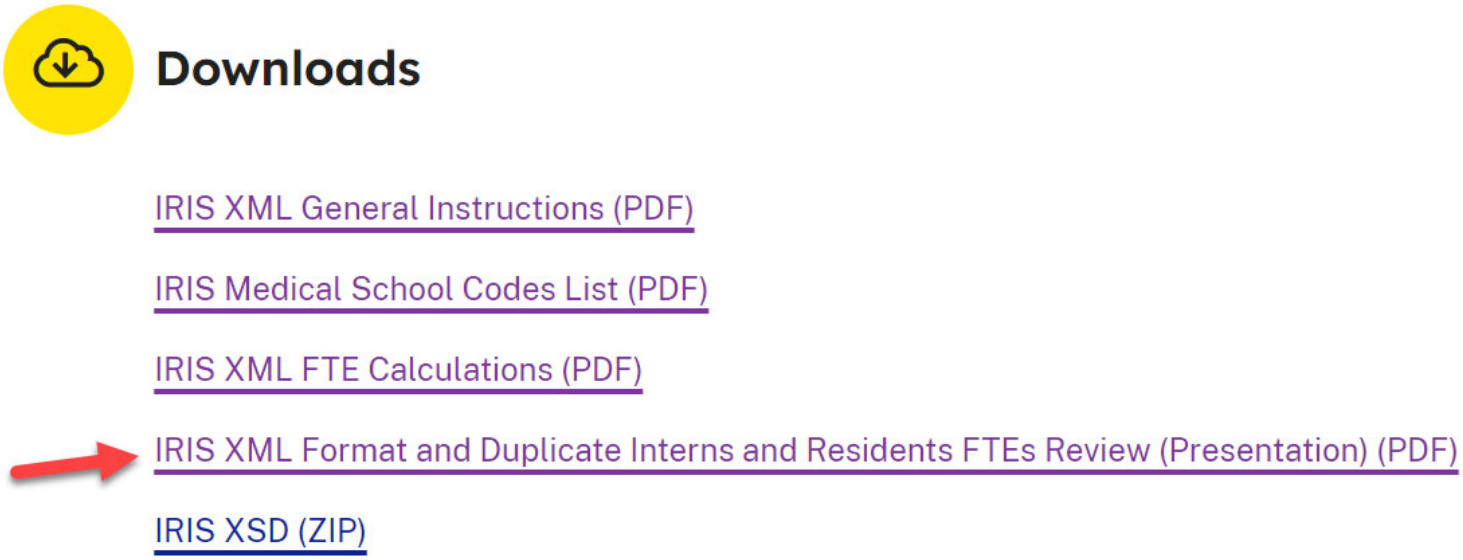
CMS' IRIS Changes

- CMS has their own IRIS system included in STAR that MACs load all IRIS data into it.
- This will enable the IRIS database to accumulate historical info for each resident to determine the initial residency and number of years the residents have completed.
- The other major issue is running overlaps; therefore, **it is vital to have discussions between the hospitals if residents rotate to other hospitals.**

CMS' IRIS Changes

- CMS has updated the IRIS website with the XML information; however, the residency code table is missing along with edits which we asked for.

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/IRIS



- The prior slide shows the presentation of the Duplicate I&R FTE Review. We have been notified by a client who was selected for this Audit. It is being done by M&S and reviewing back to CRs ending during FFY 2017 (10-1-16 to 9-30-17). They are giving providers 30 days to upload documentation supporting your assignments identified as possible duplicates.

CMS' IRIS Changes

- We have been stressing the need for hospitals to talk to other hospitals to ensure possible duplicates are not triggered. The following 2 slides are summarizing this.

- One major point when entering the percentage where a resident rotates to another hospital, if you enter your resident that rotates to your facility in April but is at another hospital from 4-11 to 4-16 (6 days), do not enter 4-1 to 4-30 with the IME and GME % at 80 but rather split the assignment and enter 4-1 to 4-10 and 4-17 to 4-30 at 100. If the other provider lists their assignment 4-11 to 4-16 at 100, then you would have an overlap when listing your assignment from 4-1 to 4-30 at 80.

- CMS has also furnished an example below for hours spent at a second facility:

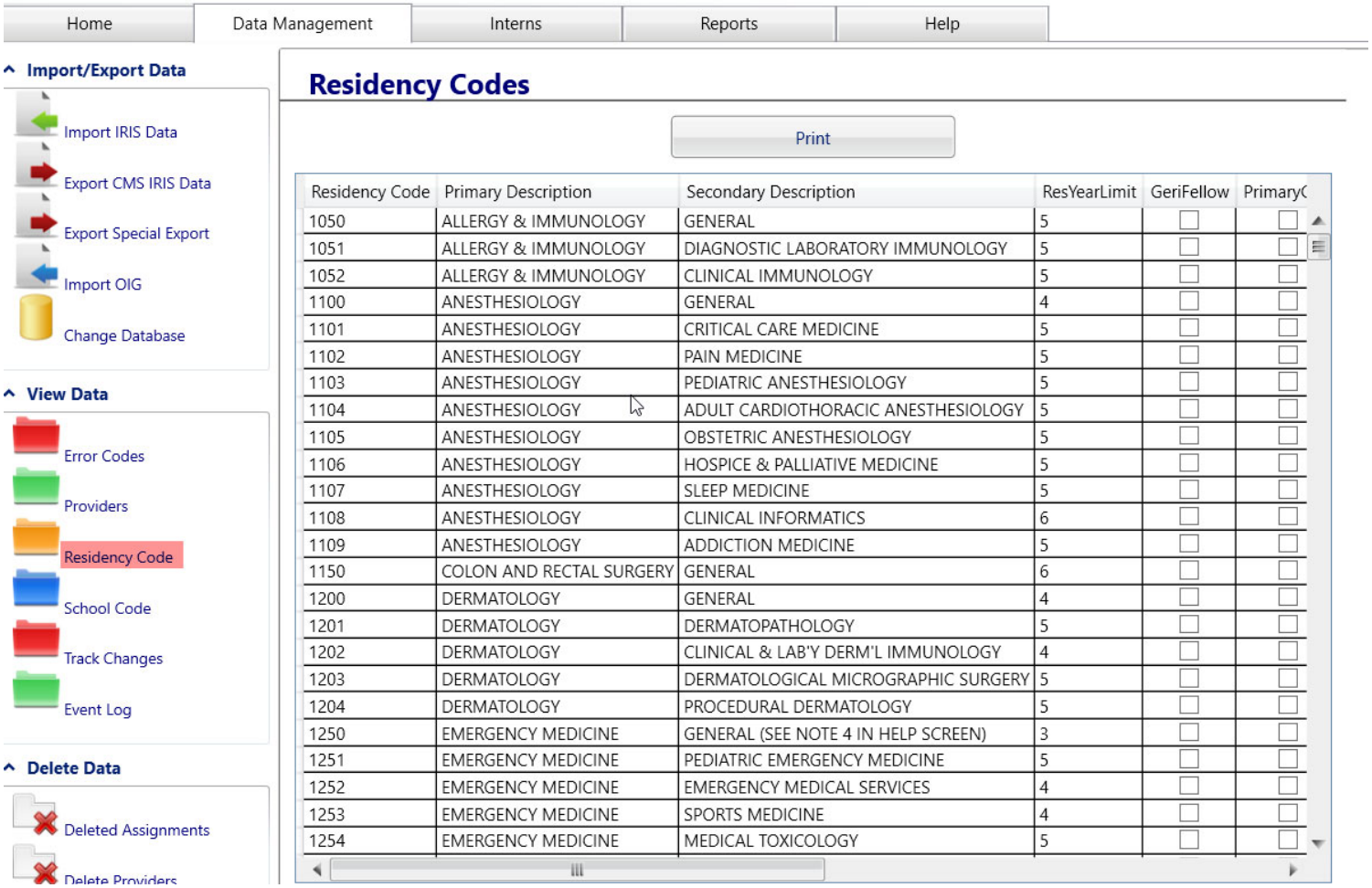
Example #2: If a resident in a fully reimbursable rotation is primarily assigned to and training at hospital A for the block rotation 1/1/15 - 1/31/15, but spending 4 hours per week on Wednesday mornings assigned to and training at hospital B during the same block rotation 1/1/15 – 1/31/15.

Option A: Complete Percentage Base where hospital A is reporting the rotational assignment time period for the resident as 1/1/15 - 1/31/15 at 94% (232 out of 248 hours) IME & GME Percentages and hospital B is reporting the rotational assignment time period for the resident as 1/1/15-1/31/15 at 6% (16 out of 248 hours) IME & GME Percentages, **not exceeding 100% and utilizing the same start and end dates for the rotational assignment time period**; *or*

Option B: Daily Percentage Base where hospital A is reporting the rotational assignment time periods and IME & GME Percentages for the resident as 1/1/15 - 1/6/15 at 100%, 1/7/15 at 50%, 1/8/15 - 1/13/15 at 100%, 1/14/15 at 50%, 1/15/15-1/20/15 at 100%, 1/21/15 at 50%, 1/22/15-1/27/15 at 100%, 1/28/15 at 50%, and 1/29/15-1/31/15 at 100%; and hospital B is reporting the rotational assignment time periods and IME & GME Percentages for the resident as 1/7/15 at 50%, 1/14/15 at 50%, 1/21/15 at 50%, and 1/28/15 at 50%, with agreement on the days and **no day or period of time exceeding 100%.**

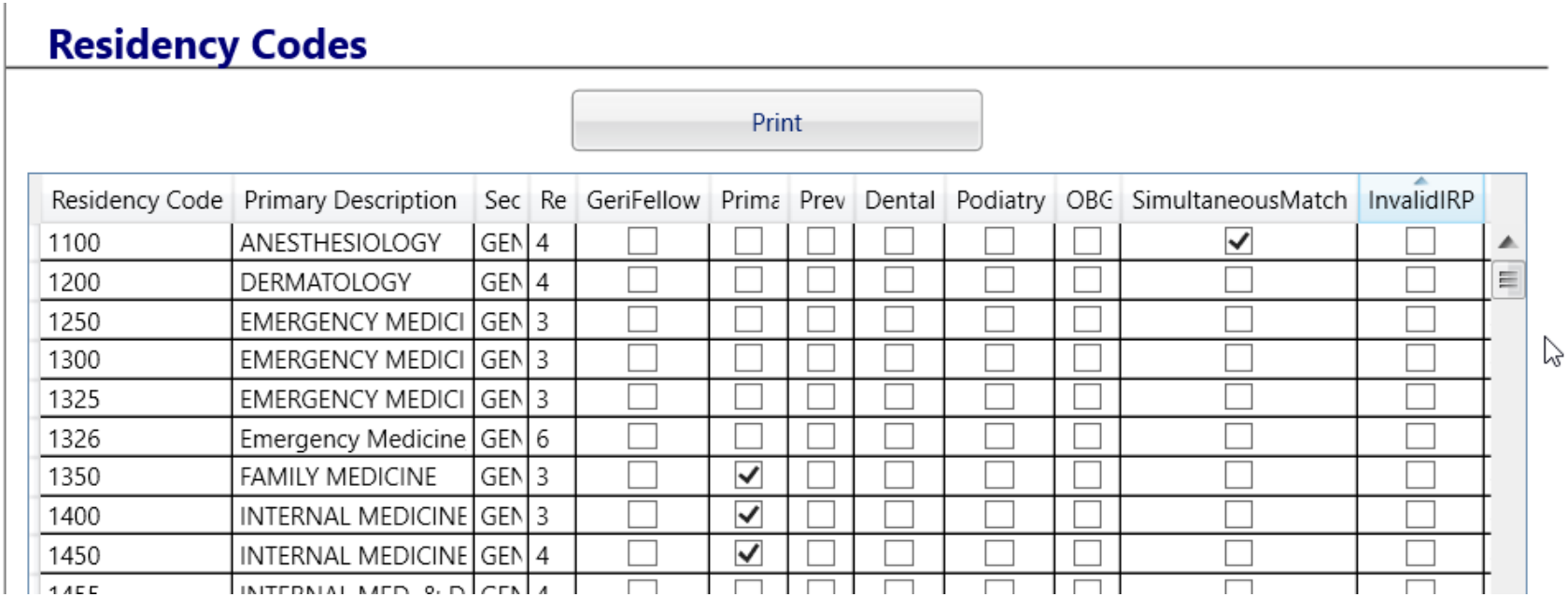
Single day rotational assignment time periods are allowed and there is no restriction on the number of individual rotational assignment time periods that may be reported for a single IR.

- You can see the Residency Code table in the Data Management tab and can select the headers to sort codes:



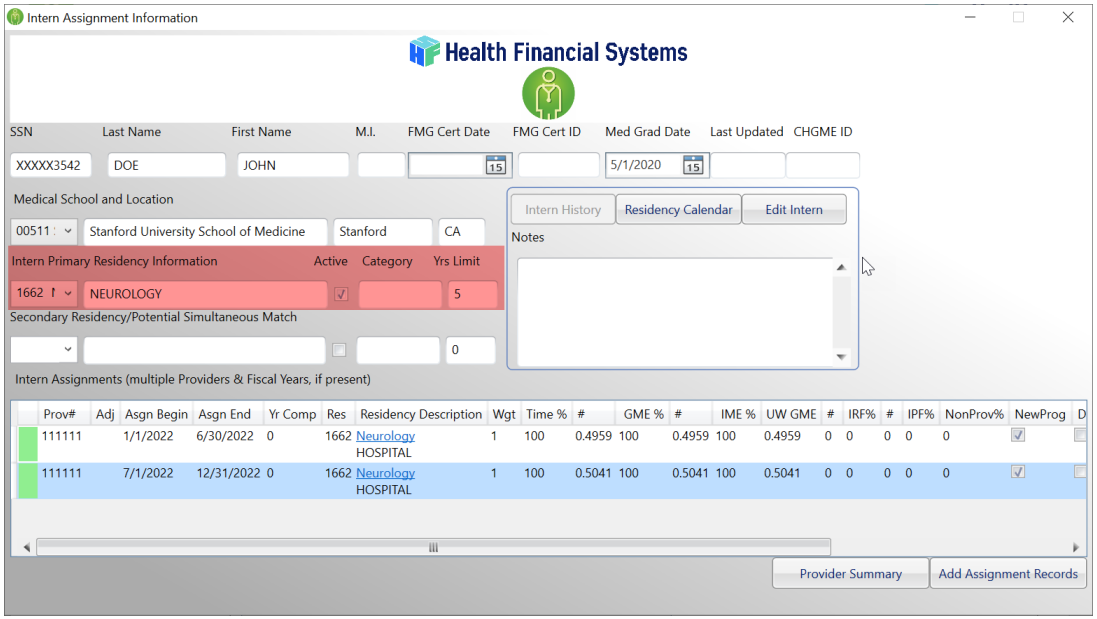
Residency Code	Primary Description	Secondary Description	ResYearLimit	GeriFellow	PrimaryC
1050	ALLERGY & IMMUNOLOGY	GENERAL	5	☐	☐
1051	ALLERGY & IMMUNOLOGY	DIAGNOSTIC LABORATORY IMMUNOLOGY	5	☐	☐
1052	ALLERGY & IMMUNOLOGY	CLINICAL IMMUNOLOGY	5	☐	☐
1100	ANESTHESIOLOGY	GENERAL	4	☐	☐
1101	ANESTHESIOLOGY	CRITICAL CARE MEDICINE	5	☐	☐
1102	ANESTHESIOLOGY	PAIN MEDICINE	5	☐	☐
1103	ANESTHESIOLOGY	PEDIATRIC ANESTHESIOLOGY	5	☐	☐
1104	ANESTHESIOLOGY	ADULT CARDIOTHORACIC ANESTHESIOLOGY	5	☐	☐
1105	ANESTHESIOLOGY	OBSTETRIC ANESTHESIOLOGY	5	☐	☐
1106	ANESTHESIOLOGY	HOSPICE & PALLIATIVE MEDICINE	5	☐	☐
1107	ANESTHESIOLOGY	SLEEP MEDICINE	5	☐	☐
1108	ANESTHESIOLOGY	CLINICAL INFORMATICS	6	☐	☐
1109	ANESTHESIOLOGY	ADDICTION MEDICINE	5	☐	☐
1150	COLON AND RECTAL SURGERY	GENERAL	6	☐	☐
1200	DERMATOLOGY	GENERAL	4	☐	☐
1201	DERMATOLOGY	DERMATOPATHOLOGY	5	☐	☐
1202	DERMATOLOGY	CLINICAL & LAB'Y DERM'L IMMUNOLOGY	4	☐	☐
1203	DERMATOLOGY	DERMATOLOGICAL MICROGRAPHIC SURGERY	5	☐	☐
1204	DERMATOLOGY	PROCEDURAL DERMATOLOGY	5	☐	☐
1250	EMERGENCY MEDICINE	GENERAL (SEE NOTE 4 IN HELP SCREEN)	3	☐	☐
1251	EMERGENCY MEDICINE	PEDIATRIC EMERGENCY MEDICINE	5	☐	☐
1252	EMERGENCY MEDICINE	EMERGENCY MEDICAL SERVICES	4	☐	☐
1253	EMERGENCY MEDICINE	SPORTS MEDICINE	4	☐	☐
1254	EMERGENCY MEDICINE	MEDICAL TOXICOLOGY	5	☐	☐

- You can print to csv or can also change the column width and header sort which is helpful:

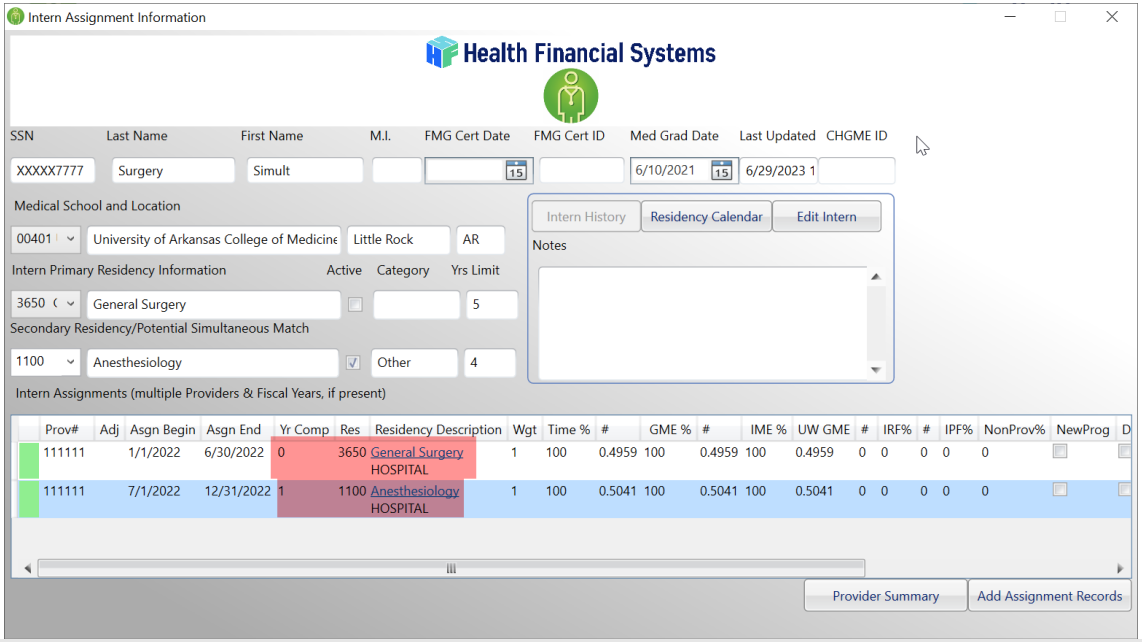


CMS' IRIS Changes

- You want to be aware of 2 specific columns – the InvalidIRP and SimultaneousMatch columns.
- CMS requires the master record to contain what residency code the resident was in for their 1st year of residency. This establishes the years allowed prior to GME weighting. If the box InvalidIRP is checked off, this means the resident did not start in this program in year 1 so it should not be identified in the Master.



- The SimultaneousMatch code identifies there is a possibility the resident identified to go into this program in year 2 and if this is the case, CMS now wants the year one code to be identified. The example below is 3650 General Surgery.



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
SSN	FNAME	MNAME	LNAME	EMPLOYEI	RESTYPCODE	nonIRPyr1SimCode	nonIRPyr1preTran	MEDSCHO	MSGRADD/	FORCERTI	PROVNUN	FYBEGIN	FYEND	TIMEPERC	IMEPERC	GMEPERC	ASGNBEGI	ASGNENDDAT	ARESYEAR	ARESTYPE
U3334	SIMULT		SURGERY	HOSPITAL	1100	3650		401	6/10/2021		111111	1/1/2022	12/31/2022	100	100	100	1/1/2022	6/30/2022	0	3650
U3334	SIMULT		SURGERY	HOSPITAL	1100	3650		401	6/10/2021		111111	1/1/2022	12/31/2022	100	100	100	7/1/2022	12/31/2022	0	1100

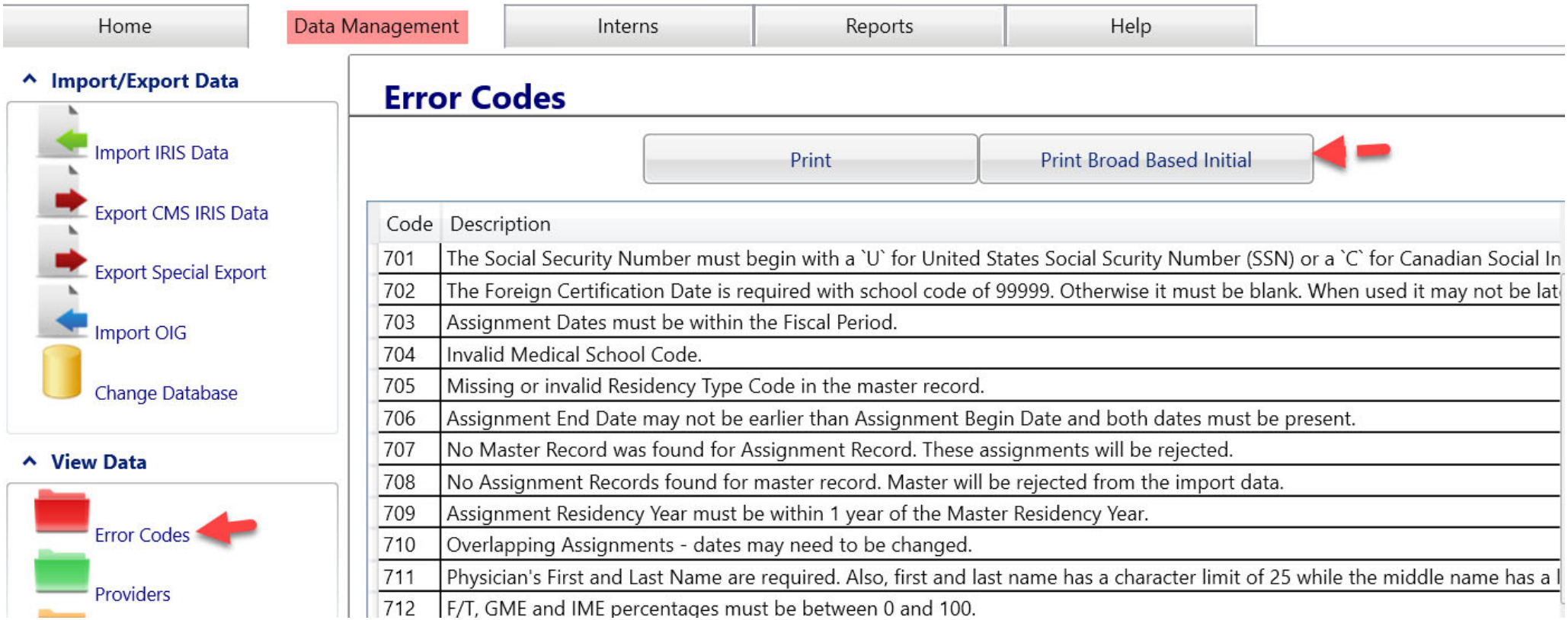
CMS' IRIS Changes

- CMS has identified a table of possible year 1 Broad-Based programs allowed when simultaneous match, the edit kicking out by CMS' IRIS is shown below.

Errors/Informational Messages Detail

Category	Severity	Resident	SSN	Assignment Start	Assignment End	Additional Info
Year One Residency Code Was Not Valid For Broad Based Initial Training	Error	NIMER, RYAN LYNN	XXXXXXX2246			A Simultaneous Match was recorded, but the resident's claimed Year One Residency Code (3650 - GENERAL SURGERY - GENERAL) is not valid for Broad Based Initial Training.

- CMS stated this was a fatal edit but have reduced it to a warning. We have the table in the new v6.40.0.0.



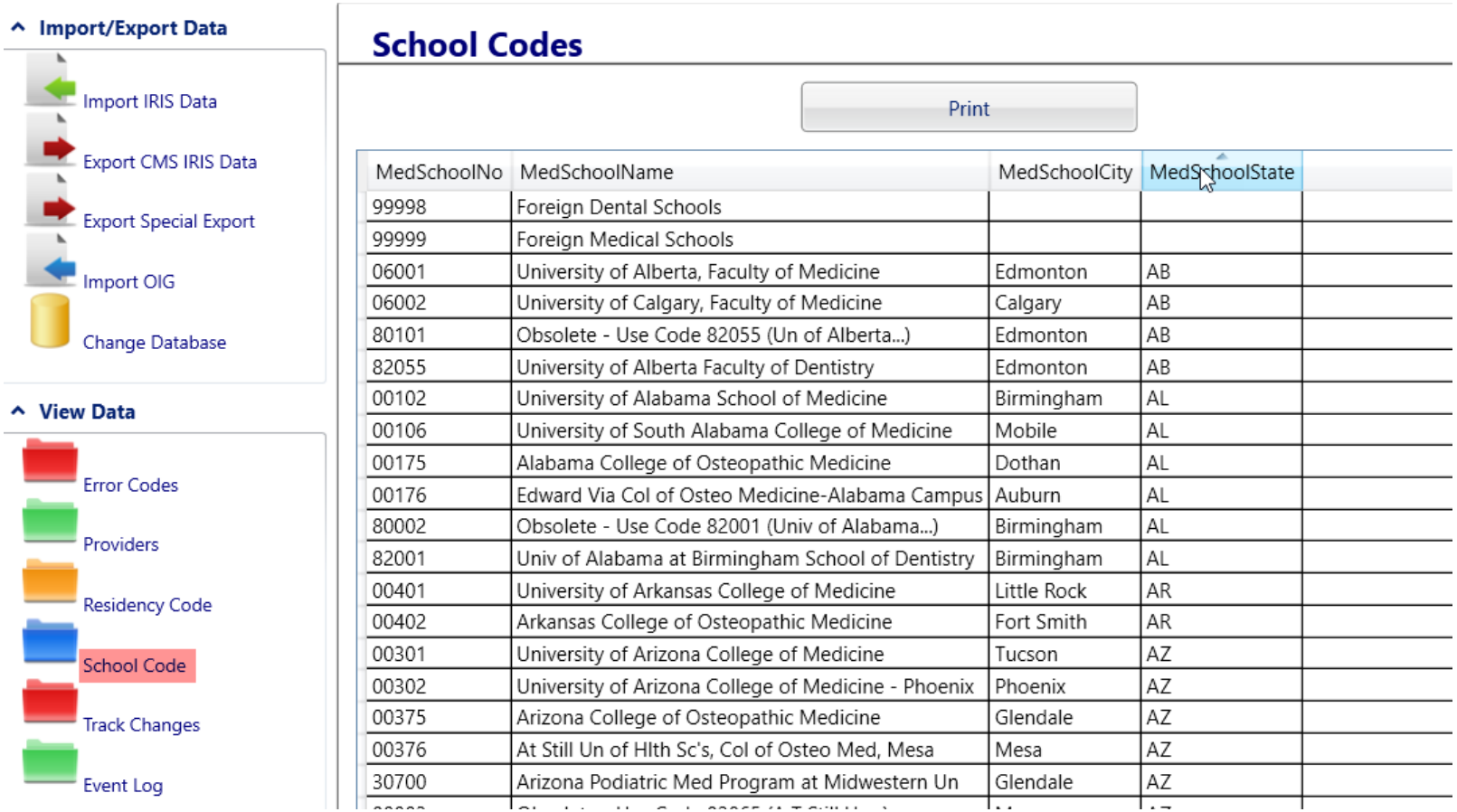
- The list of possible Broad-Based Initial Training codes are shown below:

Residency Codes - Possible Valid Codes for Broad-Based Initial Training

Type	PrimDescription	SecDescription	GeriFellow	PrimaryCare	PreventMed	ResYea
1250	Emergency Medicine	General (See Note 4 In Help Screen)	False	False	False	3.00
1350	Family Medicine	General	False	True	False	3.00
1400	Internal Medicine	General	False	True	False	3.00
1450	Internal Medicine /Pediatrics	General	False	True	False	4.00
1505	Internal Medicine/Family Medicine	General	False	True	False	4.00
1515	Internal Medicine/Preventive Med.	General	False	True	False	4.00
1750	Obstetrics & Gynecology	General	False	False	False	4.00
2000	Pediatrics	General	False	True	False	3.00
2150	Preventive Medicine	General	False	True	True	3.00
2450	Surgery	General	False	False	False	5.00
2525	Transitional Year (Allopathic Med.)	General	False	False	False	1.00
2550	Preliminary Medicine	General	False	False	False	1.00
2600	Preliminary Surgery	General	False	False	False	2.00
3600	Family Medicine	General	False	True	False	3.00
3650	General Surgery	General	False	False	False	5.00
3900	Internal Medicine	General	False	True	False	3.00
4450	Obstetrics & Gynecology	General	False	False	False	4.00
5250	Pediatrics	General	False	True	False	3.00
5400	Preventive Medicine	General	False	True	True	3.00
5425	Public Health & Preventive Medicine	General	False	True	False	3.00
6350	Internal Medicine/Pediatrics	General	False	True	False	4.00

Type	PrimDescription	SecDescription
6400	Trad'l Rot'g Intern'p (Osteo. Med.)	General

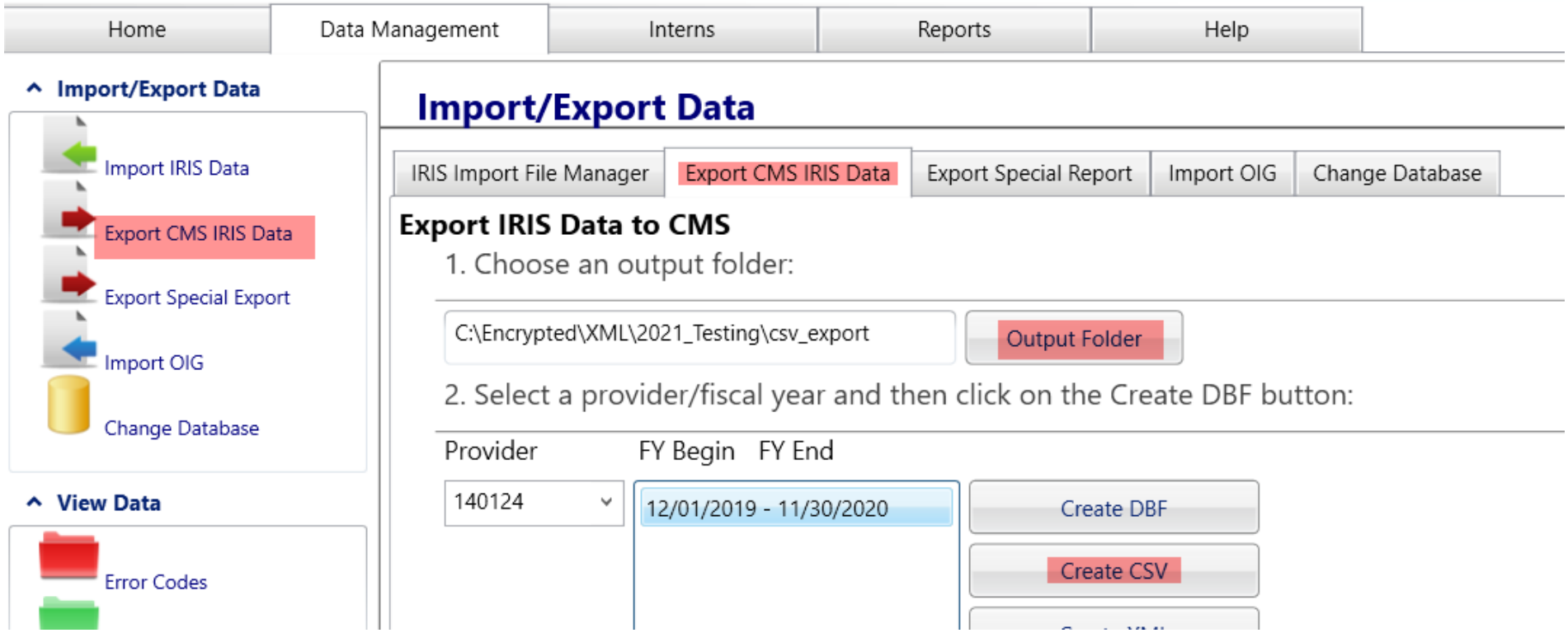
- The Medical School table can also be sorted by state which is also beneficial in locating any school code.



MedSchoolNo	MedSchoolName	MedSchoolCity	MedSchoolState
99998	Foreign Dental Schools		
99999	Foreign Medical Schools		
06001	University of Alberta, Faculty of Medicine	Edmonton	AB
06002	University of Calgary, Faculty of Medicine	Calgary	AB
80101	Obsolete - Use Code 82055 (Un of Alberta...)	Edmonton	AB
82055	University of Alberta Faculty of Dentistry	Edmonton	AB
00102	University of Alabama School of Medicine	Birmingham	AL
00106	University of South Alabama College of Medicine	Mobile	AL
00175	Alabama College of Osteopathic Medicine	Dothan	AL
00176	Edward Via Col of Osteo Medicine-Alabama Campus	Auburn	AL
80002	Obsolete - Use Code 82001 (Univ of Alabama...)	Birmingham	AL
82001	Univ of Alabama at Birmingham School of Dentistry	Birmingham	AL
00401	University of Arkansas College of Medicine	Little Rock	AR
00402	Arkansas College of Osteopathic Medicine	Fort Smith	AR
00301	University of Arizona College of Medicine	Tucson	AZ
00302	University of Arizona College of Medicine - Phoenix	Phoenix	AZ
00375	Arizona College of Osteopathic Medicine	Glendale	AZ
00376	At Still Un of Hlth Sc's, Col of Osteo Med, Mesa	Mesa	AZ
30700	Arizona Podiatric Med Program at Midwestern Un	Glendale	AZ

- The HFS IRIS can also import csv files that are prepared in excel for those users that have many residents and are much more comfortable entering data in excel. We now accommodate a single consolidated file for our users to import rather than 2 files in the M and A dbf format.

- We feel the best way to begin the CY IRIS data is by exporting the PY IRIS data to a csv which will be a template to use to update to CY info.



- Below is an example of the csv file, please note the new fields in cols G, H, V - AC. You will need to update columns M, N, R, S and T to the CY information, delete residents no longer rotating and add new resident information.

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
SSN	FNAME	MNAME	LNAME	EMPLOYEI	RESTYPCO	nonIRPyr1	nonIRPyr1	MEDSCHO	MSGRADC	FORCERTC	PROVNUM	FYBEGIN	FYEND	TIMEPERC	IMEPERC	GMEPERC	ASGNBEG	ASGNEND	ARESYEAR	ARESTYPE	IRFDPUPE	IPFDPUPE	NONPRO\	ISNEWPR(	ISDISPLAC	ISNEWPR(	ISNEWPR(	ISNEWPRO	GRAMIRFE	XCEPTIO
C185	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	########	########	0	1100			24.28	FALSE	FALSE	FALSE	FALSE	FALSE		
C18	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	########	########	0	1100			78	FALSE	FALSE	FALSE	FALSE	FALSE		
C1	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	########	########	0	1100			20.96	FALSE	FALSE	FALSE	FALSE	FALSE		
C18	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	########	4/8/2021	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		
C185	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	4/9/2021	5/6/2021	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		
C18	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	5/7/2021	6/3/2021	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		
C185	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	6/4/2021	6/8/2021	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		
C18	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	6/9/2021	########	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		
C185	Alex		Considine	Lakin - Bra	1100	1400		99999	1/1/2020	6/5/2020	140124	########	########	100	100	100	########	########	0	1100				FALSE	FALSE	FALSE	FALSE	FALSE		

Column definitions:

SSN
The intern/resident's (IR) Social Security Number (SSN). Include ONLY those IRs who participate in teaching programs approved under 42 CFR 412.105(f) and 413.75(b). SSNs are ten character strings. The first character must contain either "U" (US) or "C" (Canada). This character is used for dual tracking of nine digit United States SSNs and nine digit Canadian Social Insurance Numbers as identification numbers. Must be capital U or C.

FNAME
Resident first name

MNAME
Resident middle name

LNAME
Resident last name

EMPLOYER
Select the name of the hospital or provider that is currently paying the intern/resident's (IR) salary.

RESTYPCODE
Enter the 4 digit Residency Type Code for the medical specialty program the intern/resident (IR) was participating in on the first day of the resident's first rotation after graduating from medical school, even if that rotation did not occur within the provider submitting the IRIS file or within the provider's current cost reporting period. Note that this still applies even for residents going into additional residency programs, whether first residency is completed or not. Once the initial program has been established this value shall remain constant across all IRIS submissions, aside from a few exceptions. These are coded with the "Non-IRP Year One Residency Code" fields described below.
These codes are grouped as follows:
1050-2960 Allopathic specialties (MD)
3050-6650 Osteopathic specialties (OD)
7050-7350 Podiatric specialties
8050-8900 Dental specialties (DDS)
9050-9100 Other specialties

The list of residency codes can be found in the Data Management tab | Residency Code.

nonIRPyr1SimCode - Residents participated in simultaneous match

- "nonIRPyr1SimCode".....put the program the resident matched to for **first year** in simultaneous match

nonIRPyr1preTran - Residents participated in a preliminary/transitional year (can only be codes 2525, 2550, 2600 or 6400)

- "nonIRPyr1preTran".....is field for program codes that are Transitional or Preliminary (i.e. 2525, 2550, 2600 or 6400)

Both of the above are for documenting Resident Non-Initial Residency Period (Non-IRP) **Year One** Residency Codes.

MEDSCHOOL
Enter the five digit code for the medical school from which the intern/resident (IR) graduated. If you do not know the code, enter a blank field to open a selection window for the desired code. Enter "99998" for foreign dental school or "99999" for foreign medical school if the IR did not graduate from an allopathic, osteopathic, dental, or podiatry school accredited or approved as having met the standards necessary for accreditation by one of the following organizations: the Liaison Committee on Medical Education of the American Medical Assoc., American Osteopathic Assoc., Commission on Dental Accreditation, and Council on Podiatric Medical Education. Medical schools are grouped as follows:
00102-06801 Allopathic or Osteopathic Schools
30000-30800 Podiatric Schools
81250-84255 Dental Schools
99998 Foreign Dental Schools
99999 Foreign Medical Schools

The list of school codes can be found in the Data Management tab | School Code.

MSGRADDATE
Enter the date the intern/resident graduated from medical school. Format is MM/DD/YYYY.

FORCERTDAT
This field is entered only if medical school code "99999" is entered, indicating that the resident graduated from a foreign medical school.
Enter the date the IR passed the United States Medical Licensing Examination (USMLE), Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), OR Parts I and II of the National Board of Medical Examiners Examination OR prior to July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates (ECFMG). Format is MM/DD/YYYY.

PROVNUMBER
Hospital six digit provider number, do not include hyphen, cannot be a subprovider, must be the main hospital number only.

FYBEGIN
Hospital's fiscal year beginning date. Format is MM/DD/YYYY.

FYEND
Hospital's fiscal year ending date. Format is MM/DD/YYYY.

The following fields are percentages; however, you are to enter as whole numbers with a maximum of 2 decimals.

TIMEPERC
Enter "100" percent if the intern/resident (IR) worked full time during the assignment period. This is usually always 100. It is very rare to have a part time resident.

IMEPERC
Enter the percentage of time the intern/resident (IR) worked in the inpatient area of the hospital subject to PPS, or in the outpatient department during the assignment period. Include the time the IR worked in a non-provider setting under agreement with the hospital during the assignment period. Refer to 42 CFR 412.105(f).
If the IR worked in more than one hospital or non-provider setting, enter the percentage of time spent in the inpatient and/or outpatient areas of the hospital as compared to the total time worked at all facilities. Example: an IR worked 4 hours/day in the inpatient area of hospital A and 8 hours/day in hospital B. Hospital A would report 33% under Indirect Medical Education (IME). If the IR worked an additional 4 hours/day in hospital A's home health unit, which cannot be included in the IME computation, hospital A would report 25% (4 inpatient hours at hospital A divided by 16 total hours).
NOTE - The IME percentage may be computed based upon hours, days, or months (if appropriate). No more than 100%, in the aggregate, may be reported for any IR, by all hospitals reporting. HOSPITALS MUST COORDINATE IME DATA (ESPECIALLY FOR THOSE IRs WORKING IN MORE THAN ONE HOSPITAL) REPORTED IN IRIS.

GMEPERC
Enter the unweighted percentage of time the intern/resident (IR) worked in any area of the hospital complex or in a non-provider setting under agreement with the hospital during the assignment period. **This percentage of time is not weighted for IRIS reporting purposes**. Refer to 42 CFR 413.78. If the IR worked in more than one hospital or non-provider setting not under agreement with the hospital during the assignment period, enter the percentage of time worked in the hospital in comparison to the total time worked at all facilities. Example: an IR worked 4 hours/day at hospital A and 8 hours/day at hospital B. Hospital A would report 33% under Graduate Medical Education (GME). If the IR worked 4 days a week at hospital A and 3 days a week at hospital B, hospital A would report 57% (4 days at hospital A divided by 7 total days).
NOTE - The GME percentage may be computed based upon hours, days, or months (if appropriate). No more than 100%, in the aggregate, may be reported for any IR by all hospitals reporting. HOSPITALS MUST COORDINATE GME DATA (ESPECIALLY FOR THOSE IRs WORKING IN MORE THAN ONE HOSPITAL) REPORTED IN IRIS.

ASGNBEGDAT and **ASGNENDDAT**
Enter start and end dates of each rotational assignment during which the intern/resident (IR) was assigned to and worked at the hospital or any of its hospital based providers (Home Health Agency, Skilled Nursing Facility, etc.).

ARESYEAR
For the first rotational assignment, enter the residency year (RY). The RY is the number of years the intern/resident (IR) has COMPLETED in all types of approved residency programs. For example, enter "0" if the IR has completed less than one program year in all types of approved programs, enter "1" if the IR has completed less than two program years in all types of approved programs, etc. The range for the total number of program years is 0 through 9. Enter "9" if the total number of program years exceeds 9 years.

ARESTYPE
For the first rotational assignment, enter the 4 digit Residency Type Code (RTC) for the medical specialty program in which the intern/resident (IR) is training if this program is different from the RTC that was entered in the master record. For example, enter RTC 2525 for the IR's transitional year if the master record contains RTC 2650 for the IR's intended Board certification in urology. In most cases **ARESTYPE** will match the code entered for **RESTYPCODE.**

The following fields are percentages; however, you are to enter as whole numbers with a maximum of 2 decimals.

IRFDPUPERC
The percentage of the IR's rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Inpatient Rehabilitation Facility (IRF) PPS. This corresponds to the FTEs claimed in 2552-10 Cost Report's Worksheet E-3 Part III.
This should only include time spent at an inpatient rehabilitation hospital or an inpatient rehabilitation distinct part unit (DPU) of a hospital. Refer to 42 CFR 412.25 (for units) and 412.29. See 2552-10 instructions CMS Pub. 15-2, Section 4005.1 S-3, Part I, col. 9 for a definition of IRF FTEs. Note that IME, IRF, and IPF FTEs are all distinct pools and time being claimed under IPPS IME should not overlap with time being claimed under IRF. **For any one assignment, the sum total of its IME, IRF, and IPF percentages must not exceed 100%.**

IPFDPUPERC
The percentage of the IR's rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Inpatient Psychiatric Facility (IPF) PPS. This corresponds to the FTEs claimed in 2552-10 Cost Report's Worksheet E-3 Part II.
This should only include time spent at an inpatient psychiatric hospital or an inpatient psychiatric distinct part unit (DPU) of a hospital and critical access hospitals (CAHs). Refer to 42 CFR 412.02.
See 2552-10 instructions CMS Pub. 15-2, Section 4005.1 S-3, Part I, col. 9 for a definition of IPF FTEs. Note that IME, IRF, and IPF FTEs are all distinct pools and time being claimed under IPPS

IME should not overlap with time being claimed under IRF. **For any one assignment, the sum total of its IME, IRF, and IPF percentages must not exceed 100%.**

NONPROVSITEPERC
The percentage of the IR's rotational assignment time that was spent in allowable non-provider site settings. Refer to 42 CFR 413.78(g). See 2552-10 CR W/S S-2 Lines 66 & 67.

When populating the following fields, the system uses TRUE FALSE

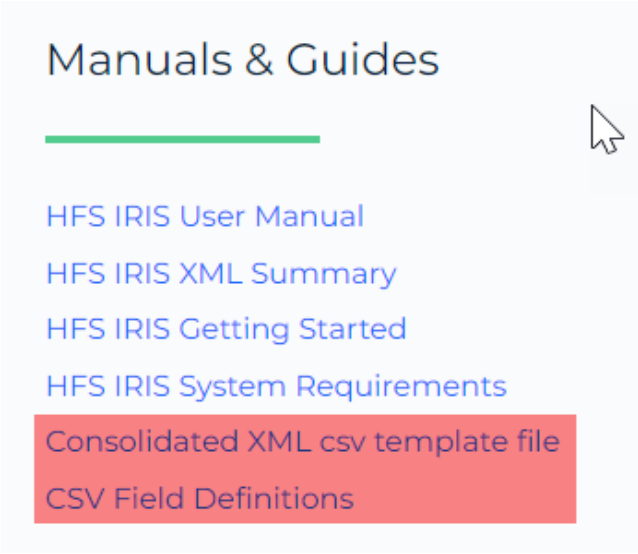
Y	Z
ISNEWPROGRAMFTE	ISDISPLACEDRESFTE
FALSE	FALSE
FALSE	FALSE

ISNEWPROGRAMFTE
Indicates whether the resident is in the "initial years of a program that meets the exception to the rolling average rules" as per the CR instructions. Refer to 42 CFR 413.79(e).
See 2552-10 WS E-4 Line 15 (DGME), WS E Part A Line 16 (IME), WS E-3 Part II Line 7 (Psych), and WS E-3 Part III Line 8 (Rehab).

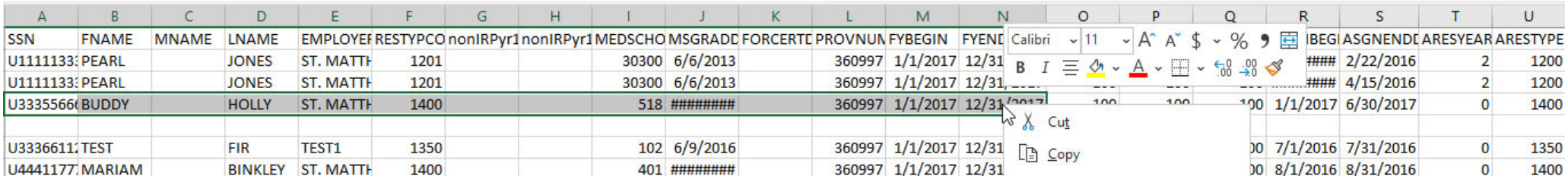
ISDISPLACEDRESFTE
Indicates whether the IR is an allowable displaced resident for which the hospital may receive a temporary cap adjustment.
The provider has to file correspondence with their MAC within 60 days of beginning to train the resident in order to be able to claim resident as displaced. Refer to 42 CFR 413.79(h)(2)(ii).
Note that IRIS will track the raw number of displaced resident FTEs, while what gets recorded in the CR is an adjustment whose calculation takes into account free cap slots. The displaced resident assignments recorded in IRIS do NOT directly sum to the displaced resident FTEs recorded in the CR. Allowable displaced residents should be flagged as displaced in IRIS regardless of whether their FTE contribution ends up being claimed under a temporary cap adjustment or not. Refer to displaced resident FTE calculations in CMS Change Request 7746.
Displaced residents at Psych (IPF) and Rehab (IRF) facilities should be accounted for similarly to those at IPPS hospitals. For IPF refer to the May 6 2011 Federal Register pages 26453-56 and August 7 2012 Federal Register pages 47233-35. For IRF, refer to August 5 2011 Federal Register pages 47846-48.
See 2552-10 WS E-4 line 16 (DGME), WS E Part A line 17 (IME), WS E-3 Part II Line 4.01 (Rehab), and WS E-3 Part III line 5.01 (Psych).

ISNEWPROGRAMIPPSEXCEPTION/IPFEXCEPTION/IRFEXCEPTION
For residents included in New Programs (ISNEWPROGRAMFTE field above) where the program is not eligible to be counted as a GME New Program, indicates which IME subcategory (IPPS, IPF, or IRF) the program is eligible to count as a New Program for. (We have a separate column for each possibility.) This is generally for providers reclassifying from Urban to Rural or providers with new IPF or IRF teaching programs without a previously established cap. When populating these fields, the system uses TRUE FALSE

- Below is the link where you can find the template and definitions:
  https://hfssoft.com/product/92

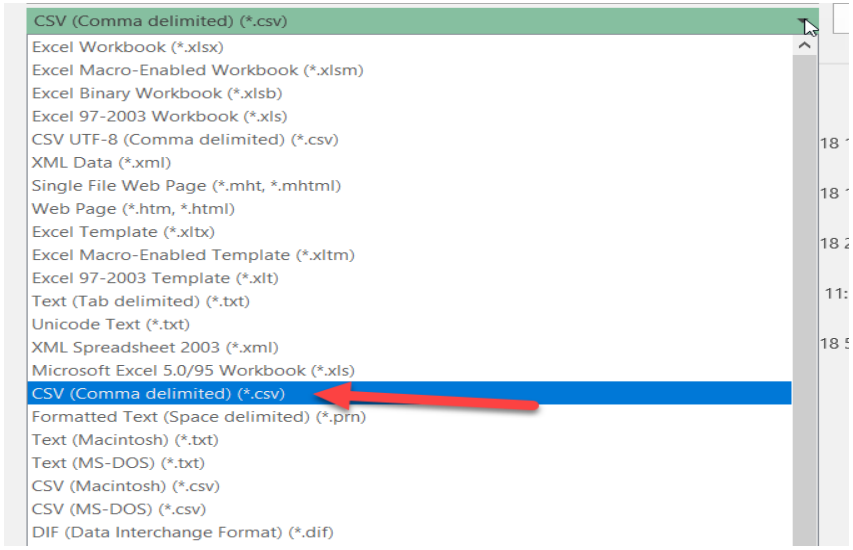


- You need to change the FYB and FYE to the CY. Then you delete residents that are no longer rotating in the CY. If you have multiple assignments, you insert a line and enter the assignment info and copy the Master info to account for all assignments (ensure the master information is identical – do not change anything):



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
SSN	FNAME	MNAME	LNAME	EMPLOYEF	RESTYPCO	nonIRPyr1	nonIRPyr1	MEDSCHO	MSGRADL	FORCERTL	PROVNUM	FYBEGIN	FYENL				BEGI	ASGNENDL	ARESYEAR	ARESTYPE
U1111133	PEARL		JONES	ST. MATTH	1201			30300	6/6/2013		360997	1/1/2017	12/31				####	2/22/2016	2	1200
U1111133	PEARL		JONES	ST. MATTH	1201			30300	6/6/2013		360997	1/1/2017	12/31				####	4/15/2016	2	1200
U3335566	BUDDY		HOLLY	ST. MATTH	1400			518	########		360997	1/1/2017	12/31				1/1/2017	6/30/2017	0	1400
U3336611	TEST		FIR	TEST1	1350			102	6/9/2016		360997	1/1/2017	12/31				7/1/2016	7/31/2016	0	1350
U4441177	MARIAM		BINKLEY	ST. MATTH	1400			401	########		360997	1/1/2017	12/31				8/1/2016	8/31/2016	0	1400

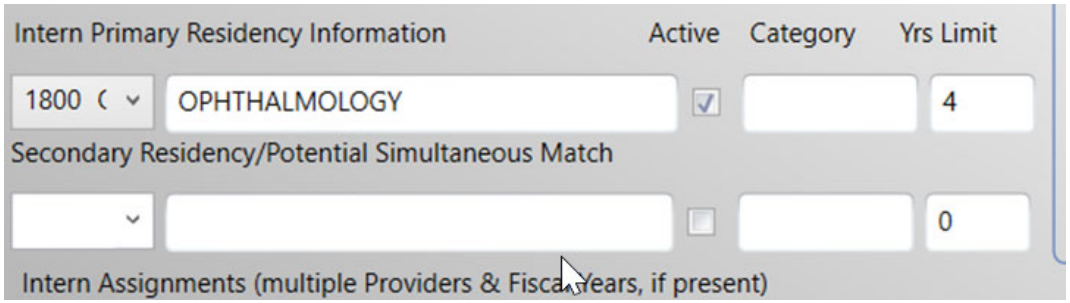
- You then need to enter any new residents and their assignments. You save the file as a CSV, do not worry about leading zeroes missing, we account for that. You cannot have any commas in the name fields, this causes a new column in csv, so just remove these or the import will have errors.



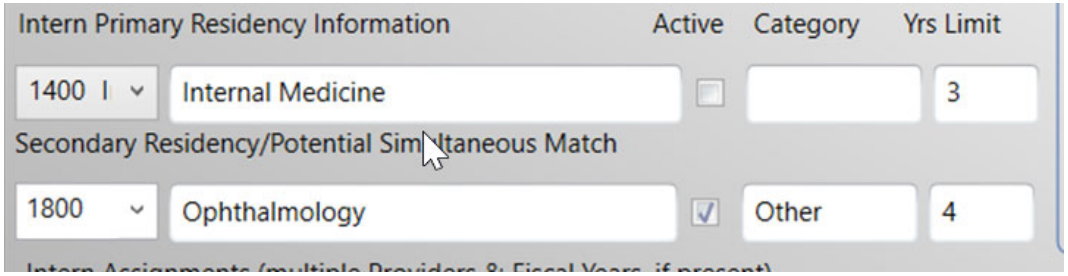
- We have created a warning edit 934:
  - The edit kicks out when the IRP is not a valid Initial Residency Program (IRP) but is a simultaneous match code, we expect a non-IRP Yr 1 residency code.

Field	Record	XML Field(s)	Instructions
Non-IRP Year One Residency Code	Resident	nonIRPYearOneResidencyCode (Code and Type pair)	For IRs that either participated in a preliminary/transitional year or a simultaneous match, this records the code for the residency type they were enrolled in during their first year as well as a 'type' attribute indicating whether it was a preliminary year or a simultaneous match. If an IR participated in a simultaneous match, that is indicated in an IRIS submission by having this field populated with a type value of "Simultaneous Match". For example, if an IR simultaneously matched into a 1400 Internal Medicine initial year and an 1100 Anesthesiology program, then their Initial Residency Type code would be 1100 and this Non-IRP Year One Residency Code would be recorded as 1400 with type "Simultaneous Match". Refer to Federal Register Vol. 69, No. 154 (Aug 11, 2004) pg 49169-49172, 42 CFR 413.79(a)(10), and Federal Register Vol 70, No. 155, (Aug 12, 2005) pg 47449-47452. For IRs that did not participate in a preliminary/transitional year or a simultaneous match, this field should be left blank.

- The edit is not fatal at this time but may become one in the future.
- An example of this would be code 1800 – Ophthalmology which is a simultaneous match code but not a valid IRP. If the intern record is shown as follows, the edit will kick out:



- To fix it, see below – in this example the resident was in Internal Medicine in year 1:



- Below is the Audit Report showing the computed FTEs to the cost report:

IRIS Intern Audit - Provider: 140124 **Ordered by SSN**

Fiscal Year: 12/01/2019 **to** 11/30/2020 **(All Interns Reporting)**

	FTE	Overlaps	Net FTE
Worksheet E, Part A			
Line 10 Allopathic & Osteopathic (IME unweighted)	146.33	0.00	146.33
Line 11 Dental & Podiatry (IME unweighted)	25.66	0.00	25.66
Line 16 CY FTE New	23.04	0.00	23.04
Line 17 CY FTE Displaced	16.68	0.00	16.68
Worksheet E-3, Part II			
Line 4.01 Col 1 CY FTE Displaced	0.07	0.00	0.07
Line 6, Col 1 CY FTE excluding New Program	0.54	0.00	0.54
Line 7, Col 1 CY FTE in New Program	0.08	0.00	0.08
Worksheet E-3, Part III			
Line 5.01 Col 1 CY FTE Displaced	0.03	0.00	0.03
Line 7, Col 1 CY FTE excluding New Program	0.35	0.00	0.35
Line 8, Col 1 CY FTE in New Program	0.08	0.00	0.08
Worksheet S-3, Part I			
Line 14 Col 9 Total Hospital	209.97	0.00	209.97
Line 16 Col 9 Subprovider - IPF	0.62	0.00	0.62
Line 17 Col 9 Subprovider - IRF	0.43	0.00	0.43

- Below is the Audit Report showing the computed FTEs to the cost report:

IRIS Intern Audit - Provider: 140124
Fiscal Year: 12/01/2019 **to** 11/30/2020

Ordered by SSN
(All Interns Reporting)

Worksheet E-4	FTE	Overlaps	Net FTE
Line 6 Allopathic & Osteopathic (GME unweighted)	147.89	0.00	147.89
Line 8 Col 1 OB / GYN & Primary (weighted)	39.38	0.00	39.38
Line 8 Col 2 Other (weighted)	92.19	0.00	92.19
Line 10 Col 2 Dental (weighted)	6.82	0.00	6.82
Line 10 Col 2 Podiatry (weighted)	14.66	0.00	14.66
Line 10 Col 2 Dental & Podiatry (weighted)	21.49	0.00	21.49
Line 10.01 Col 2 Dental (unweighted)	7.24	0.00	7.24
Line 10.01 Col 2 Podiatry (unweighted)	18.42	0.00	18.42
Line 10.01 Col 2 Dental & Podiatry (unweighted)	25.66	0.00	25.66
Line 15 Col 1 OB/GYN & Primary - New Program (weighted)	7.65	0.00	7.65
Line 15 Col 2 Other - New Program (weighted)	11.58	0.00	11.58
Line 15.01 Col 1 OB/GYN & Primary - New Program (unweighted)	7.84	0.00	7.84
Line 15.01 Col 2 Other - New Program (unweighted)	13.76	0.00	13.76
Line 16 Col 1 OB/GYN & Primary - Displaced (weighted)	5.09	0.00	5.09
Line 16 Col 2 Other - Displaced (weighted)	10.13	0.00	10.13
Line 16.01 Col 1 OB/GYN & Primary - Displaced (unweighted)	5.17	0.00	5.17
Line 16.01 Col 2 Other - Displaced (unweighted)	11.62	0.00	11.62

- Below is the Audit Report showing the computed FTEs to the cost report:

IRIS Intern Audit - Provider: 140124
Fiscal Year: 12/01/2019 **to** 11/30/2020

Ordered by SSN
(All Interns Reporting)

Worksheet S-2, Part I	**FTE**	**Overlaps**	**Net FTE**	
Line 66 Col 1 Unweighted Non-primary FTEs in Non-Provider Settings	7.28	0.00	7.28	***
Line 66 Col 2 Unweighted Non-Primary FTEs at Hospital	163.60	0.00	163.60	***

Line 67 Primary FTE summary

Program Name	**Program Code**	**Unweighted FTEs Non-Prov Site**	**Unweighted FTEs in Hospital**
FAMILY MEDICINE	1350	1.2682	20.7316
INTERNAL MEDICINE	1400	0.5631	9.4440
INTERNAL MEDICINE /PEDIATRICS	1450	0.0000	2.0000
PEDIATRICS	2000	0.3634	6.5260
PUBLIC HEALTH & GEN. PREVEN. MED.	2175	0.0000	0.0138
OBSOLETE - USE CODE 1515 (IM/PRM)	2765	0.0000	0.1530
	Grand Total:	**2.19**	**38.87**

*** There is no Non-Provider Setting % in IRIS, ensure this is correct prior to posting to the cost report.

Questions

- Questions?