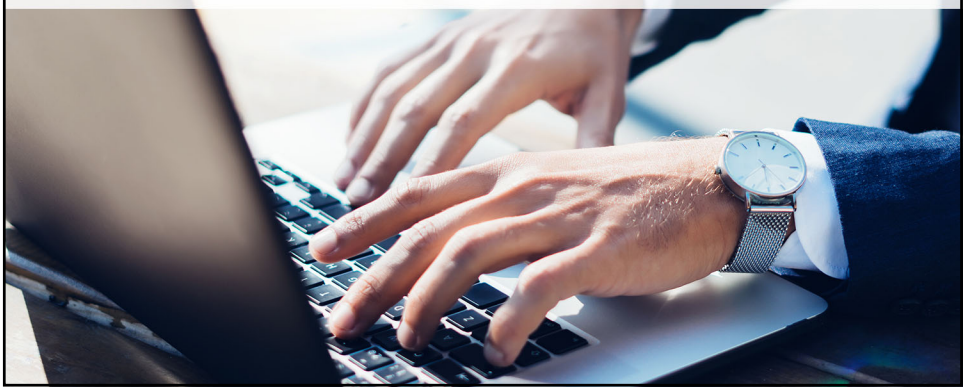
Health Financial Systems

HFS MCR and Software Update

Eric Swanson, Luke DiSabato & Becky Dolin

November 3, 2022



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Overview

Agenda

- HFS Introduction
- HFS MCR Software Update
- MCR Update – T17
- Clarifications
- Open items (PRA Notice)
- Other Form Updates
- Amended Reports
- FFY 2023 Final Rule
- HFS Auditor
- HFS IRIS
- Questions

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Health Financial Systems

About HFS

- Small Company in Elk Grove, CA.
- 41 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

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
287-05	X	X	X	*		X	X	*	*

* Coming soon

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State Systems and Customizations

- CHDR - CA Hospital Disclosure Report
- LTCIR – Long Term Care Integrated Report
- VA – DRG 796 and PIRS 1090
- NY - NYICR

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HFS Cybersecurity

HITRUST Assessments run in two year cycles.

The first year is a full assessment and the second year is an interim assessment.

HFS recently completed a full assessment in December 2021.

We are about to begin our 2022 interim assessment.

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Web Based Development

- **SaFE**
  - Processed and Stored about 30,000 submissions.
  - 18,157 or 70% were electronically signed
- **HCRIS**
  - 1,400,000 MCR reports
  - Upgrade in 2023
- **HFS Plus – Partnership Developing MCR Wokpaper Product**

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Application Programming Interface

Computer Programs Talking to Each Other

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

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Batch Processing

- **Batch Print**
- **Batch Import**
- **Batch Data Extractor**
- **Batch AAI**

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Testing

Updates are tested in batch mode. 100's of files are compared with before and after update settlement results and edits.

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MCRIF32 Development

- **So far this year we have issued:**
  - MCRIF32 Updates – 7
  - MCRIF32 Patches – 23
  - IRIS Updates - 11

    HCRIS Data – 4
  - WI PUF

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HFS Development

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

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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

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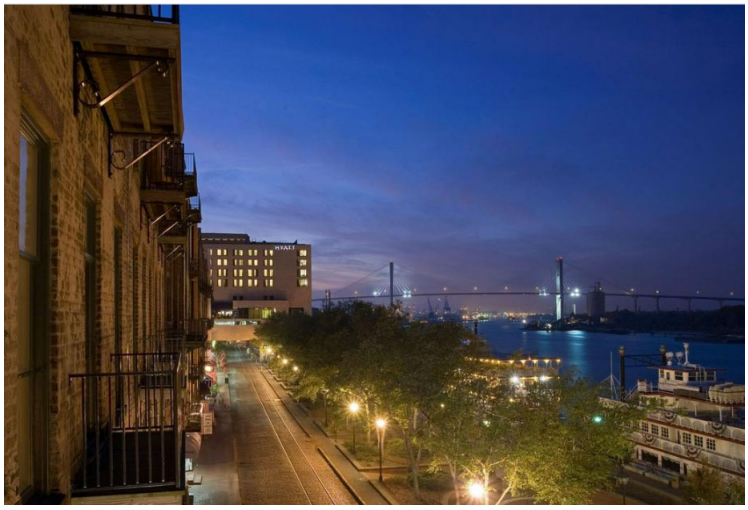
2023 HFS User Meeting

August 10 – 11, 2023

Hyatt Regency – Savannah, GA



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Extensions

- **While no current extension for the PHE 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.

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Medicare Cost Report Filing Extension for Hospitals Reporting Allogeneic Hematopoietic Stem Cell Transplant Acquisition Costs for Cost Reimbursement

- The Medicare cost report due date has been extended for hospitals seeking cost reimbursement for allogeneic hematopoietic stem cell transplant (HSCT) acquisition costs for cost reporting periods beginning on or after October 1, 2020. Medicare Administrative Contractors (MACs) must approve a cost report submission extension for a hospital seeking cost reimbursement for allogeneic HSCT acquisition costs when the hospital PS&R data indicate that the hospital billed revenue code 815 and Medicare paid DRG 014.
- A hospital seeking cost reimbursement for allogeneic HSCT acquisition costs must submit their Medicare cost report to their MAC no later than 30 days after CMS approves the cost reporting software updated to report allogeneic HSCT acquisition costs and contractors must final settle the cost report using the latest available software updated to compute payment of allogeneic HSCT acquisition costs at reasonable cost.
- A hospital may submit their Medicare cost report prior to the availability of updated software to report allogeneic HSCT acquisition costs and subsequently submit an amended cost report using the updated software.

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Hospital 2552-10 T-17

General Information

Instructional Changes

Form Changes

Edit Changes

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General Information

- **On January 10, 2022, CMS published Transmittal 17 to Form CMS-2552-10**
  - Effective for cost reporting periods ending on or after December 31, 2021.
  - T-17 does not reflect all the proposed changes issued in Accordance with the Paperwork Reduction Act (PRA) issued November 10, 2020.
    - CMS issued another 30-day comment period for the DRAFT changes which will now be issued as DRAFT T18 on June 22, 2022. The 30-day comment period ended 7-22-2022 and CMS is working on replying to the comments brought up.
  - HFS was approved for Transmittal 17 on January 21, 2022.
  - HFS updated the Hospital 2552-10 system the week of January 24th, 2022.

Instructional Changes

- Worksheet D-4 – MA Kidney reimbursement for Services on or after 1/1/2021:

Line 63--Enter the total Medicare usable organs that are included on line 62. Medicare usable organs include organs transplanted into Medicare beneficiaries (this excludes Medicare Advantage beneficiaries), organs sent to military hospitals (that have a reciprocal sharing agreement with the Organ Procurement Organization (OPO) in effect prior to March 3, 1988, and approved by the contractor), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other providers and organs sent to OPOs. Do not include organs used for research, organs sent to military hospitals (without a reciprocal sharing agreement with the OPO) in effect prior to March 3, 1988, and approved by the contractor), organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, organs that were paid by a Medicare Advantage plan, and organs procured from a non-certified OPO. Effective for services rendered on or after January 1, 2021, include kidneys transplanted into Medicare Advantage beneficiaries in the count of Medicare usable kidneys (this does not include non-renal organs, but is limited to kidney).

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Instructional Changes

- Worksheet E, Part A – Additional Payment for High Percentage of ESRD Beneficiary Discharges:

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48447 and 48520 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals. *Effective for discharges occurring on or after October 1, 2020, exclude discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from the denominator (see 85 FR 58844 (September 18, 2020)).*

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR 49087 (August 11, 2004)) excluding MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48520 and 48447 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals. *Effective for discharges occurring on or after October 1, 2020, exclude discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from the numerator (see 85 FR 58844 (September 18, 2020)).*

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Instructional Changes

- Worksheet E, Part A – Additional Payment for High Percentage of ESRD Beneficiary Discharges. Average weekly cost still has not been updated since 2013.

Line 45--Enter the average weekly cost per dialysis treatment calculated by multiplying the unadjusted composite rate per treatment by 3. For example, the average weekly cost per dialysis treatment for CY 2013 is $435.60 ($145.20 times the average weekly number of treatments of 3). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

HFS Note: Old w/s E part A, line 5.05.
HFS Note: $401.43 for 2009; $405.45 for 2010; $417.06 for 2011; $425.82 for 2012, $435.60 for 2013.
HFS Note: HFS has been informed that there is NO increase for 2014 and subsequent years relating to the ESRD Average weekly cost per dialysis treatment.

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Instructional Changes

- Worksheet E-4 – Not in T-17 but the CY 2018 MC+ DGME reduction was revised from 7% to 4.12% for CY 2018:

Line 29.01--If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in columns 2 and 2.01, the applicable reduction percentage to MA direct GME payments. Enter in column 2, the MA reduction percentage for the portion of the cost reporting period prior to January 1; and enter in column 2.01, the MA reduction percentage for the portion of the cost reporting period on or after January 1. Calendar year providers complete only column 2.

CY	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018 **	*2019 **
Percent reduction to MA DGME	*9.77*	*7.85*	*7.16*	*6.41*	*5.86*	*5.32*	*4.99*	*4.44*	*4.12*	*4.07*

HFS Note: CY 2018 revised per CR12596 issued 2/4/2022 and CY 2019 updated via CR 12407 issued 10/21/2021.

- Per FFY 2023 FR (Slide 51)
  - CY 2020 – 3.71%
  - CY 2021 – 3.22%

- Worksheet M-3 – Incorporated changes to account for CMS' update for RHC cost limits initiated in CR12185, dated May 4, 2021 which now requires a split at 4-1-21:

Line 8--Enter the per visit payment limit. Obtain this amount *from your* contractor.

NOTE: *For services rendered prior to April 1, 2021, i*f you are based in a *small hospital* with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR 412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: *In accordance with §1833(f)(3) of the Act, as amended by §130 of the Consolidated Appropriations Act of 2021, effective for services on or after April 1, 2021, hospital-based RHCs with less than 50 beds (as calculated above) will have their per visit payment limit calculated in accordance with §1833(f)(3)(B) of the Act by their contractor. See CR 12185, dated May 4, 2021, or subsequent applicable CRs.*

For hospital-based RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

- Worksheet M-3 – Incorporated changes to account for CMS' update for RHC cost limits initiated in CR12185, dated May 4, 2021 which now requires a split at 4-1-21. See MM12185 explaining Hospital based RHCs:

PB RHCs

Beginning April 1, 2021, under Section 1833(f)(3)(A) of the Act, PB RHCs that meet the definition in Section 1881(f)(3)(B), will have a payment limit per visit established at an amount equal to the **greater** of:

1. The payment per visit amount applicable to the PB RHC for services furnished in 2020 (interim amount if MACs don't have a final cost settled amount), increased by the percentage increase in CY 2021 MEI of 1.4%, or
2. The payment limit per visit applicable to RHCs (listed above)

Then, in a subsequent year (that's, after 2021), the PB RHC's payment limit per visit will be the **greater** of:

1. The payment per visit amount applicable to each PB RHC for services furnished in the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of that year, or
2. The payment limit per visit applicable to each year for RHCs (listed above)

PB RHCs that meet the definition in Section 1881(f)(3)(B) are grandfathered into the establishment of their payment limit per visit. That is, a PB RHC must have been in a hospital with fewer than 50 beds and enrolled in Medicare as of December 31, 2019, to receive their payment per visit based on their average allowable costs. For purposes of determining RHCs that meet the definition of Section 1881(f)(3)(B), CMS will take into account the policy we finalized in the interim final rule with comment, published in the May 8, 2020, Federal Register (90 FR 27550-27529). RHCs with PB status that were exempt from the national payment limit per visit in the period prior to the effective date of the PHE (January 27, 2020) that have experienced temporarily added surge capacity beds will be considered grandfathered.

PB RHCs that are new in 2020 are subject to the payment limit per visit applicable to independent RHCs.

We plan to discuss certain policies and processes used in establishing PB RHCs' per visit payment amount in the CY 2022 Physician Fee Schedule rules.

We will continue to provide the MEI update and applicable rate updates in the Recurring Annual RHC CR.

- Worksheet M-3 – If you qualify, you will need to enter the rate from the 2020 cost report updated by 1.4% otherwise you get no cost:

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 1302	Period From: 10/01/2020	Worksheet M-3
	Component CCN: 3411	To: 09/30/2021	
	Title XVIII	RHC I	Cost

		1.00	2.00	3.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	4,784,472			1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	563,117			2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	4,221,355			3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	21,305			4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0			5.00
6.00	Total adjusted visits (line 4 plus line 5)	21,305			6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	198.14			7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	198.14	198.14	0.00	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,000	6,241	2,500	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	198,140	1,236,592	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,434,732		16.00

- Worksheet M-3 – See HFS Note below (in blue) on which column to use for reports that have 3 columns:

Lines 8 and 9--The payment limits are updated every January 1; however, the possibility exists that payment limits may also be updated other than on January 1. Complete columns 1, 2, and 3, if applicable (add column 3 for lines 8 through 14 if the cost reporting period overlaps three payment limit periods) for lines 8 and 9, to identify costs and visits affected by different payment limits within a cost reporting period, as may be the case when implementing §130 Consolidated Appropriates Act of 2021, effective for services rendered on or after April 1, 2021, where an RHC may span three payment limit periods within a single cost reporting period (see CR 12185, dated May 4, 2021, or subsequent applicable CRs). If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

HFS Note – For Cost Reporting Periods that overlap 1-1-2021 and 4-1-2021, for lines 8 through 14 column 1 is from the FYB to 12-31-2020, column 2 is for 1-1-2021 to 3-31-2021 and column 3 is from 4-1-2021 to FYE. For Cost Reporting Periods that overlap 4-1-2021 and 1-1-2022, for lines 8 through 14 column 1 is from the FYB to 3-31-2021, column 2 is for 1-1-2022 to FYE and column 3 is from 4-1-2021 to 12-31-2021.

Line 8--Enter the per visit payment limit. Obtain this amount from your contractor.

NOTE:For services rendered prior to April 1, 2021, if you are based in a small hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: In accordance with §1833(f)(3) of the Act, as amended by §130 of the Consolidated Appropriations Act of 2021, effective for services on or after April 1, 2021, hospital-based RHCs with less than 50 beds (as calculated above) will have their per visit payment limit calculated in accordance with §1833(f)(3)(B) of the Act by their contractor. See CR 12185, dated May 4, 2021, or subsequent applicable CRs.

For hospital-based RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

• Worksheet S, Part I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically *prepared* cost report Date: _____ Time: _____ 2. [ ] Manually *prepared* cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received:_____ 7. Contractor No.:_____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date:_____ 11. Contractor's Vendor Code: _____ 12. [ ] If line 5, column 1, is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION *BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)*

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIV ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1	*CHECKBOX* 2	*ELECTRONIC SIGNATURE STATEMENT*	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	*1*
2	*Signatory Printed Name:*			*2*
3	*Signatory Title:*			*3*
4	*Signature date:*			*4*

• Worksheet S, Part I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically *prepared* cost report Date: _____ Time: _____ 2. [ ] Manually *prepared* cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received:_____ 7. Contractor No.:_____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date:_____ 11. Contractor's Vendor Code: _____ 12. [ ] If line 5, column 1, is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION *BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)*

Consistent with other Form Sets - Modification to the Worksheet S, Part II, Certification Statement to collect electronic signature data within the EC file export.

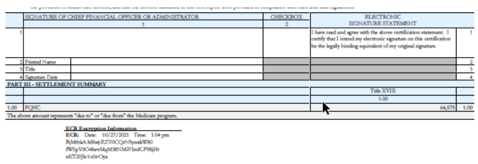
Part I previously modified to clarify that the cost report is electronically prepared vs submitted.

and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1	*CHECKBOX* 2	*ELECTRONIC SIGNATURE STATEMENT*	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	*1*
2	*Signatory Printed Name:*			*2*
3	*Signatory Title:*			*3*
4	*Signature date:*			*4*

• Worksheet S, Part I & II

The Signed Certification page also does not have the PI encryption anymore.



	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Printed Name				2
3	Title				3
4	Signature Date				4

PART III - SETTLEMENT SUMMARY

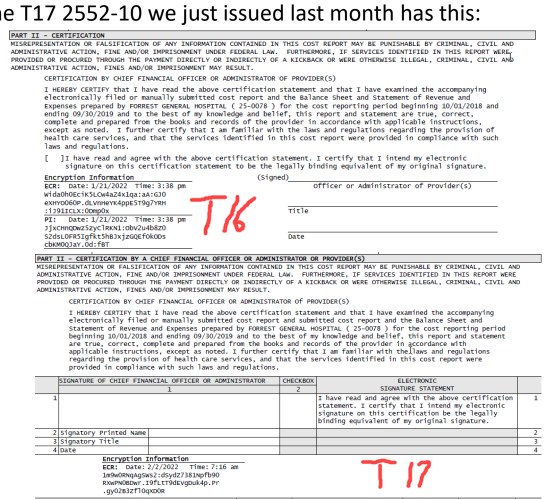
		Title XVIII	
		1.00	
1.00	FQHC	64,575	1.00

The above amount represents "due to" or "due from" the Medicare program.

ECR Encryption Information
ECR: Date: 10/27/2021 Time: 1:04 pm

• Worksheet S, Part I & II

The T17 2552-10 we just issued last month has this:



PART II - CERTIFICATION

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CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FORREST GENERAL HOSPITAL (25-0078) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

Encryption Information
ECR: Date: 1/21/2022 Time: 3:38 pm
Wida0h0EciK5LCw4aZ4x1qa:aA:GJ0
eXHYO060P.dLVnHeYK4ppE5T9g7YRH
:iJ91ICLX:0Dmp0x
PI: Date: 1/21/2022 Time: 3:38 pm
JjxCHnQDwz5zyClRKN1:0bV2u4b8Z0
S2dsL0FR5Igfkt5hBJxjzGQEfOkODs
cbKM0QJaY.0d:fBT

(Signed) ______________________
Officer or Administrator of Provider(s)

____
Title

____
Date

T16

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FORREST GENERAL HOSPITAL (25-0078) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

Encryption Information
ECR: Date: 2/2/2022 Time: 7:16 am
1m9w0RNqAgSWs2:dSydZ7381Npfb90
RXwPN0BDwr.I9fLtT9dEVgDuk4p.Pr
.gy02B3Zfl0qXD0R

T17

Title XVIII

• Worksheet S-2, Part I

22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.
22.04	*Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.*

The addition of Worksheet S-2, Part I, line 22.04 for "For cost reporting periods ending on or after October 1, 2020, and before October 1, 2022, The FY 2021 IPPS final rule (CMS-1735-F; 85 FR 58746, September 18, 2020) provided for a 2 year transition (in accordance with 42 CFR 412.102) to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2021. Impacted hospitals whose DSH payment adjustment exceeded 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2021 and 1/3 of the difference between the urban and rural operating DSH for FY 2022. "

• Multiple Forms - Removed references to the term "Nursing School" and replacing them with "Nursing Program".

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING *PROGRAM*
		18	19	20
	GENERAL SERVICE COST CENTERS			
1	Capital Related Costs-Buildings and Fixtures			
2	Capital Related Costs-Movable Equipment			
4	Employee Benefits Department			
5	Administrative and General			
6	Maintenance and Repairs			
7	Operation of Plant			
8	Laundry and Linen Service			
9	Housekeeping			
10	Dietary			
11	Cafeteria			
12	Maintenance of Personnel			
13	Nursing Administration			
14	Central Services and Supply			
15	Pharmacy			
16	Medical Records & Medical Records Library			
17	Social Service			
18	Other General Service (specify)			
19	Nonphysician Anesthetists			
20	Nursing *Program*			

Health Financial Systems

Form Changes

- **Worksheet M-4** – Columns added similar to free-standing RHC for Covid-19 Vaccines and Monoclonal Antibody Products.

COMPUTATION OF HOSPITAL-BASED *RHC/FQHC VACCINE* COST			PROVIDER CCN: _____ COMPONENT CCN:	PERIOD: FROM _____ TO _____	WORKSHEET M-4
Check applicable boxes:	[ ] Hospital-based RHC [ ] Hospital-based FQHC	[ ] Title V [ ] Title XVIII [ ] Title XI			

		PNEUMOCOCCAL *VACCINES*	INFLUENZA *VACCINES*	*COVID-19 VACCINES*	*MONOCLONAL ANTIBODY PRODUCTS*	
		1	2	*2.01*	*2.02*	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)					1
2	Ratio of *injection/infusion* staff time to total health care staff time					2
3	*Injection/infusion* health care staff cost (line 1 x line 2)					3
4	*Injections/infusions and related m* edical supplies cost*s* (from your records)					4

Health Financial Systems

Form Changes

- **Worksheet N-3** – Similar changes for hospital-based FQHC.

COMPUTATION OF HOSPITAL-BASED *FQHC VACCINE* COST	PROVIDER CCN: _____ COMPONENT CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET N-3

		PNEUMOCOCCAL *VACCINES*	INFLUENZA *VACCINES*	*COVID-19 VACCINES*	*MONOCLONAL ANTIBODY PRODUCTS*	
		1	2	*2.01*	*2.02*	
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)					1
2	Ratio of *injection/infusion* staff time to total health care staff time					2
3	*Injection/infusion* health care staff cost (line 1 x line 2)					3
4	*Injections/infusions* and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, *48.10,* and *48.11* , respectively)					4

- **Worksheet N-1** – One additional change with hospital-based FQHC, CMS added lines to identify COVID-19 and Monoclonal Antibody Products costs.

12-21 FORM CMS-2552-10 4090 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES FOR HOSPITAL-BASED FQHC | PROVIDER CCN: | COMPONENT CCN: | PERIOD: FROM: TO: | WORKSHEET N-1

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	REIMBURSABLE PASS THROUGH COSTS								
47	Pneumococcal Vaccines & Med Supplies								47
48	Influenza Vaccines & Med Supplies								48
48.10	*COVID-19 Vaccine & Med Supplies*								*48.10*
48.11	*Monoclonal Antibody Products*								*48.11*
49	Subtotal - Reimbursable Pass through Costs								49
	OTHER FQHC SERVICES								
60	Medicare Excluded Services								60

- **Additional Edit**
  - Edit 12040S added for cost reporting periods ending on or after 11/31/2020.

12040S If Worksheet S-2, Part I, line 26, column 1, and line 27, column 1, are "2", then Worksheet S-2, Part I, line 45, column 2, must be "N". [11/30/2020]

  - If the provider is rural for the complete cost reporting period, they do not qualify for capital DSH.

Health Financial Systems

Edit Changes

- **Additional Edits**
  - The following edits were Level Two edit but will be upgraded to Level One edits for non-governmental providers for cost reporting periods ending on or after 10/31/2020.

The 10000G series of edits apply to all provider types, except governmental providers. Consequently, do not apply these edits to providers where the response to Worksheet S-2, Part I, line 16, is "7" through "13". This exception applies to the following edits: 10000G, 10050G, 10100G, and 10150G:

10000G Total assets on Worksheet G (sum of each of columns 1 through 4, lines 1 through 10, 12 through 29 (subscripts as indicated), and 31 through 34, must equal total liabilities and fund balance (sum of each of columns 1 through 4, lines 37 through 44, 46 through 49, and 52 through 58). This edit was previously 20000G. [10/31/2020]

10050G Total patient revenue (Worksheet G-2, Part I, column 3, line 28) must equal the sum of inpatient and outpatient revenue (Worksheet G-2, Part I, sum of columns 1 and 2, line 28). This edit was previously 20050G. [10/31/2020]

10100G Net income or loss (Worksheet G-3, column 1, line 29) must not equal zero. This edit was previously 20100G. [10/31/2020]

10150G Contractual allowances (Worksheet G-3, column 1, line 2) must not be negative. This edit was previously 20150G. [10/31/2020]

  - These may impact previously submitted cost reports.

Health Financial Systems

Edit Changes

- **Additional Edits**
  - The following edits were added for cost reporting periods beginning on or after 1/1/2022.

10300M Worksheet M-4, line 13.01, columns 2.01 and 2.02, must be zero, for cost reporting periods beginning on or after January 1, 2022. [01/01/2022b]

10350N Worksheet N-3, line 13.01, columns 2.01 and 2.02, must be zero, for cost reporting periods beginning on or after January 1, 2022. [01/01/2022b]

  - These edits will eliminate Covid-19 Vaccine and Monoclonal Antibody (cost report) reimbursement for MA enrollees after 12/31/2021.

T-17 Clarifications

- **We received a number of clarifications subsequent to the issuance of T-17:**
  - Sequestration
    - 0% period 5/1/2020 – 3/31/2022
    - 1% period 4/1/2022 – 6/30/2022
    - 2% after 7/1/2022
  - DGME MA reduction of 4.12% for CY 2018

CY	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Percent reduction to MA DGME	9.77	7.85	7.16	6.41	5.86	5.32	4.99	4.44	~~7.00~~ 4.12	4.07

  - Multiple RHC/FQHCs
    - Up to 50RHC
    - Up to 36 FQHCs

T-17 Clarifications

- New Edits

12110S If Worksheet S-2, Part I, line 39, either column 1 or 2, is "N" for no, then Worksheet E, Part A, lines 70.96, 70.97, and 70.98, must be zero; and vice versa. [07/01/2022]

12115S If Worksheet S-2, Part I, line 40, columns 1 and 2, are "N" for no, then Worksheet E, Part A, line 70.99, must be zero and vice versa, and if Worksheet S-2, Part I, line 40, columns 1 or 2, are "Y" for yes, then Worksheet E, Part A, line 70.99, must be greater than zero and vice versa. [07/01/2022]

10201D Worksheet D-1, Part I, column 1, sum of lines 7 and 8, must equal Worksheet S-3, Part I, column 8, line 6. [02/28/2022]

- Revised Edits

The 10000G series of edits apply to all provider types, except governmental providers. Consequently, do not apply these edits to providers where the response to Worksheet S-2, Part I, line 216, is "7" through "13". This exception applies to the following edits: 10000G, 10050G, 10100G, and 10150G:

20325S If Worksheet S-2, Part I, line 26, column 1, is "1" (urban status), and line 27, column 1, is "2" (rural status), then Worksheet L, Part I, line 1, column 1.01, must be greater than zero. *Do not apply this edit to a CAH (Worksheet S-2, Part I, line 105 is "Y").* [04/30/2021]

Health Financial Systems

T-17 Clarifications

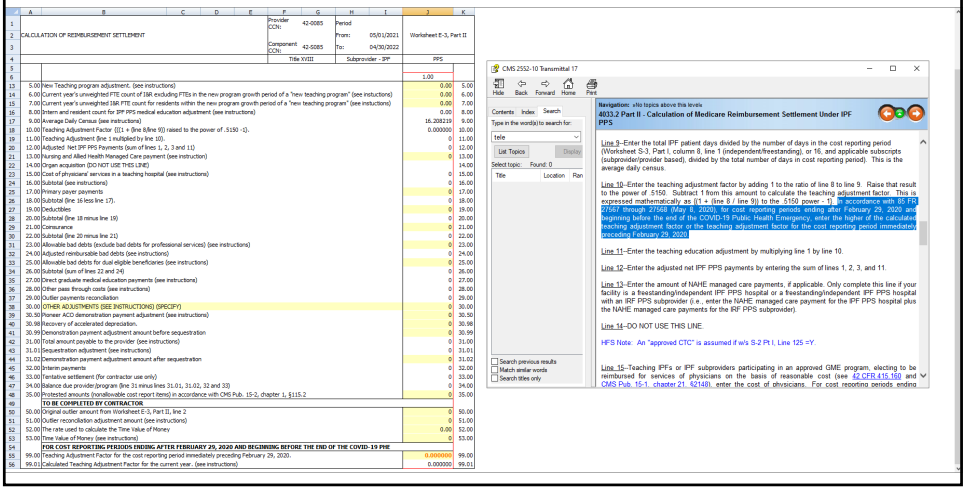
- In accordance with 85 FR 27567 through 27568 (May 8, 2020), for cost reporting periods ending after February 29, 2020 and beginning before the end of the COVID-19 Public Health Emergency, enter the higher of the calculated teaching adjustment factor or the teaching adjustment factor for the cost reporting period immediately preceding February 29, 2020.

- HFS Implements these IPF/IRF teaching adjustment hold harmless provisions using lines 99 and 99.01.

Health Financial Systems

T-17 Clarifications

- HFS Implements these IPF/IRF teaching adjustment hold harmless provisions using lines 99 and 99.01.



1						Provider CCN:	42-0085	Period			
2	CALCULATION OF REIMBURSEMENT SETTLEMENT							From:	05/01/2021	Worksheet E-3, Part II	
3						Component CCN:	42-0085	To:	04/30/2022		
4						Title XVIII		Subprovider - IPF		PPS	
5											
6										1.00	
13	5.00	New Teaching program adjustment. (see instructions)								0.00	5.00
14	6.00	Current year's unweighted FTE count of 1&E excluding FTEs in the new program growth period of a "new teaching program" (see instructions)								0.00	6.00
15	7.00	Current year's unweighted 1&E FTE count for residents within the new program growth period of a "new teaching program" (see instructions)								0.00	7.00
16	8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)								0.00	8.00
17	9.00	Average Daily Census (see instructions)								16.208219	9.00
18	10.00	Teaching Adjustment Factor {[(1 + (line 8/line 9)) raised to the power of .5150 -1).								0.000000	10.00
19	11.00	Teaching Adjustment (line 1 multiplied by line 10).								0	11.00
20	12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)								0	12.00
21	13.00	Nursing and Allied Health Managed Care payment (see instruction)								0	13.00
22	14.00	Organ acquisition (DO NOT USE THIS LINE)									14.00
23	15.00	Cost of physicians' services in a teaching hospital (see instructions)								0	15.00
24	16.00	Subtotal (see instructions)								0	16.00
25	17.00	Primary payer payments								0	17.00
26	18.00	Subtotal (line 16 less line 17).								0	18.00
27	19.00	Deductibles								0	19.00
28	20.00	Subtotal (line 18 minus line 19)								0	20.00
29	21.00	Coinsurance								0	21.00
30	22.00	Subtotal (line 20 minus line 21)								0	22.00
31	23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)								0	23.00
32	24.00	Adjusted reimbursable bad debts (see instructions)								0	24.00
33	25.00	Allowable bad debts for dual-eligible beneficiaries (see instructions)								0	25.00
34	26.00	Subtotal (sum of lines 22 and 24)								0	26.00
35	27.00	Direct graduate medical education payments (see instructions)								0	27.00
36	28.00	Other pass through costs (see instructions)								0	28.00
37	29.00	Outlier payments reconciliation								0	29.00
38	30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)								0	30.00
39	30.50	Pioneer ACO demonstration payment adjustment (see instructions)								0	30.50
40	30.98	Recovery of accelerated depreciation.								0	30.98
41	30.99	Demonstration payment adjustment amount before sequestration								0	30.99
42	31.00	Total amount payable to the provider (see instructions)								0	31.00
43	31.01	Sequestration adjustment (see instructions)								0	31.01
44	31.02	Demonstration payment adjustment amount after sequestration								0	31.02
45	32.00	Interim payments								0	32.00
46	33.00	Tentative settlement (for contractor use only)								0	33.00
47	34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)								0	34.00
48	35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2								0	35.00
49		TO BE COMPLETED BY CONTRACTOR									
50	50.00	Original outlier amount from Worksheet E-3, Part II, line 2								0	50.00
51	51.00	Outlier reconciliation adjustment amount (see instructions)								0	51.00
52	52.00	The rate used to calculate the Time Value of Money								0.00	52.00
53	53.00	Time Value of Money (see instructions)								0	53.00
54		FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE									
55	99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.								0.000000	99.00
56	99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)								0.000000	99.01

Health Financial Systems

T-17 Clarifications

- Line 10 – IPF Line 10 flows from the Higher of lines 99 or 99.01
  - IRF calculated (line 99.01) and compared to Teaching Adjustment Factor from the report immediately preceding February 29, 2020 (input on line 99)
- Line 11 – IRF Line 11 flows from the Higher of lines 99 or 99.01
  - IRF calculated (line 99.01) and compared to Teaching Adjustment Factor from the report immediately preceding February 29, 2020 (input on line 99)

Health Financial Systems

PRA Notice

- **New 30-day comment period notice published 6/22/2022**
  - Form Changes
  - Instructional Changes

Health Financial Systems

PRA Notice – Form Changes

- **Worksheet S-2 – Additional Lines for TEFRA Target adjustments**

			Approved for Permanent Adjustment (Y/N) 1	Number of Approved Permanent Adjustments 2	
88	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				88
		Wkst. A Line No. 1	Effective Date 2	Approved Permanent Adjustment Amount Per Discharge 3	
89	Column 1: If line 88 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.				89

- **Purpose to identify each permanent adjustment to the TEFRA Target amount and effective dates.**
- **Provides for multiple adjustments (line 88 column 2 and detail for each on line 89 and subscripts.**

Health Financial Systems

PRA Notice – Form Changes

- **Worksheet S-2 – Additional Line for identification purchased professional services.**

123	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is Y, were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123

- **Line 123 column 1 Y/N column 2 "Over 50% from unrelated organization outside of CBSA.**

Health Financial Systems

PRA Notice – Form Changes

- **Worksheet S-3**

DRAFT — FORM CMS-2552-10 — 4090 (Cont.)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | PROVIDER CCN: | PERIOD FROM ____ TO ____ | WORKSHEET S-3, PART I

PART I - STATISTICAL DATA

	Component	Wkst. A Line Number	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips: Title V	Title XVIII	Title XIX	Total All Patients	Full Time Equivalents: Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Discharges: Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)																1
2	HMO and other (see instructions)																2
3	HMO IPF Subprovider																3
4	HMO IRF Subprovider																4
5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds. Swing Bed NF																6
7	Total Adults and Peds. (exclude observation beds) (see instructions)																7
8	Intensive Care Unit																8
9	Coronary Care Unit																9
10	Burn Intensive Care Unit																10
11	Surgical Intensive Care Unit																11
																	12
	Line 34--Effective March 1, 2020, through the end of the COVID-19 public health emergency (PHE), enter the number of temporary expansion COVID-19 PHE acute care beds in column 2 and the number of bed days available for temporary expansion COVID-19 PHE acute care beds in column 3. In columns 5, 6, 7, and 8, enter the number of inpatient days for temporary expansion COVID-19 PHE acute care beds for title V, title XVIII, title XIX, and all patients, respectively. The beds and days entered on this line are a subset of the beds and days that must be entered on line 1 and lines 8 through 12. The temporary expansion COVID-19 PHE acute care bed days available are excluded from the calculation of the IPPS hospital inpatient bed days available on Worksheet E, Part A, line 4.															13
																	14
																	15
																	16
																	17
																	18
																	19
																	20
																	21
																	22
																	23
24																	24.10
																	27
																	28
																	29
30	Employee discount days (see instructions)																30
31	Employee discount days -IRF																31
32	Labor & delivery (see instructions)																33
32.01	Total ancillary labor & delivery room outpatient days (see instructions)																32.01
33	LTCH non-covered days																33
33.01	LTCH site neutral days and discharges																33.01
34	*Temporary Expansion COVID-19 PHE Acute Care*																*34*

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Health Financial Systems

PRA Notice – Form Changes

- **Worksheet S-10 Split into Two Parts**
  - Part I Hospital and Hospital Complex Data
  - Part II Hospital Data

48

PRA Notice – Form Changes

- **Worksheet E-5**

4090 (Cont.) FORM CMS-2552-10 DRAFT

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-5

	TO BE COMPLETED BY CONTRACTOR		
1	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		1
2	Capital outlier from Wkst. L, Pt. I, line 2		2
3	Operating outlier reconciliation adjustment amount (see instructions)		3
4	Capital outlier reconciliation adjustment amount (see instructions)		4
5	The rate used to calculate the time value of money (see instructions)		5
6	Time value of money for operating expenses (see instructions)		6
7	Time value of money for capital related expenses (see instructions)		7

General Information

- **The new S-12 – Median Payer-Specific Negotiated Charge Data is not finalized and per the 2021 Final IPPS Rule this is being eliminated.**

PRA Notice – Form Changes

- **Worksheet A**
  - Additional lines:
  - Line 77 Allogeneic HSCT Acquisition (07700)
    - Reimbursed as pass-through (Worksheet D-6)
  - Line 78 CAR T Cell Immunotherapy (07800)
    - Reimbursed as IP/OP Services
  - Line 102 Opioid Treatment Program (10200)

PRA Notice – Instructional Changes

- **Worksheet A**

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 *CMS Pub. 100-04, chapter 3, §90.3.1, and* CMS Pub. 100-04, chapter 4, §231.11. *This includes 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 services intended for transplant but not resulting in transplant, i.e., due to death of the intended recipient or other causes. Do not include costs for allogeneic HSCT 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.

Health Financial Systems

PRA Notice – Instructional Changes

- **Worksheet A**

Line 102--Effective for cost reporting periods ending on or after January 1, 2022, enter the cost of providing services for the treatment of Opioid Use Disorder 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.

Health Financial Systems

Latest Transmittal Updates

Form	Type	Latest Transmittal	CMS Issued	HFS Approved	HFS Released	Effective Date
2552-10	Hospital	17	1/10/2022	1/21/2022	1/24/2022	Ending O/A 12/31/2021
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	3	8/31/2022	9/12/2022	9/15/2022	Ending O/A 8/31/2022
265-11	ESRD	6	4/30/2021	6/9/2021	6/25/2021	Ending O/A 3/31/2021
224-14	FQHC	4	4/30/2021	6/9/2021	6/25/2021	Ending O/A 3/31/2021
1984-14	Hospice	4	4/30/2021	6/9/2021	6/18/2021	Ending O/A 12/31/2020
222-17	RHC	3	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
No Recent Changes						
287-05	HO					

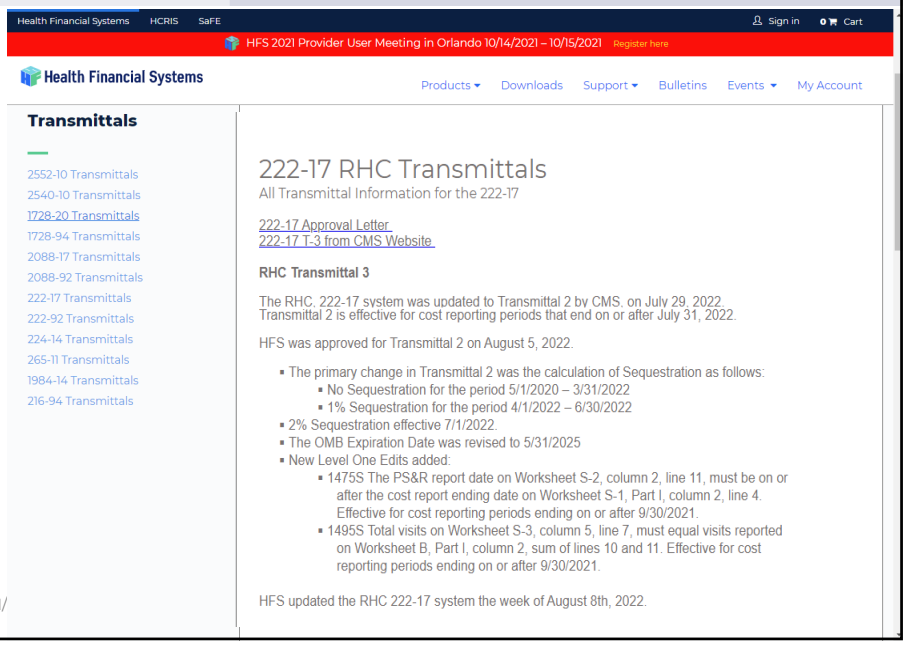
Health Financial Systems

Latest Transmittal Updates

- CMS did just release on Friday October 28, 2022 the new 287-22 T1 for the Home Office Cost Statement which is effective for cost reporting periods beginning on or after October 1, 2022. This implements an electronic reporting requirement for the home office cost statement.
- CMS also released the 224-14 T5 (FQHC) on the same date. Many of these changes were already implemented via vendor notification – implemented the increase in possible consolidated FQHCs to 198. Also updated the sequestration computation to account for the 1% update effective 4-1-2022 thru 6-30-2022 and 2% on or after 7-1-2022. The OMB termination date was also changed to 8-31-2025.

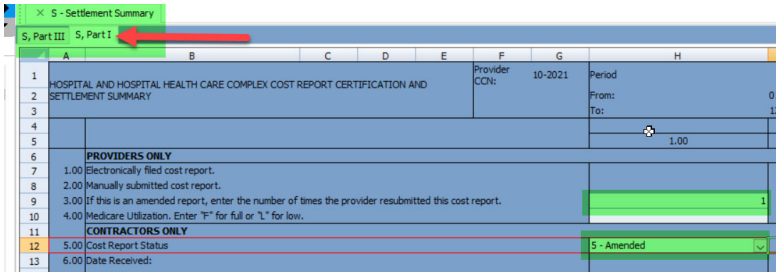
Health Financial Systems

Latest Transmittal Updates



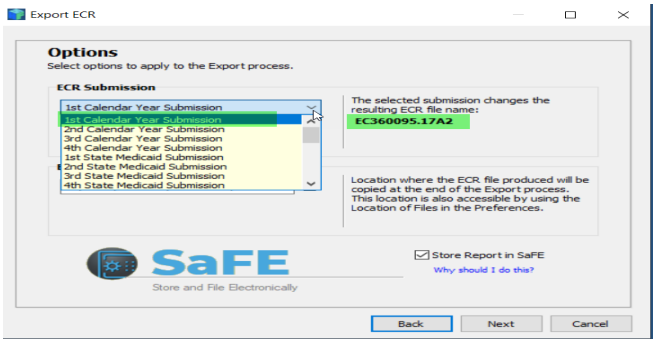
Amended Cost Report Clarification

- **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.



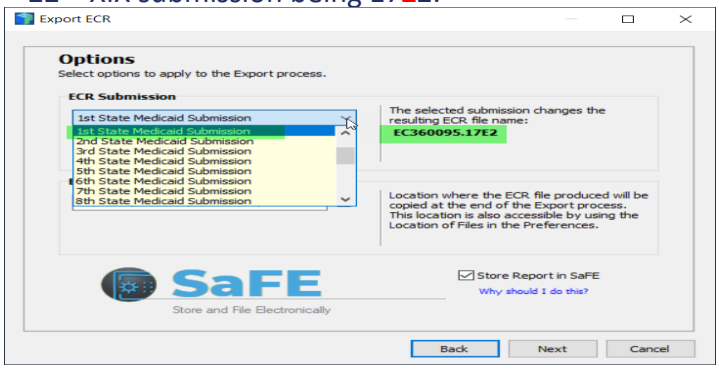
Amended Cost Report Clarification

- **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.



FFY 2023 Final Rule

- After reviewing the statutory language regarding the direct GME FTE cap and the court's opinion, we have decided implement a modified policy to be applied prospectively for all teaching hospitals, as well as retroactively to the providers and cost years in Hershey and certain other providers as described in greater detail in section V.F.2. of the preamble of this final rule. The modified policy will address situations for applying the FTE cap when a hospital's weighted FTE count is greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their initial residency period to an amount less than 0.5. Specifically, effective for cost reporting periods beginning on or after October 1, 2001, we are specifying that if the hospital's unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds that FTE cap, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the FTE cap. If the number of weighted FTE residents does not exceed that FTE cap, then the allowable weighted FTE count for direct GME payment is the actual weighted FTE count.

- They are also working to incorporate changes associated with Sections 126, 127 and 131 of the Consolidated Appropriations Act (CAA), 2021 with the Hershey case.

- CMS did instruct MACs to reopen cost reports for the plaintiffs in the Hershey case and furnished us the computation that is to be used for the Worksheet E-4 changes. We released this change in late October by utilizing a non-CMS W/S E-4 lines 109 and 122 (as these will override the current calculations for lines 9 and 22 when the report is affected by the lawsuit). Line 109 column 0 will be changed to YES and this will trigger the new computation, below is what is listed in the Help | 2552-10 CMS Instructions for W/S E-4:

HFS Note: HFS has added Contractor Only lines 109 and 112 to implement the Federal Fiscal Year Final Rule Worksheet E-4, line 9 and 22 revised calculations for cost reporting periods beginning prior to 10/01/2021 in accordance with the Hershey Case.

Line 109 - Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. If "Y", transfer the amounts in line 109 column 1 and 2 to line 9 columns 1 and 2. For columns 1 and 2, If line 8, column 3, is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in line 109 columns 1 and 2. Otherwise, if the total weighted FTE count from line 8, column 3 is greater than the amount on line 5, then enter in line 109 column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) x FTE cap)). The formula for this is (E-4 line 8 col 1 / line 8 col 3) * E-4 line 5. Enter in line 109 column 2 the result of ((other weighted FTEs/ total weighted FTEs) x FTE cap)). The formula for this is (E-4 line 8 col 2 / line 8 col 3) * E-4 line 5.

Line 122 - Line 122 on E-4 will override line 22 when line 109 column 0 is Y. If (E-4 line 8 col 3 – E-4 line 9 col 3) > E-4 line 20 then enter line 20 on line 122, else, (E-4 line 8 col 3 – E-4 line 9 col 3).

- Please note it states Contractor Only, this is due to CMS not publishing the final changes (in what we expect to be T18). Providers are able to change line 109 column 0 to YES and it will compute the new values, however, there will be a HFS level I edit so you will not be able to file with this. You always can include an Other Adj amount and then amend the cost report when the transmittal is release. Below is the change to the W/S E-4 screen:

	E-4 Calculation - In accordance with the FY 2023 IPPS Final Rule.	Y/N	Primary Care	Other	Total	
109.00	Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	- - NO	0.00	0.00	0.00	109.00
122.00	Override of line 22 for cost reporting periods beginning prior to 10/1/2021. (see instructions)		0.00			122.00
If line 109 column 0 is Y, you MUST open up the PY and Penultimate cost reports and answer line 109 column 0 "Y" and calculate, then input amounts from line 11 columns 1 & 2 to the CY lines 12 & 13 columns 1 & 2 respectively.						

- Percentage Reduction to MA for DGME Payments now to be published in Rulemaking. CY 2020 and 2021.
- CMS has notified us on Friday October 28, 2022 to implement these changes, see next slide.

	CY 2020	SOURCE	CY 2021	SOURCE
NAH Pass-Through	$ 264,332,386	Cost reports ending in FY 2018 HCRIS	$ 276,790,522	Cost reports ending in FY 2019 HCRIS
Part A Inpatient Days	64,285,989	Cost reports ending in FY 2018 HCRIS	66,512,964	Cost reports ending in FY 2019 HCRIS
MA Inpatient Days	9,473,935	Cost reports ending in FY 2018 HCRIS	10,702,732	Cost reports ending in FY 2019 HCRIS
Part A Direct GME	$ 2,772,451,903	CY 2019 HCRIS + CPI-U	$ 2,732,276,287	CY 2019 HCRIS + CPI-U
MA Direct GME	$1,608,018,609	CY 2019 HCRIS + CPI-U	$ 1,840,934,928	CY 2019 HCRIS + CPI-U
Pool (not to exceed $60 million)	$ 60,000,000	((Part A DGME/MA DGME) * (NAH Pass-through))	$ 60,000,000	((Part A DGME/MA DGME) * (NAH Pass-through))
Percent Reduction to MA DGME Payments	3.71%	(Pool/MA direct GME)	3.22%	(Pool/MA direct GME)

- The Worksheet E-4, line 29.01 HMO GME reduction for Calendar Years 2020 and 2021 is released. This will not automatically update to your mcrx file, you must go into the form and make this change. We will issue an edit telling you the rate is not equal to the CMS' rate when different. This update is to be released the first week of November.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS [page 40-216.2]

Line 29.01--If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in columns 2 and 2.01, the applicable reduction percentage to MA direct GME payments. Enter in column 2, the MA reduction percentage for the portion of the cost reporting period prior to January 1; and enter in column 2.01, the MA reduction percentage for the portion of the cost reporting period on or after January 1. Calendar year providers complete only column 2.

CY	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	*2020*	*2021*
Percent reduction to MA DGME	9.77	7.85	7.16	6.41	5.86	5.32	4.99	4.44	~~7.00~~ *4.12*	4.07	*3.71*	*3.22*

- CMS also instructed us to update the Cancer Hospital PCR amount for CY 2022 on E Part B line 5:

4030.2 Worksheet E, Part B - Medical and Other Health Services.--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, sub-providers, SNFs and providers participating in the PARHM demonstration. [page 40-178]

Line 5--Enter the hospital specific payment to cost ratio provided by your contractor. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51.)

For a cancer hospital, enter the target PCR as published in the applicable OPPS final rule (or correction notice), and subscript column 1 for each PCR period when the cost reporting period overlaps a PCR revision date. Following is a table of the PCRs beginning with CY 2012.

CY	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	*2022*
PCR	0.91	0.91	0.90	0.90	0.92	0.91	0.88	0.88	0.89	0.89	*0.89*

- Low Volume Payment Adjustment
  - Effective 10/1/2022 reverts to previous Methodology
    - Located more then 25 road miles from another subsection (d) hospital.
    - Less than 200 Discharges.
  - Hospital must submit a written request for LV Status
    - No Later than 9/1/2022 or effective 30-days after MAC determination.
  - 25% add-on payment adjustment.
    - Implement on Cost Report or Claim payment?
- MDH Hospitals
  - MDH Provision expires 10/1/2022.
  - Current MDH may apply for SCH status.
    - Request Prior to 9/1/2022 for effective date of 10/1/2022
- Biden extended these programs thru December 16, 2022 by the Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023. This was detailed in CR12970.
  - Low Volume – MACs must receive provider's written request or verification no later than 11-16-22.
  - MDH- will be extended unless provider requested cancellation of their rural classification under §412.103(b).

Health Financial Systems

Requests for .Auditor files

Auditor creates adjusted cost report.

- Created when adjustments applied
- Same filename as cost report.
- Filename ends with ".mcax".

Health Financial Systems

Requests for .Auditor files

Example of properly named cost report and .Auditor files

HFS Test Case 2018.mcrx
HFS Test Case 2018.Auditor

Health Financial Systems

Requests for .Auditor files

1. Enter the Wage Index adjustments.
2. Apply and see the changed amounts.
3. Submit the .Auditor file to your MAC.
4. Why?
    1. Isolates changes if S-10 or other review started
    2. MAC can import adjustments and include with their adjustments.

Health Financial Systems

CMS' IRIS Changes

- CMS has been having meetings since April 2015 with all the IRIS vendors to assist them in creating their own IRIS system.
- CMS has tied the IRIS into the PS&R and STAR system to incorporate a National Database.
- MACs are now uploading the IRIS files submitted with the Medicare Cost Reports.
- CMS issued CR9984 on March 17, 2017 instructing MACs to load a minimum of 4 years of historical IRIS dbf files to the new STAR IRIS.

CMS' IRIS Changes

- 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 is pushing to compare the cost report FTEs to what they calculate the FTEs from the submitted IRIS files. They are planning to begin holding up the acceptance of cost reports in the near future where they do not trace (the FFY 22 IPPS **Proposed Rule** wanted to begin with cost reporting periods beginning on or after 10-1-2021).
- The FFY 22 IPPS Final Rule removed the requirement to trace the IRIS FTEs to the cost report, however, they did state the implementation of XML rather than DBF will begin with cost reporting periods beginning on or after 10-1-2021.

- The Final Rule is 86 FR 45311 through 45313 dated August 13, 2021.
- https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf

CMS is validating vendor IRIS software to ensure that it meets the IRIS XML specifications and will release the list of all approved IRIS software vendors. However, we agree with the commenters that we should delay the implementation of the new policy requiring MACs to reject cost reports where the total number of reported submitted IRIS GME and IME FTEs do not match the total IME and GME FTEs reported on the cost report.

After consideration of the public comments we received, we are modifying 42 CFR 413.24(f)(5)(i)(A) to require that for cost reporting periods beginning on or after October 1, 2021, the GME weighted and unweighted) and IME FTE counts on the submitted IRIS must match the total GME and IME FTE counts reported on the cost report. However, for cost reporting periods beginning on or after October 1, 2021 and before October 1, 2022, the cost reports will not be rejected if the total IME and GME FTEs (weighted and unweighted) on the submitted IRIS do not match the total related FTEs reported on the cost report.

We are also revising this sub-section to include a requirement that for cost reporting periods beginning on or after October 1, 2021, the IRIS data must be in the XML format.

- 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.

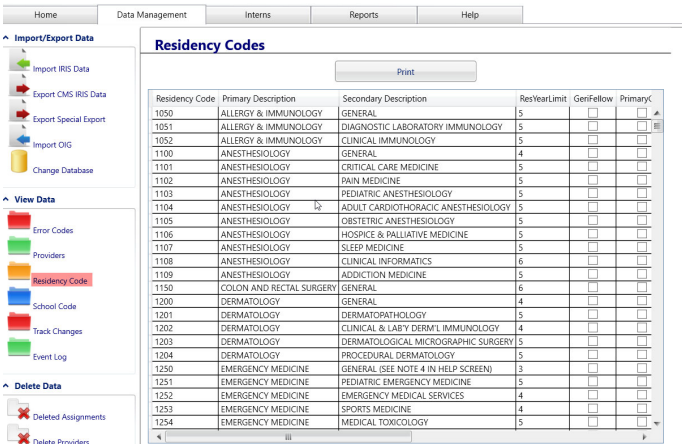
Total Unweighted IME FTEs

- 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".

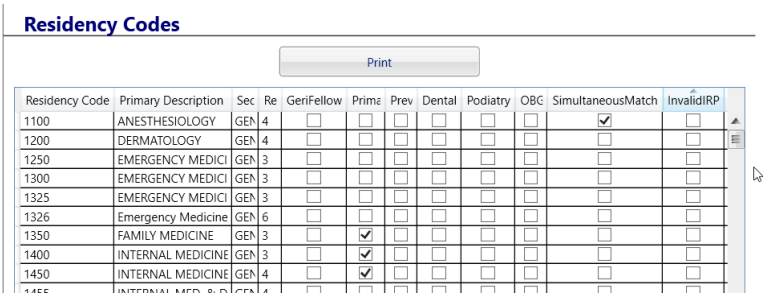
- During the IRIS build by CMS, they have reviewed the Residency Code table to produce a table which will be used by all to determine the proper FTE count. We wanted to wait on CMS to publish this final table before our release but could not.
- We have received a draft and there are changes which we have implemented prior to CMS publishing this table.
- One example is with Podiatry. We just received clarification from CMS that the only programs that are 3-year programs are those that are Podiatric Medicine and Surgical which are codes 7250, 7300, and 7350.

- One item that came up in the discussions with CMS is the Primary Care and OB/GYN.
  - OB/GYN is not Primary for Worksheet S-2, Part I but they are included with Primary on Worksheet E-4.
  - For the E-4 OB/GYN, the only codes to be included as OB/GYN for E-4 are 1750 and 4450 (the general codes).

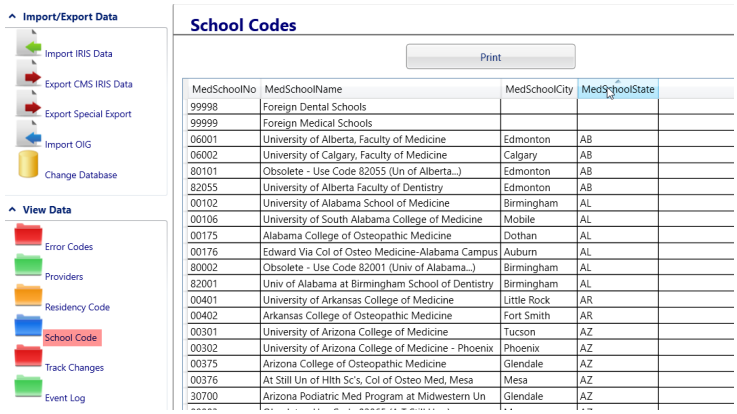
- You can see the Residency Code table in the Data Management tab and can select the headers to sort codes:



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



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



Health Financial Systems

CMS' IRIS Changes

- We are waiting on the **publishing** of the XML instructions.
- We are waiting on the tables showing the Initial Residency Period lengths to be used in calculation of FTEs, the Medical Schools and Residency Codes.
- We have also asked for the list of Edits to ensure consistency.

Health Financial Systems

CMS' IRIS Changes

- As shown on previous slides, CMS is moving to get rid of the M & A dbf files and going to 1 xml file for submission of IRIS with the cost reports.
- This will get rid of the free dos-based IRIS system and require providers to submit with the new system – more than likely with an IRIS vendor.
- We released these changes on March 27, 2020 along with the changes summarized in the following slides.
- The XML is now required with FYB 10-1-2021 and we have included the XML export but the FYB must be on or after 10-1-2021.

CMS' IRIS Changes

- CMS will be adding 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

CMS' IRIS Changes

- 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' instructions for the new non-IRP Yr 1 residency code (been a confusing field on what is needed):

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.

CMS' IRIS Changes

- The plan is to then be able to trace FTE amounts from IRIS files to the cost report for the following fields:
  - E Part A lines 10, 11, 16 (displaced), and 17 (new)
  - S-2 Part I line 66 cols 1 & 2, line 67 cols 3 & 4
  - E-3 Part II (Psych) lines 6 & 7 (new)
  - E-3 Part III (Rehab) lines 7 & 8 (new)
  - E-4 line 6, line 8 & 16 cols 1 & 2, line 10 col 2, and line 15 cols 1 & 2
  - E-4 lines 10.01, 15.01, and 16.01 (added in T10)

CMS' IRIS Changes

- CMS has instructed vendors there is an additional field to take into account New Programs for Urban hospitals who received Rural redesignations. They FTEs are considered new for IME but not for GME so this required a field to identify these assignments.

- Below is how they defined these:

New Program	Assignment	isNewProgramFte (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 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).
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, 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"

- We are in the process of programming this and submitting another test case to CMS for approval in the XML file. Below is how we are implementing this in the csv template:

Y	Z	AA	AB	AC
ISNEWPROGRAMFTE	ISDISPLACEDRESFTE	ISNEWPROGRAMIPPSEXCEPTION	ISNEWPROGRAMIPFEXCEPTION	ISNEWPROGRAMIRFEXCEPTION
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	TRUE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	TRUE	FALSE	FALSE

Health Financial Systems

Questions

- Questions?
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