Health Financial Systems

# Medicare Cost Report Changes

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# Overview

## Agenda

- Extensions (or lack of)
- MCR Update
- IRIS Alerts
- HFS Software Update
- Questions

# Extensions

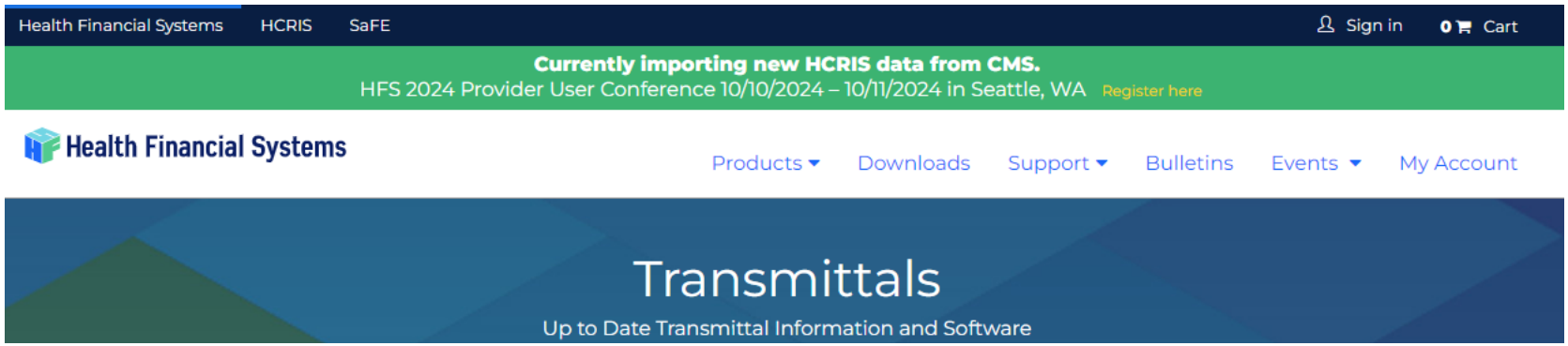
- **While no current extension for the PHE after 12/31/2020 cost reports:**
  - 42 CFR 413.24(f)(2)(ii)
    - (ii) Extensions of the due date for filing a cost report may be granted by the contractor only when a provider's operations are significantly adversely affected due to extraordinary circumstances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

Health Financial Systems

# Latest Transmittal Updates

| | Type | Latest Transmittal | CMS Issued | HFS Approved | HFS Released | Effective Date |
|---|---|---|---|---|---|---|
| 2552-10 | Hospital | 19/20/21/**22** | 2/29/2024 | 3/22/2024 | 4/1/2024 | Beginning O/A 10/1/2023 |
| 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 | 5/6 | 4/29/2024 | 2/14/2024 | 5/13/2024 | Beginning O/A 1/1/2024 |
| 265-11 | ESRD | 7/8/9 | 4/28/2023 | 6/14/2023 | 6/12/2023 | Beginning O/A 1/1/2023 |
| 224-14 | FQHC | 6/**7** | 2/29/2024 | 3/28/2024 | 4/1/2024 | Ending O/A 1/1/2024 |
| 1984-14 | Hospice | 6 | 1/19/2024 | 1/26/2024 | 3/11/2022 | Ending O/A 121/31/2023 |
| 222-17 | RHC | 4/**5** | 3/2024 | 4/2/2024 | 4/8/2024 | Services on or after 1/1/2024 |
| 2088-17 | CMHC | 4 | 2/29/2024 | 4/9/2024 | 4/8/2024 | Services on or after 1/1/2024 |
| 287-22 | HO | 3 | 3/29/2024 | 4/12/2024 | 4/12/2024 | Ending O/A 12/31/2023 |

# Latest Transmittal Updates




www.HFSSoft.com – Support/Transmittals

Click here to download 2552-10 Transmittals

**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
- 287-22 Transmittals

## 2552-10 Hospital Transmittals

All Transmittal Information for the 2552-10

2552-10 T-22 HFS MCRIF32 Approval Letter
2552-10 T-22 from CMS Website

**Hospital Transmittal 22**

CMS issued Transmittal 22 to the 2552-10 on February 29th, 2024. Transmittal 22 has been issued with an effective date of Cost Reporting Periods Beginning on or After October 1, 2023, and implements changes including:

Accommodation for rural emergency hospitals (REH) claiming medical education costs for interns and residents effective for portions of cost reporting periods on or after October 1, 2023, in accordance with FY 2024 IPPS final rule, 88 FR 59053 (August 28, 2023).

Accommodation for intensive outpatient program (IOP) visits in accordance with the Consolidated Appropriations Act (CAA) of 2023, §4124, effective for services rendered on or after January 1, 2024.

Updated the MC+GME payment reduction to direct graduate medical education (GME) for CY 2022.

Revised instructions for Worksheet L to reflect revisions for providers that underwent a geographic reclassification in accordance with 42 CFR 412.103 per the FY 2024 IPPS final rule, 88 FR 59117 (August 28, 2023).

Revised M, N and O series instructions to accommodate marriage and family therapists

# Background

- New Provider type - Rural Emergency Hospital (REH)
- Intensive Outpatient Program (IOP) costs incurred for IOP services rendered to hospital outpatients, effective for services rendered on or after January 1, 2024, in accordance with the Consolidated Appropriations Act (CAA) of 2023, §4124.
- Covered Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC), respectively, in accordance with the CAA 2023, §4121, effective for services on or after January 1, 2024.
- Supporting Documentation Requirements (Exhibits T-18)
- FY 2023 IPPS final rule GME Changes (Hershey changes T-18)
- Sections 126, 127, 131 of the CAA 2021 (T-18)
- Sequestration Changes.

- **Supporting Documentation Requirements (Exhibits)**
  - FY 2019 Final Rule
    - Required supporting documentation for CR beginning after 10/1/2018.
  - 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 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.

- **Supporting Documentation Requirements (Exhibits)**
  - CMS has set up a website with the templates for the various exhibits at the following link:

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

  - You are not specifically required to use these templates, however, should follow the columns needed for the support.

- **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

- **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

# Background

- Reminder when doing GME reports that may be affected by Hershey case, you will need to pull the prior year mcrx and penultimate year mcrx files and then open S-2 Pt I and change line 68 to Y and calculate. This will make revisions to W/S E-4 which you will then need to adjust on the CY mcrx file's E-4 lines 12 and 13. You may also need to look at line 15 of the previous reports if they have new training programs whose exemption has expired.

- **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).

# Background 2552-10 T-18

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

- The FFY24 IPPS Rule also updated the CY 2022 HMO Reduction amounts shown on Worksheet E-4 line 29.01. This also was included in T22.
  - CY 2022 – 3.27%
- The FFY25 IPPS Rule updated the CY 2023 HMO Reduction amount shown on E-4 line 29.01 to 2.74% (8-28-24 federal register page 69384). We are waiting for CMS to update the instructions to implement this change.

- **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%

# 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 (Donor) 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 updated 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 updated the Hospital 2552-10 system the week of August 21st, 2023**

# Hospital 2552-10 Transmittal 22

- **CMS issued Transmittal 22 to the 2552-10 on February 29th, 2024. Transmittal 22 has been issued with an effective date of Cost Reporting Periods Beginning on or After October 1, 2023, and implements changes including:**
  - Accommodation for rural emergency hospitals (REH) claiming medical education costs for interns and residents effective for portions of cost reporting periods on or after October 1, 2023, in accordance with FY 2024 IPPS final rule, 88 FR 59053 (August 28, 2023).
  - Accommodation for intensive outpatient program (IOP) visits in accordance with the Consolidated Appropriations Act (CAA) of 2023, §4124, effective for services rendered on or after January 1, 2024.
  - Updated the MC+GME payment reduction to direct graduate medical education (GME) for CY 2022.
  - Revised instructions for Worksheet L to reflect revisions for providers that underwent a geographic reclassification in accordance with 42 CFR 412.103 per the FY 2024 IPPS final rule, 88 FR 59117 (August 28, 2023).
  - Revised M, N and O series instructions to accommodate marriage and family therapists (MFT) and mental health counselors (MHC), in accordance with the CAA 2023, §4121.
- **The T-22 changes were approved by CMS on March 22, 2024, and HFS updated the Hospital 2552-10 system the week of April 1st, 2024.**

# Hospital 2552-10 Transmittal 22

- We want to highlight the change effective with discharges on or after 10-1-2023 and how to complete L.
- If you are in an Urban CBSA the entire year and was redesignated Rural the entire year, you complete S-2, Pt I line 3, column 3 with the Urban CBSA. You also show S-2, Pt I lines 26 and 27 as 2 for Rural.

**Hospital and Hospital-Based Component Identification:**

| | | Component Name | CCN Number | CBSA Number | Provider Type |
|---|---|---|---|---|---|
| 3.00 | Hospital | | | 42700 | 1 - General Short Term |

| | | Urban/Rural Status | Date of Geographic Reclassification |
|---|---|---|---|
| 26.00 | Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. | 2 | |
| 27.00 | Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. | 2 | |

# Hospital 2552-10 Transmittal 22

- For Worksheet L, the column 1 will be subscripted when overlapping 10-1-23 for this change.
- Column 1 will be post 10-1 and will get capital DSH, column 1.01 will be pre-10-1 and is considered Rural and no Capital DSH.

  - Worksheet L: Revised instructions to reflect revisions for providers that underwent a geographic reclassification in accordance with 42 CFR 412.103 per the FY 2024 IPPS final rule, 88 FR 59117 (August 28, 2023).

| CALCULATION OF CAPITAL PAYMENT | | Provider CCN: [redacted]0001 | Period From: 01/01/2023 To: 12/31/2023 | Worksheet L, Part I | |
|---|---|---|---|---|---|
| | | Title XVIII | Hospital | PPS | |
| | | | Urban Post 10/1 | Rural Pre 10/1 | |
| | | | 1.00 | 1.01 | |
| | **PART I - FULLY PROSPECTIVE METHOD** | | | | |
| | **CAPITAL FEDERAL AMOUNT** | | | | |
| 1.00 | Capital DRG other than outlier | | 884,128 | 2,660,207 | 1.00 |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | | 0 | 0 | 1.01 |

# Hospital 2552-10 Transmittal 22

- Our review of the FFY 25 IPPS Final Rural, there are many changes in County – CBSA crosswalk due to the 2020 Census that is effective 10-1-24. There are many counties that went from Urban to Rural and vice-versa. This can affect the qualification of Capital DSH so we brought up a question to CMS asking if cost report changes would be needed for this.
- We are still awaiting guidance on this.

# Hospital 2552-10 Transmittal 22

- For the state of MN, we see Lake County went from Duluth CBSA 20260 and is now Rural MN. Rock County went the different direction, it was Rural but effect 10-1-24 it is now under CBSA 43620, Sioux Falls, SD – MN.
- We pulled HCRIS data and no MN IPPS hospitals are affected, however, CAHs may be and based on the final rule, you may need to request to continue being Rural for CAH qualification. See Federal Register dated 8-28-2024 page 69260.
- This would also be the case for SCH / MDH when applicable.

- Another change in T22 which you may need to be aware of is cost report instruction for E, Part A, line 20 for teaching hospitals. See the changes in red.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the Form CMS-2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e) for a new program started prior to October 1, 2012, add to the numerator of the prior year intern and resident to bed ratio (i.e., line 12 of the prior cost report, which might be zero, if applicable), the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (line 16) (i.e., the period of years is the minimum accredited length of the program). For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, then divide line 16 of this cost report by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), for each new program started, if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each particular new program, then add the amount from line 12 of the prior year (if greater than zero) and line 16 of this cost report, and divide the sum by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). If the provider is participating in a Medicare GME affiliation agreement or rural track Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap *(difference of the sum of current year line 8 and line 7.02, and sum of prior year line 8 and line 7.02 is positive) and increased its current year allowable* FTE count *(difference of current year line 12 (excluding current year dental and podiatry from line 11) and prior year line 12 (excluding prior year dental and podiatry from line 11) is positive)* due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator *line 15* and the prior year numerator *line 12 of the prior year cost report,* and b) the number by which the FTE cap increased per the affiliation agreement *(difference of sum of current year line 8 and line 7.02, and sum of prior year line 8 and line 7.02)*, and add the lower of these two numbers to the prior year's numerator *line 12 of the prior year cost report. If the lower of these two numbers is a negative number, do not adjust the prior year numerator line 12* (see 42 CFR 412.105(a)(1)(i) *and FY 2024 IPPS final rule, 88 FR 59047 (August 28, 2023)*). If the hospital is participating in a valid emergency Medicare GME affiliation agreement under a §1135 waiver, and a portion of this cost report falls within the time frame covered by that emergency affiliation agreement, then, effective on and after October 1, 2008, enter the current year resident-to-bed ratio from line 19 (see 73 FR 48649 (August 19, 2008) and 42 CFR 412.105(f)(1)(vi)). Effective for cost reporting periods beginning on or after October 1, 2002, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (see 42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17. For cost reporting periods beginning on or after October 1, 2022, for urban and rural hospitals participating in a rural track program(s), adjust the numerator by adding to the amount on Worksheet E, Part A, line 12, of the prior year cost report (if greater than zero) the FTEs in the rural track program(s) on line 16 of this worksheet, if this cost report is still prior to the cost reporting period that coincides with or follows the start of the sixth program year of that rural track program.

- Reminder if you are a Small Rural Hospital (under 50 beds – majority will be CAHs) with a RHC subunit. Effective 4-1-21, CMS has limited grandfathered RHC's to the PY cost multiplied by the CMS' updates (see CR12185 dated 5-4-21 for the original instruction). See following slide.

**2. Provider-Based RHCs in a hospital with less than 50 beds**

**a. Provider-based RHCs that are Determined to be Grandfathered**

Beginning April 1, 2021, provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are entitled to special payment rules, as described in section 1833(f)(3)(A) of the Act.

Provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are considered to be "grandfathered" into the establishment of their payment limit per visit. Meaning, those provider-based RHCs that meet the following criteria will have a payment limit per visit established (beginning with services furnished 4/1/2021) based on their AIR. A "grandfathered provider-based RHC" is an RHC that --

- As of December 31, 2020, was in a hospital with less than 50 beds and after December 31, 2020 in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the COVID-19 PHE); and one of the following circumstances:
    - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the COVID-19 PHE); or
    - Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.

With regard to the reference of the waiver during the COVID-19 PHE, CMS will take into account the policy finalized in the interim final rule with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27529). Provider-based RHCs that were exempt from the statutory payment limit per visit pursuant to section 1833(f)(3)(B) whose associated hospitals have experienced temporarily added surge capacity beds will be considered "grandfathered" in accordance with the policy set out in the May 8, 2020 IFC.

A grandfathered provider-based RHC will lose this designation if the hospital does not continue to have less than 50 beds. If this occurs, the provider-based RHC will be subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

Provider-based RHCs that are new beginning January 1, 2021 and after are subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

- CMS also added clarification in CR13063 dated 1-26-23 which included how to handle the “base year” reports when it is a short period report. It is important to track these “base year” cost limits for future reports.
- CMS also added in T22 a change to ensure no new RHCs can be added to the list of grandfathered consolidated RHCs.

Line 13--Is this worksheet prepared for a consolidated group of providers as defined in CMS Pub. 100-02, chapter 13, §80.2? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, the number of providers included in the consolidated group, complete line 14, and complete only one M series of worksheets for the consolidated group. If column 1, is "Y", enter in column 3 a "G" if the consolidated group consists exclusively of grandfathered providers or an "N" if comprised exclusively of non-grandfathered providers

Line 14--Report the clinic/center name and CCN number filing the consolidated cost report, and subscript line 14 to report each RHC filing consolidated under the CCN reported on line 14.

- CMS CR13667 dated 10-10-24 giving instruction to TEFRA hospitals (Cancer & Children's) regarding CAR T-cell Therapy and handling cost exceeding the target rate.
- CMS added a new D-1 line 55.03 to identify the interim payments received (and not E-3 Pt I line 17).

**Worksheet D-1, Part II** **[page 40-574]**

| | TARGET AMOUNT AND LIMIT COMPUTATION | | |
|---|---|---|---|
| 54 | Program discharges | | 54 |
| 55 | Target amount per discharge | | 55 |
| 55.01 | Permanent adjustment amount per discharge | | 55.01 |
| 55.02 | Adjustment amount per discharge (contractor use only) | | 55.02 |
| 55.03 | *CAR T-cell amount paid as an interim payment* | | 55.03 |
| 56 | Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) *plus line 55.03)* | | 56 |

4025.2. Part II - Hospital and Subproviders Only

**[page 40-149]**

*Line 55.03--Enter the CAR T-cell amount paid to your facility that agrees with the interim payments made in advance of making a request for an adjustment to your TEFRA ceiling.*

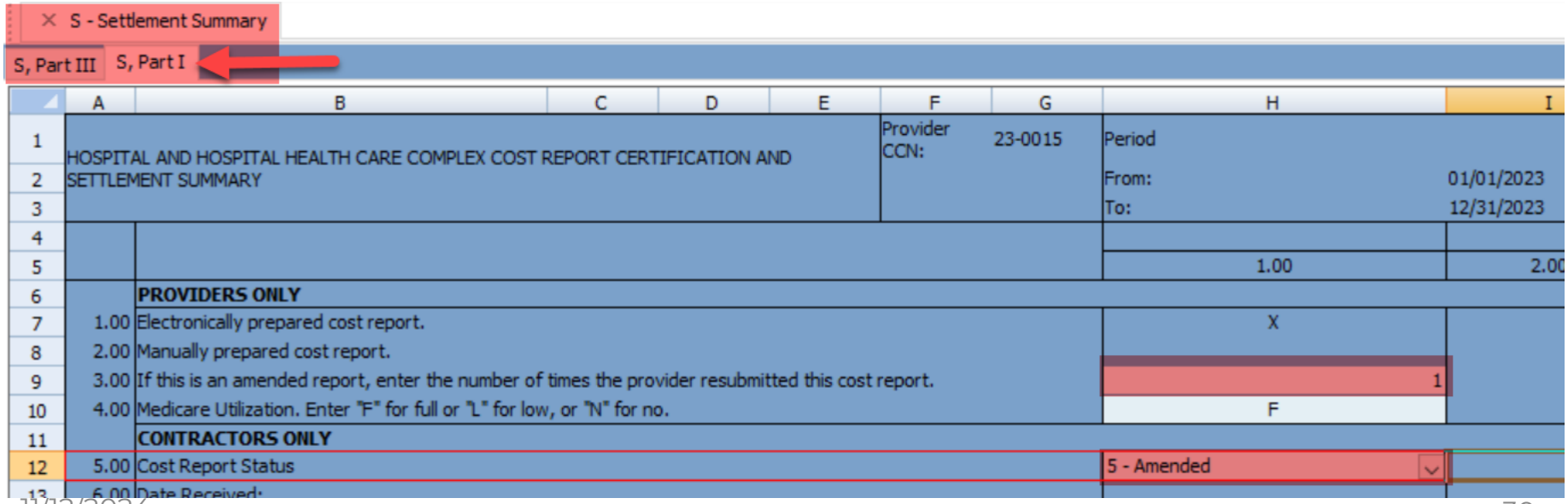
Line 56--Multiply the number of discharges on line 54 by the sum of the amounts on lines 55, 55.01, and 55.02*; plus line 55.03,* to determine the rate of increase ceiling.

- **Anticipated T-23 Changes:**
  - Update to weekly ESRD cost on Worksheet E, Part A.
    - Level One Edit for earlier reports (no cost update since 2013 - $435.60).
    - Based on FYB date and not CY update.

- **2552-xx in process**
  - Remove obsolete data
  - Renumbering for subscripts
  - Effective date TBD

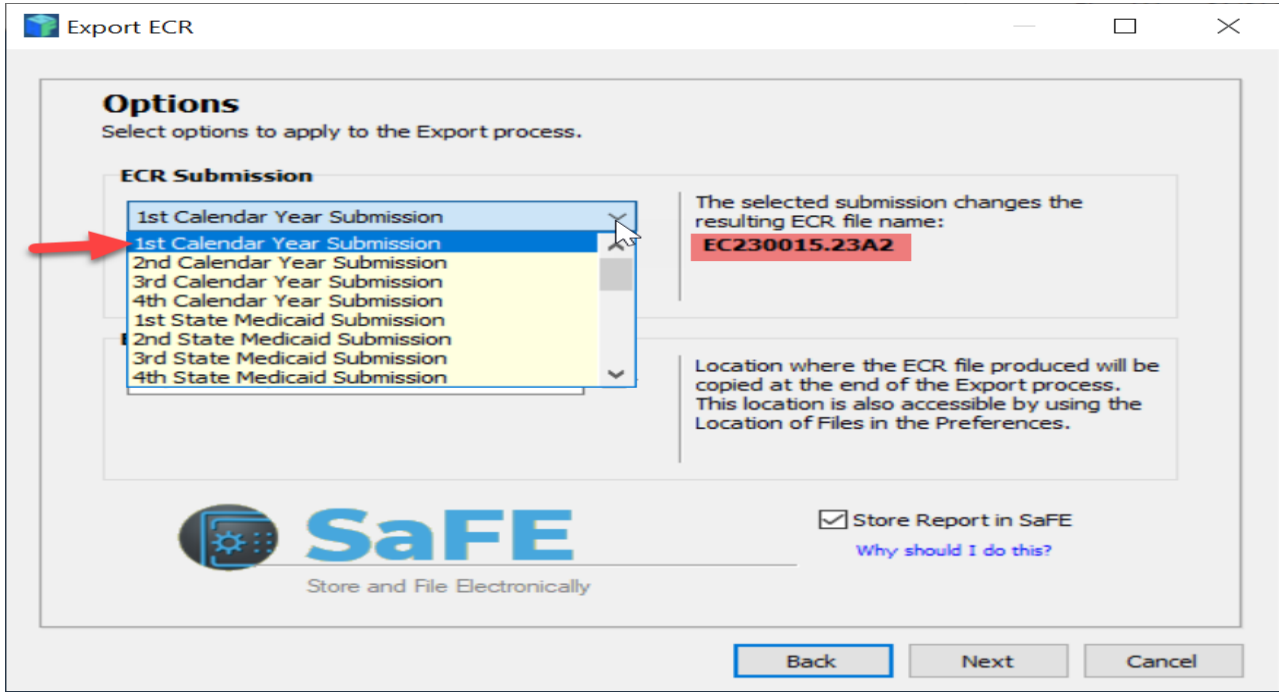
# Amended Cost Report Clarification

- **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.



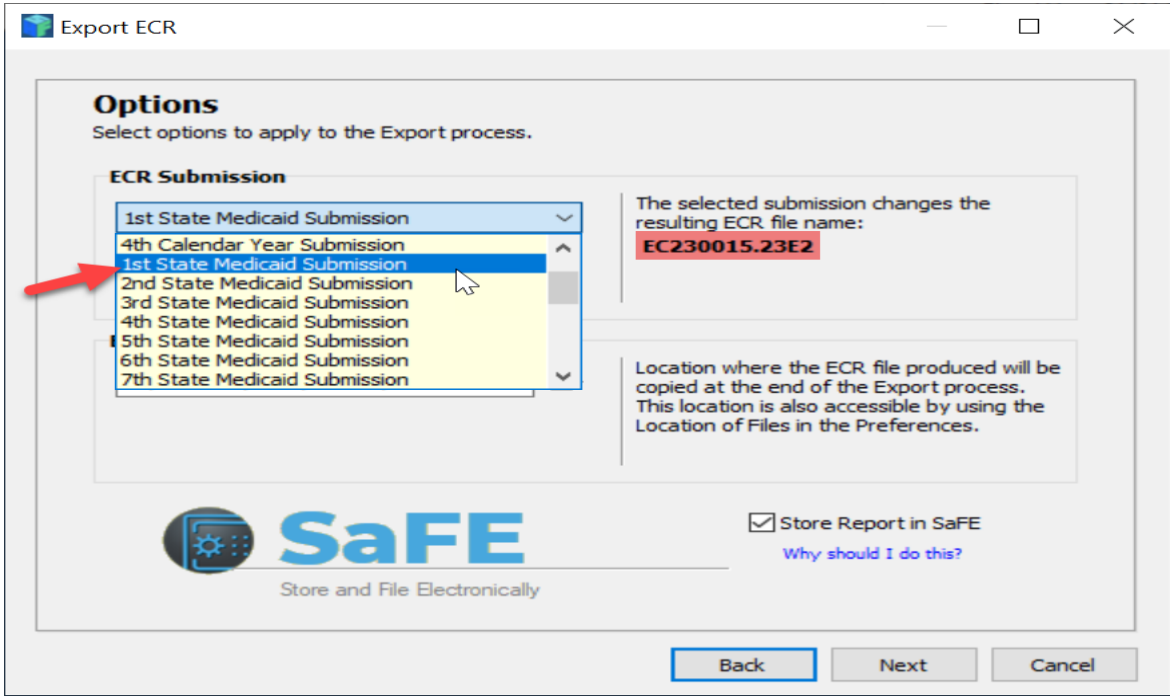
# Amended Cost Report Clarification

- **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 23A2.



# 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 23E2, 2nd would be 23F2 & we allow for 22nd XIX submission being 23Z2.



# Other Anticipated Changes

- **SNF – 2540-24 – Effective CR periods beginning 10/1/2024.**
- **OMB Renewals (no proposed changes)**
  - CMHC 2088-17
  - HO 287-22
  - OPO – 216-94 (New iteration in process 216-xx).

# Hospital 2540-10 Transmittal 10

**The SNF, 2540-10 system was updated to Transmittal 10 by CMS, on June 11, 2021. Transmittal 10 is effective for cost reporting periods that end on or after March 31, 2021.**

- **HFS was approved for Transmittal 10 on June 25, 2021.**
  - The primary change in Transmittal 10 was the assignment of line numbers to Worksheet S, Part II electronic signature data fields in order to capture information in the electronic cost report (ECR) file.
  - The Worksheet E 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 SNF-2540-10 system on June 30, 2021.**

# OPO 216-94 Transmittal 10

**The OPO, 216-94 system was updated to Transmittal 10 by CMS, on August 26, 2022.**

- **Transmittal 10 is effective for cost reporting periods that end on or after August 31, 2022.**
- **HFS was approved for Transmittal 10 on September 9, 2022.**
- **The primary purpose of the Transmittal was:**
  - To update the OMB Expiration date to 11/30/2024.
  - This transmittal also updated the sequestration calculation in accordance with §1 of Public Law 117-7, and §2 of the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA).
- **The HFS 216-94 system was updated for Transmittal 10 the week of September 12, 2022.**

# HHA 1728-20 Transmittal 5

**CMS issued Transmittal 5 to the 1728-20 on January 31st, 2024. Transmittal 4 has been issued with an effective date of Cost Reporting Periods Ending on or After December 31, 2023 and implements minor changes including:**

- Added option "H" to Worksheet S, line 4, for a no Medicare utilization HHA that provided hospice only services during the cost reporting period.
- Revised instructions for Worksheet F-1, Line 20 to enter net income or loss from investment; and enter losses as a negative amount. (Previous CMS Clarification)
- Revised instructions for Worksheet O, Line 36 to include Marriage and Family Therapist (MFT) and Mental Health Counselors (MHC) costs in accordance with the Consolidated Appropriations Act (CAA) 2023, effective for services rendered on or after January 1, 2024.
- Minor revisions to edits 1045S, 1215S, and 1030D.

- **The T-5 changes were approved by CMS on February 14, 2024 and HFS will update the HHA 1728-20 system the week of February 12th, 2024.**

# HHA 1728-20 Transmittal 6

**CMS issued Transmittal 6 to the 1728-20 on April 29th, 2024. Transmittal 6 has been issued with an effective date of Cost Reporting Periods Ending on or After January 1, 2024 and implements minor changes including:**

- Modified the Worksheet S, line 4, to specify that options “F”, “L” or “N” are reported in column 1, and added option “H” to Part I, line 4, column 2, for a HHA providing no Medicare HHA services but providing Medicare hospice services during the cost reporting period.
- Appropriate modifications were also made to the edits.

- **The T-6 changes were approved by CMS on February 14, 2024 and HFS updated the HHA 1728-20 system the week of May 13th, 2024.**

# 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 6

**The FQHC, 224-14 system was updated to Transmittal 6 by CMS, on July 28, 2023. Transmittal 6 is effective for cost reporting periods that end on or after July 31, 2023.**

- **HFS was approved for Transmittal 6 on August 25, 2023.**
  - The primary change in Transmittal 6 was the revision of Worksheet S, Part I, line 4 to add a fourth Medicare utilization option to reflect vaccines only utilization to accommodate CR 13218, dated June 7, 2023.
  - The Transmittal 6 also revised edit 1050B to accommodate the new utilization option.
- **HFS will update the FQHC 224-14 system the week of August 28, 2023.**

# FQHC 224-14 Transmittal 7

**The FQHC, 224-14 system was updated to Transmittal 7 by CMS, on February 29th, 2024. Transmittal 7 is effective for cost reporting periods that end on or after January 1, 2024.**

- **HFS was approved for Transmittal 7 on March 28, 2024.**
- **The primary change in Transmittal 7 was the implementation of services for Intensive Outpatient Program in accordance with the CAA 2023, §4124, and to add Marriage and Family Therapist (MFT) and Mental Health Counselor (MHC) to the types of practitioners available to beneficiaries for a mental health visit.**

**Specific changes include:**

- **Worksheet S-3, Part I:**
  - Added lines 23 through 26 to include the number of intensive outpatient program (IOP) visits in accordance with the CAA 2023, §4124, effective for services rendered on or after January 1, 2024.
- **Worksheet S-3, Parts II and III:**
  - Added lines 9.10 and 9.11 to Part I and lines 23.10 and 23.11 to Part II to include Marriage and Family Therapist (MFT) and Mental Health Counselor (MHC) to the types of practitioners available to beneficiaries for a mental health visit.
- **Worksheet A:**
  - Added new cost centers 31.10 for Marriage and Family Therapists and 31.11 for Mental Health Counselors.
- **Worksheet B, Part I:**
  - Added new cost centers 9.10 for Marriage and Family Therapists and 9.11 for Mental Health Counselors. Also added columns 8.01, 10.01, and 12.01 total IOP visits, Medicare IOP visits, and Medicare IOP costs.
- **Worksheet E:**
  - Revised line 1 instructions to include the IOP PPS payments for services rendered on or after January 1, 2024.
- **Worksheet E-1:**
  - Revised line 1 instructions to include the IOP PPS interim payments for services rendered on or after 1/1/2024.

**HFS updated the FQHC 224-14 system the week of April 1, 2024.**

# Hospice 1984-14 Transmittal 6

**On January 19, 2024, CMS published Transmittal 6 to Form CMS-1984-14. The new Transmittal will be effective for cost reporting periods ending on or after December 31, 2023. HFS was approved for Transmittal 6 on January 26, 2024, and**

- **Significant changes include:**
  - On Worksheet S, Part I, revised the instructions for line 4 to include no Medicare utilization status as a cost report filing type.
  - Revised the instructions for Worksheet A, line 36 to include the costs of marriage and family therapy services and mental health counseling services effective for services on or after January 1, 2024, in accordance with the Consolidated Appropriations Act of 2023, §4121 (this revision may impact Working Trial Balance and AAI reconciliations, from prior year reports.).
  - Minor revisions to edits 1050A and 2030A and added edits 1005S and 2050A.

**HFS updated the Hospice software the week of January 29, 2024.**

# RHC 222-17 Transmittal 4

**The RHC, 222-17 system was updated to Transmittal 4 by CMS, on July 28, 2023. Transmittal 4 is effective for cost reporting periods that end on or after July 31, 2023.**

- **HFS was approved for Transmittal 4 on August 30, 2023.**
- **The primary change in Transmittal 4 was the revision of Worksheet S, Part I, line 4 to add a fourth Medicare utilization option to reflect vaccines only utilization to accommodate CR 13218, dated June 7, 2023.**
  - The Transmittal 4 also revised edit 1050B to accommodate the new utilization option.
- **HFS updated the RHC 222-17 system the week of August 28th, 2023.**

# The RHC, 222-17 system was updated to Transmittal 5 by CMS, in March, 2024. Transmittal 5 is effective for cost reporting periods that end on or after January 1, 2024.

- HFS was approved for Transmittal 5 on April 2, 2024. The primary change in Transmittal 5 was to update the Rural Health Clinic (RHC) Cost Report, Form CMS-222-17, by implementing sections 4121 and 4124 of the Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328).

- HFS updated the RHC 222-17 system the week of April 8th, 2024.

# RHC 222-17 Transmittal 5 (Cont.)

**Other changes include:**

**Worksheet S-3:**

- **Added language to instructions to include Marriage and Family Therapist (MFT) and Mental Health Counselor (MHC) to the types of practitioners available to beneficiaries for a mental health visit in accordance with CAA 2023, §4121.**
- **Added lines 8 through 10 to include the number of Intensive Outpatient Program (IOP) visits in accordance with the CAA 2023, §4124.**

**Worksheet A:**

- **Revised instructions to reflect the inclusion of IOP costs on all applicable lines in accordance with the CAA 2023, §4124, effective for services rendered on or after January 1, 2024.**
- **Added two new cost centers on lines 8.10 (Marriage and Family Therapist) and 8.11(Mental Health Counselor).**

# RHC 222-17 Transmittal 5 (Cont.)

**Other changes include:**

**Worksheet B, Part I:**

- **Added lines 9.10 and 9.11 to capture MFT and MHC visits, respectively.**

**Worksheet C:**

- **Clarified the instructions for line 12 regarding the exclusion of Medicare IOP mental health visits.**
- **Added line 20.50 to include total Medicare payments for IOP services rendered.**
- **Added line 20.55 for total Medicare IOP costs.**
- **Added line 20.60 for Medicare coinsurance applicable to IOP payments.**
- **Updated the instructions for the calculation on line 21.**

**Worksheet C-1:**

- **Revised line 1 instructions to include the IOP OPPS interim payments for services rendered on or after January 1, 2024.**

# CMHC 2088-17 Transmittal 4

**The CMHC, 2088-17 system was updated to Transmittal 4 by CMS, on February 29, 2024.**

- **HFS was approved for Transmittal 4 on April, 9, 2024.**
- **The primary purpose of the Transmittal was to revise instructions and worksheets in accordance with §4124 of the Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328) to provide intensive outpatient program (IOP) services effective for services rendered on or after January 1, 2024.**
- **Specific revisions include:**
  - Acronyms and Abbreviations:
    - Revised instructions to include the acronym for IOP.
  - Worksheet S-1, Part II:
    - Revised instructions to reflect the inclusion of IOP services in accordance with the CAA 2023, §4124, effective for services rendered on or after January 1, 2024.
  - Worksheet C:
    - Revised instructions and worksheet to capture CMHC Medicare IOP costs.
  - Worksheet D:
    - Revised line 1 instructions to include the outpatient prospective payment system (OPPS) payments for IOP beneficiaries and clarified the worksheet description to include OPPS payments for CMHC services.
  - Worksheet D-1:
    - Clarified line 1 instructions to include all OPPS payments for CMHC services.
- **The HFS 2088-17 system was updated for Transmittal 4 the week of April 8, 2024.**

# 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.)<br><br>This is generally for providers reclassifying from Urban to Rural or providers with new IPF or IRF teaching programs without a previously established cap.<br><br>Possible values:<br>"IPPS"<br>"IPF"<br>"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 MAC | |
| | | A | B | HHH | | |
| 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.<br><br>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; the residency code table is now published but edits are missing which we asked for.

https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/intern-and-resident-information-system-iris

**Downloads**

IRIS XML General Instructions (PDF)

IRIS XML FTE Calculations (PDF)

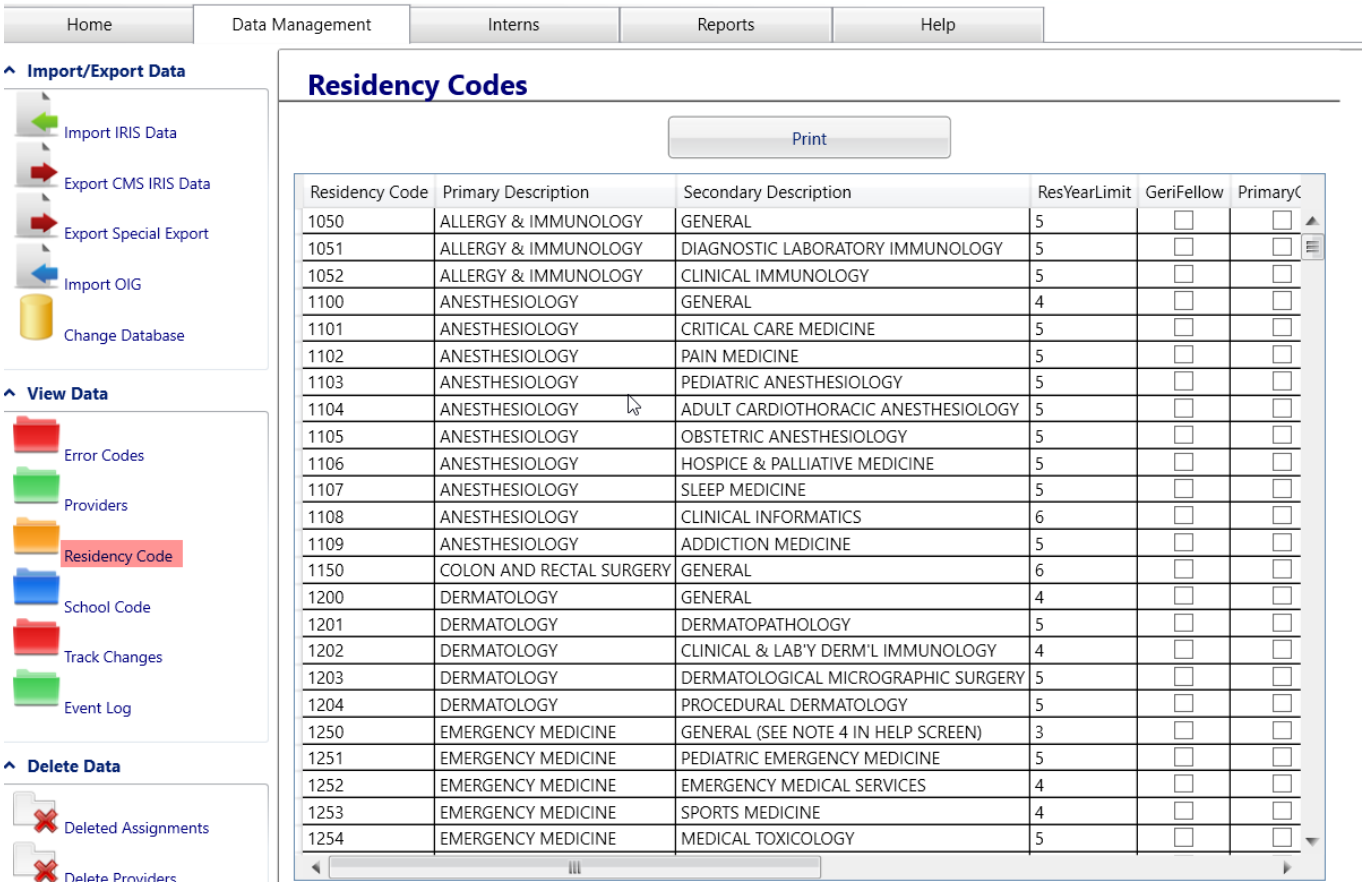
IRIS XML Format and Duplicate Interns and Residents FTEs Review (Presentation) (PDF)

IRIS XSD (ZIP)

IRIS Residency Types Reference Table 04-2024 (PDF)

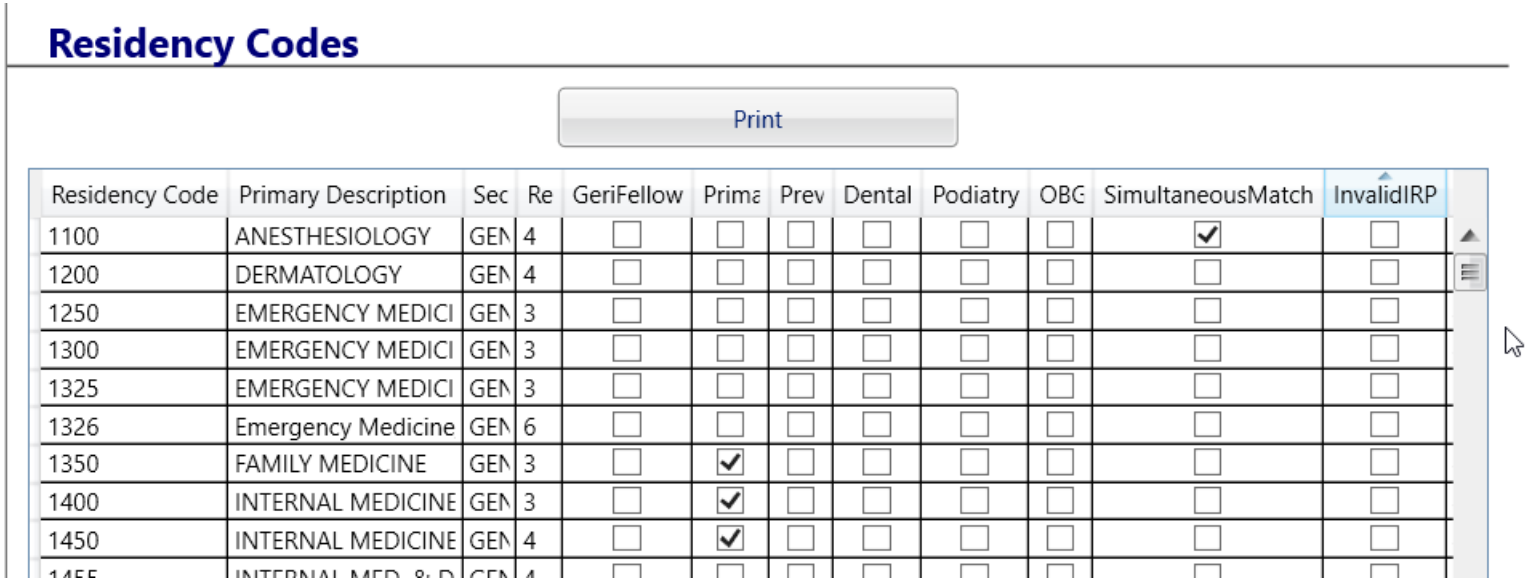
IRIS Medical School Codes List 04-2024 (PDF)

- In the HFS IRIS, you can see the Residency Code table in the Data Management tab and can select the headers to sort codes:

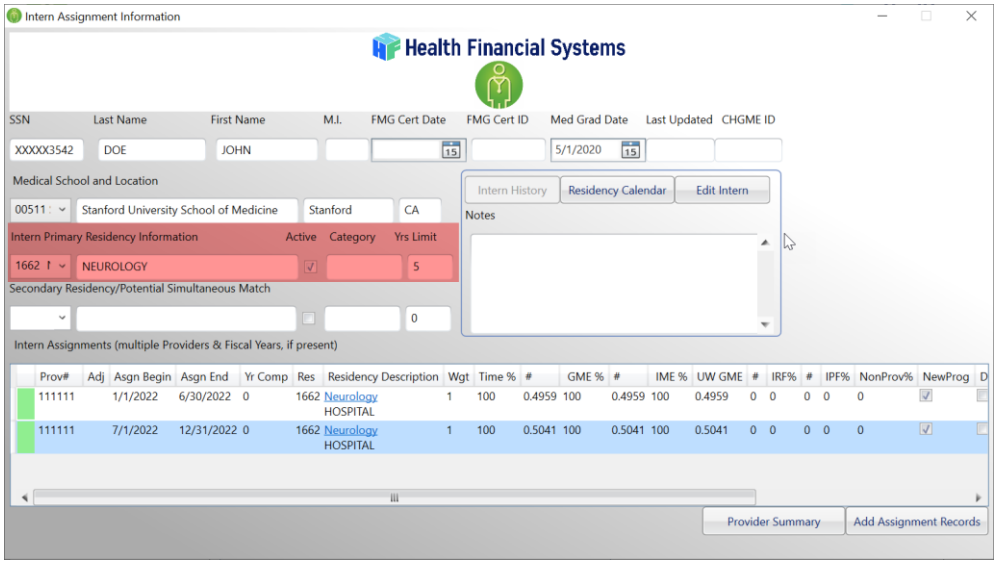



| Residency Code | Primary Description | Secondary Description | ResYearLimit | GeriFellow | PrimaryC |
|---|---|---|---|---|---|
| 1050 | ALLERGY & IMMUNOLOGY | GENERAL | 5 | ☐ | ☐ |
| 1051 | ALLERGY & IMMUNOLOGY | DIAGNOSTIC LABORATORY IMMUNOLOGY | 5 | ☐ | ☐ |
| 1052 | ALLERGY & IMMUNOLOGY | CLINICAL 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 | ☐ | ☐ |

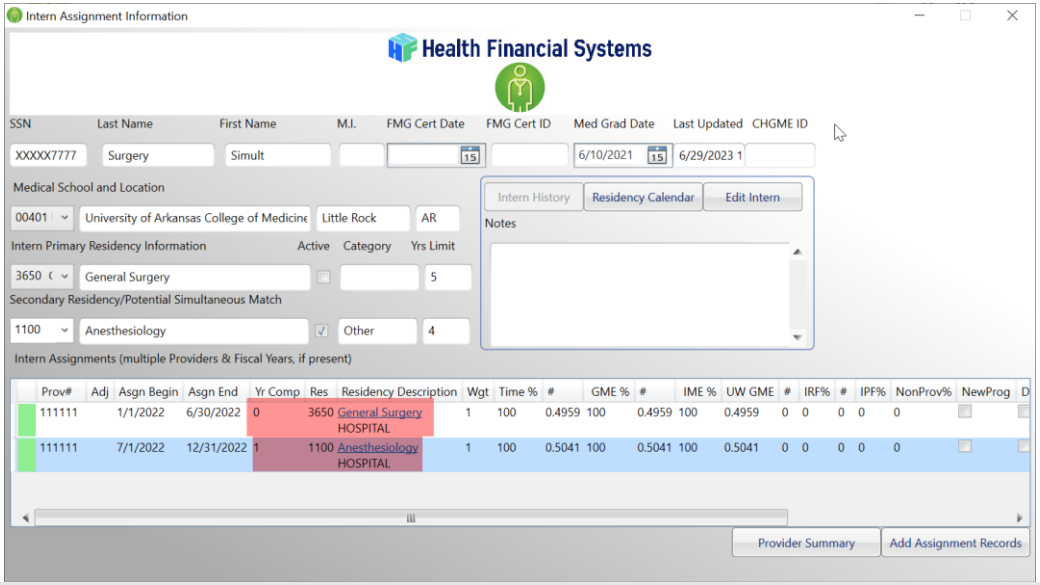
- You can print to csv or can also change the column width and header sort which is helpful:



- 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.



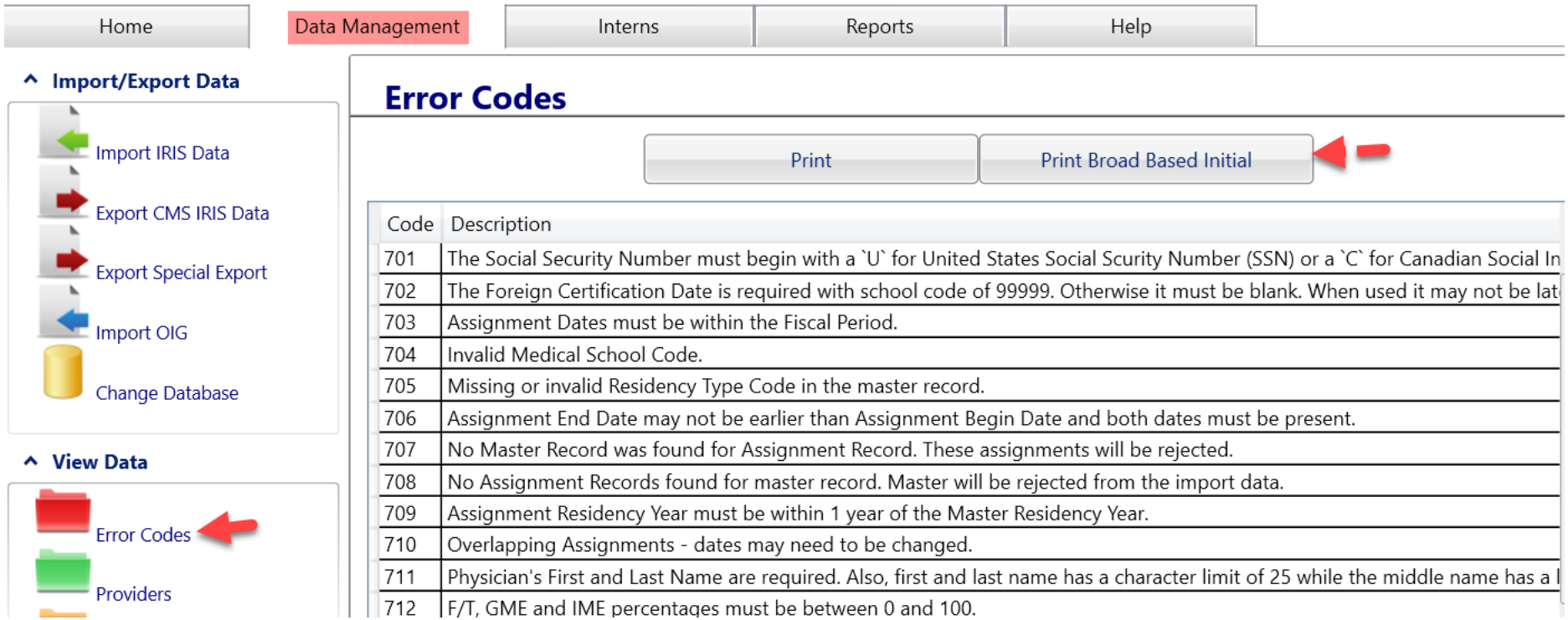

| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SSN | FNAME | MNAME | LNAME | EMPLOYEI | RESTYPCODE | nonIRPyr1SimCode | nonIRPyr1preTran | MEDSCHO | MSGRADD/ | FORCERTI | PROVNUN | 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 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:

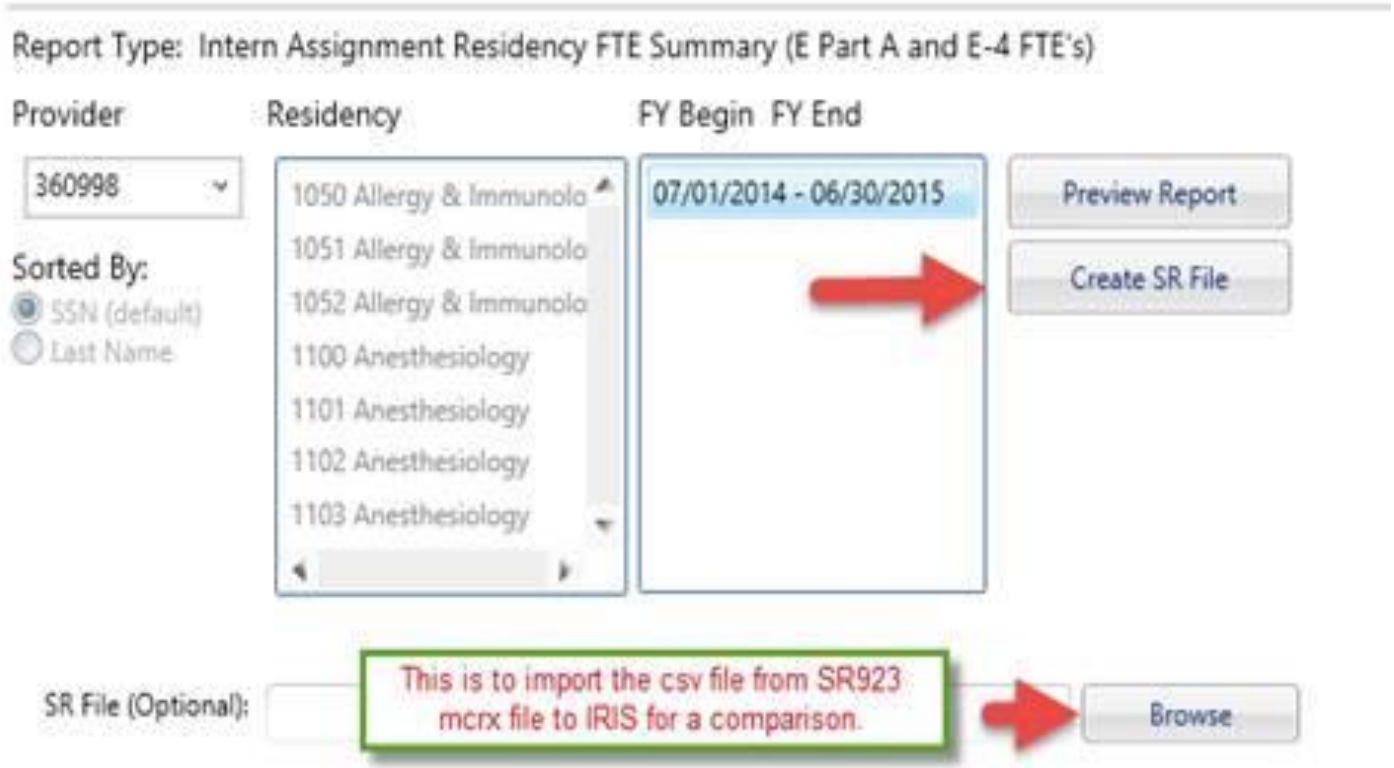
Residency Codes - Possible Valid Codes for Broad-Based Initial Training

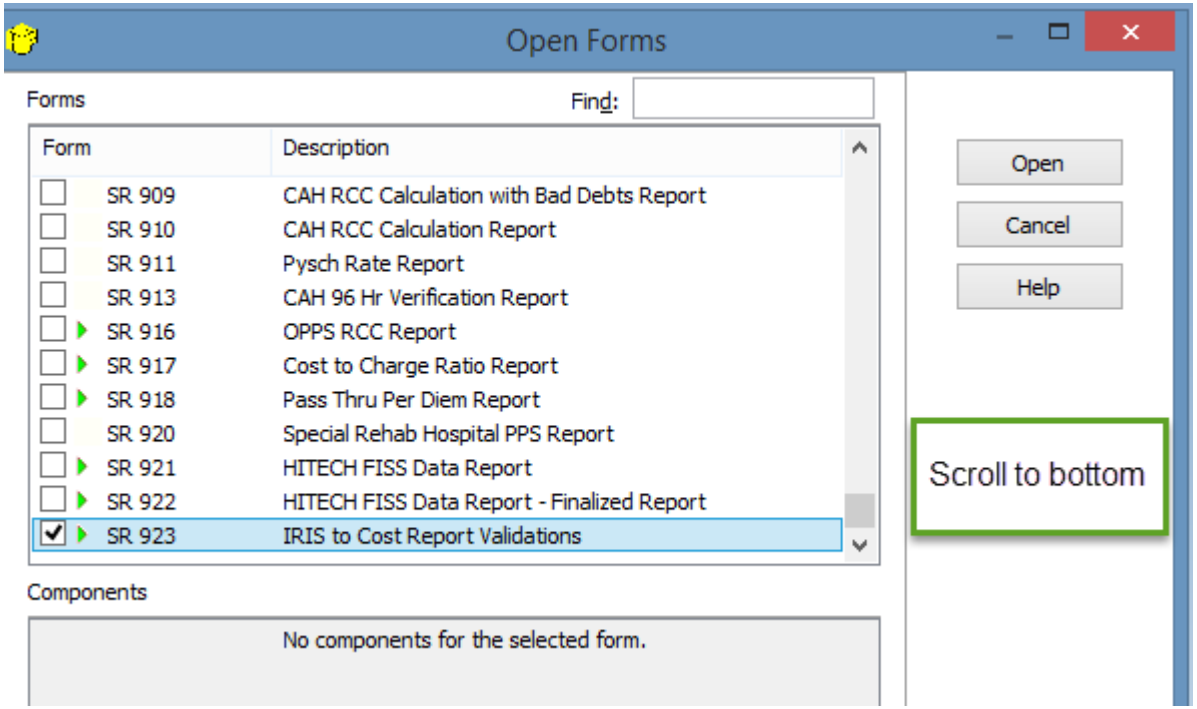
| Type | PrimDescription | SecDescription | GeriFellow | PrimaryCare | PreventMed | ResYea |
|---|---|---|---|---|---|---|
| 1250 | Emergency Medicine | General (See Note 4 In Help Screen) | False | False | False | 3.00 |
| 1350 | Family Medicine | General | False | True | False | 3.00 |
| 1400 | Internal 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 |

- To prepare for IRIS to trace to the cost report at acceptance, HFS has created a Special Report 923 (SR923) in the cost report software and in the IRIS software to run a comparison. In the MCRIF32 system (the cost report software), we issue a Level II edit relating to SR923 when the FTE count on the cost report does not agree to the IRIS FTE calculation.
- We have added the new fields to the IRIS in v6.39.0.0. We are looking into adding an extract to load data from the IRIS to the mcrx file.

- In the cost report software, the new SR923 report (can locate this thru Open Forms and scroll to the bottom) that we created in response to the CMS STAR IRIS FTE calculation. In the HFS IRIS you can export a csv file from IRIS and upload the csv file to the SR923 report.
- To get the csv from IRIS, go to reports – Residency Report and select the 3rd bullet as shown on the next slide:


Report Type: Intern Assignment Residency FTE Summary (E Part A and E-4 FTE's)
Provider
Residency
FY Begin FY End
360998
1050 Allergy & Immunolo
1051 Allergy & Immunolo
1052 Allergy & Immunolo
1100 Anesthesiology
1101 Anesthesiology
1102 Anesthesiology
1103 Anesthesiology
07/01/2014 - 06/30/2015
Preview Report
Create SR File
Sorted By:
SSN (default)
Last Name
SR File (Optional):
This is to import the csv file from SR923 mcrx file to IRIS for a comparison.
Browse


Open Forms
Forms
Find:
Form
Description
SR 909
CAH RCC Calculation with Bad Debts Report
SR 910
CAH RCC Calculation Report
SR 911
Pysch Rate Report
SR 913
CAH 96 Hr Verification Report
SR 916
OPPS RCC Report
SR 917
Cost to Charge Ratio Report
SR 918
Pass Thru Per Diem Report
SR 920
Special Rehab Hospital PPS Report
SR 921
HITECH FISS Data Report
SR 922
HITECH FISS Data Report - Finalized Report
SR 923
IRIS to Cost Report Validations
Components
No components for the selected form.
Open
Cancel
Help
Scroll to bottom

| SPECIAL REPORTS - IRIS to Cost Report Validation | | Provider CCN: | 33-0101 | Period From: | 01/01/2022 | IRIS to Cost Report Validation | |
|---|---|---|---|---|---|---|---|
| | | | | To: | 12/31/2022 | | |
| | | | | | Cost Report | IRIS | |
| | | | | 0 | 1.00 | 2.00 | |
| | **Part I - IME** | | | | | | |
| 1.00 | W/S E Part A line 10: FTE count for allopathic and osteopathic programs in the current year from your records. | | | | 1,859.26 | 0.00 | 1.00 |
| 2.00 | W/S E Part A line 11: FTE count for residents in dental and podiatric programs. | | | | 68.99 | 0.00 | 2.00 |
| 3.00 | W/S E Part A line 16: Adjustment for residents in initial years of the program. | | | | 0.00 | 0.00 | 3.00 |
| 4.00 | W/S E Part A line 17: Adjustment for residents displaced by program or hospital closure. | | | | 0.92 | 0.00 | 4.00 |
| 5.00 | W/S E-3 Part II line 6: Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". | | | | 17.47 | 0.00 | 5.00 |
| 6.00 | W/S E-3 Part II line 7: Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". | | | | 0.00 | 0.00 | 6.00 |
| 7.00 | W/S E-3 Part III line 7: Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". | | | | 4.94 | 0.00 | 7.00 |
| 8.00 | W/S E-3 Part III line 8: Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". | | | | 0.00 | 0.00 | 8.00 |
| 9.00 | Total IME FTEs | | | | 1,951.58 | 0.00 | 9.00 |
| | **Part II - Unweighted GME, Allopathic and Osteopathic** | | | | | | |
| 10.00 | W/S E-4 line 6: Unweighted resident FTE count for allopathic and osteopathic programs for the current year. | | | | 1,889.05 | 0.00 | 10.00 |
| 10.01 | W/S E-4 line 10.01: Unweighted dental and podiatric resident FTE count for the current year. | | | | 77.14 | 0.00 | 10.01 |
| 11.00 | W/S E-4 line 15.01 cols 1 & 2: Unweighted adjustment for residents in initial years of new program. | | | | 0.00 | 0.00 | 11.00 |
| 12.00 | W/S E-4 line 16.01 cols 1 & 2: Unweighted adjustment for residents displayed by program or hospital closure. | | | | 1.43 | 0.00 | 12.00 |
| 13.00 | Total Unweighted GME FTEs | | | | 1,967.62 | 0.00 | 13.00 |
| | **Part III - Weighted GME** | | | | | | |
| 14.00 | W/S E-4 line 8 Column 1: Weighted FTE count for physicians in an allopathic and osteopathic program for current year – Primary Care. | | | | 608.37 | 0.00 | 14.00 |
| 15.00 | W/S E-4 line 8 Column 2: Weighted FTE count for physicians in an allopathic and osteopathic program for current year – Other. | | | | 1,041.31 | 0.00 | 15.00 |
| 16.00 | W/S E-4 line 10 Column 2: Weighted dental and podiatric resident count for the current year. | | | | 72.45 | 0.00 | 16.00 |
| 17.00 | W/S E-4 line 15 Columns 1 and 2: Adjustment for residents in initial years of new program. | | | | 0.00 | 0.00 | 17.00 |
| 18.00 | W/S E-4 line 16 Columns 1 and 2: Adjustment for residents displaced by program or hospital closure. | | | | 0.71 | 0.00 | 18.00 |
| 19.00 | Total Weighted GME FTEs | | | | 1,722.84 | 0.00 | 19.00 |
| | **IRIS Data File** | | | | | | |
| 100.00 | Specify the IRIS CSV Data File: | | | | | Browse... | 100.00 |
| 101.00 | Compare cost report data to IRIS CSV Data File | | | | | ☑ | 101.00 |

- Then take the csv file from IRIS (will be named xxxxxx.YYYYMMDD.YYYYMMDD.SR923.csv where xxxxxx is provider # and we will have FYB and FYE identified) and open up the SR923 in the cost report and select the Browse on line 100 to import this file. We also create a csv file from the mcrx file which will be named Cost_Report_Name.SR923.csv that can be imported into the HFS IRIS Audit and Residency Reports. To import the cost report csv file, you select the Browse button shown on previous slide at the end of the SR File (Optional) section.

# Home Office 287-22 Transmittal 3

. The Home Office Cost Statement, Form CMS-287-22 Transmittal 3 was published by CMS, on March 29th, 2024.

Transmittal 3 is effective for cost reporting periods ending on or after December 31, 2023.

- The primary purpose of T-3 was to clarify that only a parent component of a Medicare-certified healthcare complex receives a home office cost allocation through the home office cost statement.
- The T-3 changes were approved by CMS on April 12, 2024.
- HFS released the Home Office Cost Statement 287-22 system on April 12, 2024

## Key items to be aware of.

- As stated on previous slide, T-3 clarified that only a parent component of a Medicare-certified healthcare complex can be included on Scheduled S-2, Part I.
- If you have components on S-2, Pts I and II or III and you are allocating cost based on pooled method (Schedule A column 8), you need to complete Schedules E and E-1, otherwise only E-1.
  - Multiple Provider Types (Dual Allocation)
  - Schedule E allocates to types (E-1 between types).

## Key items to be aware of (continued).

- If you have capital cost on Schedule A line 3, you must complete Schedule A-7.
- If you have Other Capital Cost on Schedule A lines 4 – 6 and are not directly assigning (on Schedule B), you will need to reclassify cost via A-6 based on A-7 Part II column 4 (using cols 5 – 7).

# 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.

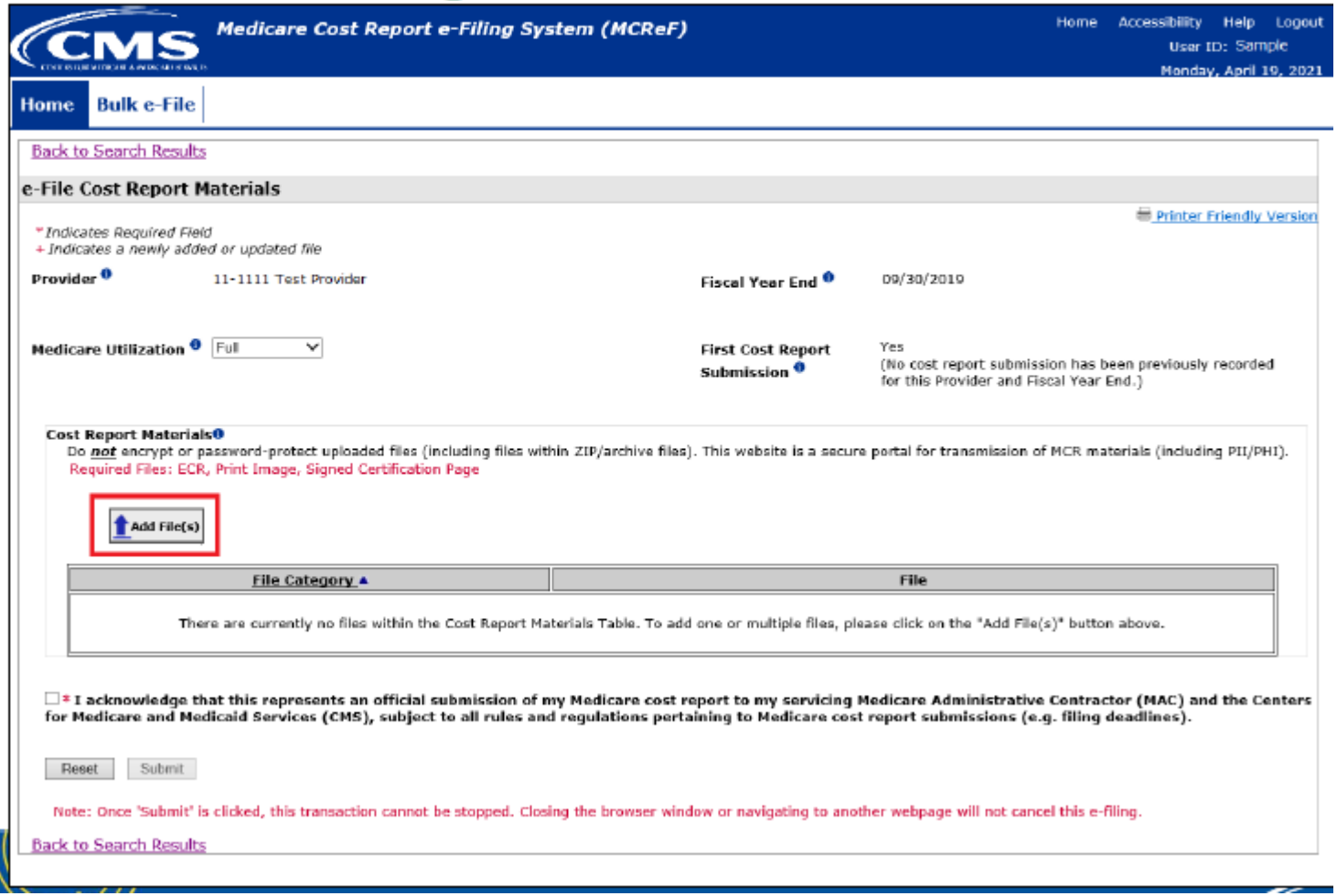
- **Transmittal 1 is effective for cost reporting periods beginning on or after October 1, 2022, was published 10/28/2022 .**
- **Transmittal 2 with the same effective date was issued April 14, 2023, with minor clarifications.**
- **Transmittal 3 is effective for cost reporting periods ending on or after December 31, 2023.**

# Electronic Signature Process

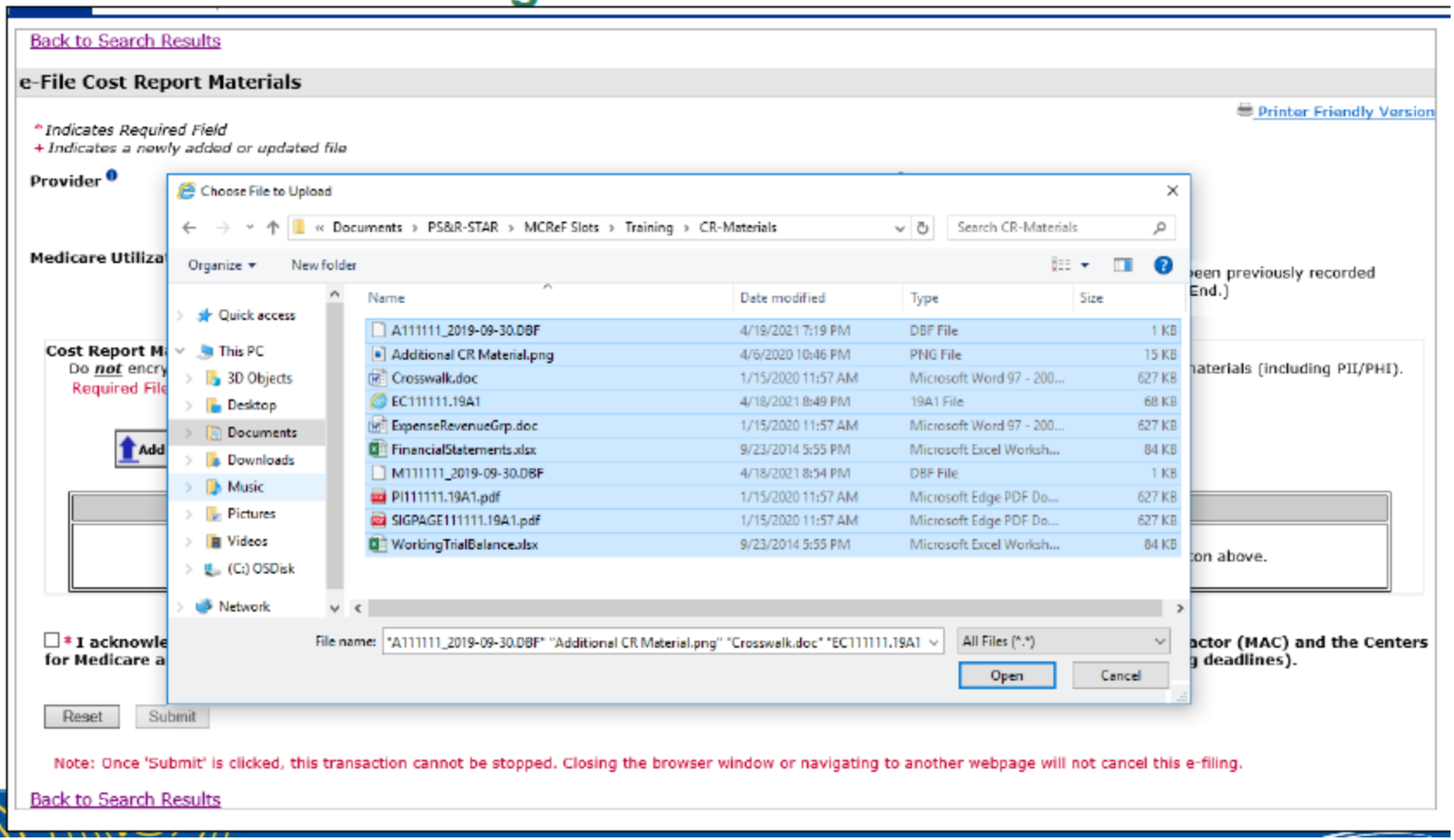
- **Electronic Signature Process begins at ECR export**
- **Three options**
  - “Wet” signature
  - Preparer completes electronic signature
  - Preparer forwards to Administrator/CFO (via email)

- **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.
  - 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
  - General Link
  - https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/medicare-cost-report-electronic-filing-mcref

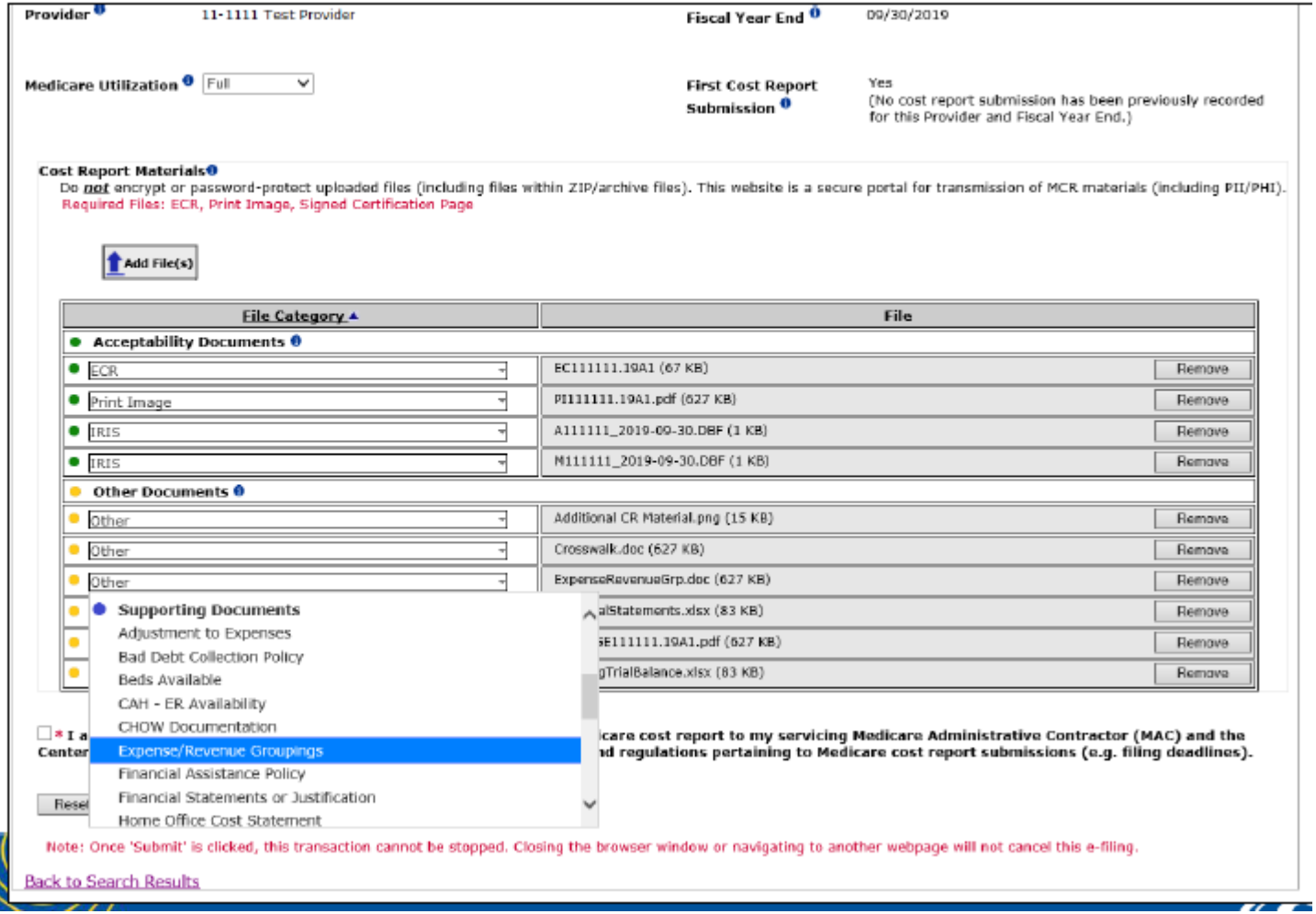
# Updated Individual e-Filing Process



# 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
  - IRIS M & A files now uploaded individually no zip file accepted.
  - XML required for FYB on or after 10/1/2021.

Health Financial Systems

# HFS Software Update

## HFMA MN Conference

November 7, 2024

Becky Dolin

Health Financial Systems

# Development

- **Monthly Update Schedule (and then some).**
- **Continued upgrade to latest Development version**
- **Printing Upgrades**

# MCRIF32 Development

- **So far this year we have issued:**
  - MCRIF32 9 Transmittals

    2 - 2552-10
    1 - 1728-20
    1 - 2088-17
    1 - 222-17
    1 - 224-14
    1 - 1984-14
    2 - 287-22

  - MCRIF32 Updates & Patches

    25 – 2552-10
    12 - 1728-20
    6 – 2088-17
    7 – 222-17
    5 – 224-14
    6 – 1984-14
    15 – 287-22
    6 – 2540-10
    4 – 265-11

# MCRIF32 Development

- **So far this year we have issued:**
  - IRIS Updates – 9
  - HCRIS Data – 3
  - WI PUF (5/23/2024)

# Example of Updated Printing

Health Financial Systems

In Lieu of Form CMS-287-22

| | | | |
|---|---|---|---|
| Provider CCN: | Period: | Run Date Time: | 8/8/2024 2:27 pm |
| | From: 10/01/2022 | MCRIF32 | 287-22 |
| | To: 09/30/2023 | Version: | 3.3.179.0 |

FUNCTIONAL ALLOCATION OF CAPITAL RELATED COSTS

**Schedule C**
**Part I**

**PART I - HEALTHCARE PROVIDER COMPONENTS**

| | COMPONENT NAME | CCN | CRC-B&F | CRC-ME | TOTAL | | |
|---|---|---|---|---|---|---|---|
| | | 0 | 1.00 | 2.00 | 3.00 | | |
| 1.00 | MOBILE NURSING SERVICES | 167157 | 0 | 0 | 0 | | 1.00 |
| 2.00 | | | 0 | 0 | 0 | | 2.00 |
| 3.00 | | | 0 | 0 | 0 | | 3.00 |
| 4.00 | | | 0 | 0 | 0 | | 4.00 |
| 5.00 | | | 0 | 0 | 0 | | 5.00 |
| 51.00 | Total | | 0 | 0 | 0 | | 51.00 |

Released in February 2024

2 presentations at 2023 User Meeting

3 webinars (last one 10/1/2024)

Health Financial Systems

# SaFE Statistics – November 2023

| November 2023 | | | | | | |
|---|---|---|---|---|---|---|
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| | | | 1 | 2 | 3 | 4 |
| | | | 40 | 37 | 25 | 3 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 4 | 38 | 61 | 53 | 47 | 32 | 8 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 4 | 68 | 95 | 120 | 115 | 156 | 21 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 4 | 211 | 297 | 253 | 1 | 38 | 18 |
| 26 | 27 | 28 | 29 | 30 | | |
| 20 | 449 | 497 | 600 | 473 | | |

| | |
|---|---|
| Total Submissions: | 3788 |
| Total Self: | 229 |
| Total Wet: | 753 |
| Total Signed: | 2602 |
| Other: | 204 |

| | Day | Number of Submissions |
|---|---|---|
| Day with most submissions: | 29 | 600 |

# SaFE Statistics May 2024

| May 2024 | | | | | | |
|---|---|---|---|---|---|---|
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| | | | 1 | 2 | 3 | 4 |
| | | | 171 | 161 | 157 | 27 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 81 | 189 | 278 | 284 | 246 | 289 | 54 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 27 | 488 | 284 | 454 | 633 | 649 | 145 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 77 | 766 | 893 | 851 | 759 | 835 | 142 |
| 26 | 27 | 28 | 29 | 30 | 31 | |
| 116 | 412 | 1711 | 2193 | 2048 | 1347 | |

| | |
|---|---|
| Total Submissions: | 16767 |
| Total Self: | 1690 |
| Total Wet: | 1951 |
| Total Signed: | 12145 |
| Other: | 981 |

| | Day | Number of Submissions |
|---|---|---|
| Day with most submissions: | 29 | 2193 |

# State Systems and Customizations

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

# 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 |

# 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?

# 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**

# MCRIF32 and HCRIS Quarterly Releases Batch Tested

- **Updates are batch tested**
  - Checks settlement amounts + key figures
  - Checks edits
  - 100 – 500 files checked mostly against HCRIS recreated data
  - MCRX systems

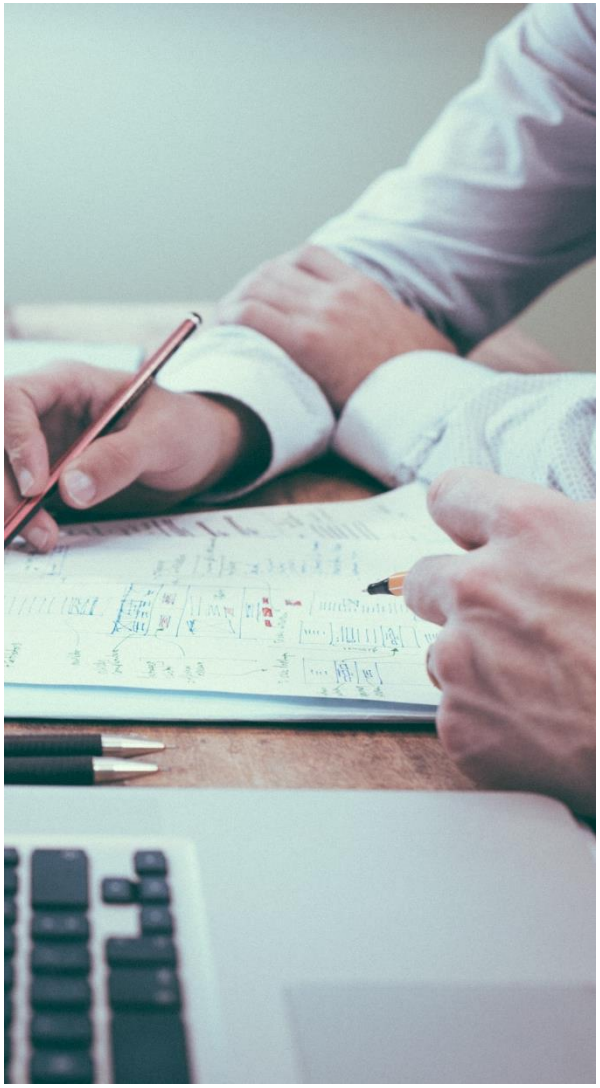
Health Financial Systems

# Advanced Online Solution for Cost Report Preparation

Built by healthcare finance professionals for healthcare finance professionals, HFS+ will be the industry's most intuitive - and simple-to-use - online cost report preparation tool.

**Health Financial Systems** (HFS) is the leader in Medicare Cost Reporting with a trusted software solution for the MAC and provider communities. Over the last 40 years the company's software has become the industry standard for hospital cost reports and estimates that 90% of all other provider type MCR's are filed using HFS software.

**At Forvis Mazars,** Healthcare Practice is the nations largest assurance, tax and consulting firms comprised of more than 1,030 professionals. Our practice's uniqueness is rooted in how we serve our clients, and our Forward Vision challenges us to Be Bold in helping unlock their full potential. From vital frontline community health centers to some of the nations largest, most complex health systems, we are proud to serve 5,200+clients across the continuum of care.



HFS started it cybersecurity program in 2014.

Prior to 2014 HFS was still concerned with security and preventing viruses, but we had not yet created a formal security policy/program.

It was a big job, starting from scratch.

Our goal was to be HIPAA and NIST 800-53 compliant.  We worked on that for several years.

HFS started receiving lots of computer security questionnaires from clients in 2017.

Vendor/Third Party Risk Management was becoming a very prevalent issue for clients.

It would be much easier if we had a certification we could share with clients.

We decided to work on a HITRUST assessment.  We hired consultants and within a year we had our HITRUST certification in 2019.

HITRUST assessments can be based on various cybersecurity laws, regulations and frameworks.

HFS HITRUST certification includes security controls from NIST (SP800-53a), HIPAA and related regulations, and the HITRUST CSF.



HFS has been HITRUST certified since 2019.

We just received our most recent certification in July.

Historically, HFS has hosted all, or almost all of its production servers on premises in the main office in Elk Grove, California.

In 2023 HFS migrated is production servers to Amazon Web Services.  AWS now hosts HFS production servers.

This virtually eliminates concerns regarding power outages, loss of ISP connections, hard drive failures and data loss because AWS architecture includes many layers of redundancy that almost eliminates these risks.

Some of the benefits of AWS cloud security:

1. Superior visibility and control of data.
2. Automated security tasks.
3. The AWS team is monitoring systems continuously, 24/7, to ensure content is constantly protected.
4. Inherit the most comprehensive compliance controls with AWS.
5. AWS supports more security standards and compliance certifications than any other offering, including FedRamp, FIPS 140-2, GDPR,HIPPA/HITECH, NIST 800-171, and PCI-DSS.

- HFS inherits the security control implemented by AWS for purposes of HITRUST assessment.
- This reduces the burden on HFS and increases the overall level of security of the data HFS stores on AWS.
- No matter how hard we may try, we probably won't make our servers more secure than AWS does.


YOUR COMPANY
AWS CLOUD SERVERS

Summary:

1. HFS takes security very seriously.
2. HFS is HITRUST certified and is required to complete a security assessment every year.
3. HFS has moved its production servers to AWS which gives HFS more capacity when we need it and is one of the most secure computing environments in the world.

# 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

# Switch to On24

- In browser testing for CPE
- Automated CPE Certificates
- Browser Only – No Downloads necessary


# August 21 - 22, 2025

# The Westin New York at Times Square

Health Financial Systems

# Thank You

## Any questions or Comments?

## Always welcome!

Becky.Dolin@HFSSOFT.com
(916)226-6269