CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4406	**Date: October 1, 2019**
	Change Request 11420

Transmittal 4357, dated August 9, 2019, is being rescinded and replaced by Transmittal 4406, dated, October 1, 2019, to revise business requirement 11420.2 to show an October 1, 2019 effective date instead of a September 30, 2019 effective date. All other information remains the same.

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020

I. SUMMARY OF CHANGES: This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update established in the "**Medicare Program; FY 2020 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2019 (FY 2020) Final Rule.** These changes are applicable to discharges occurring from October 1, 2019 through September 30, 2020 (FY 2020). This Recurring CR applies to the Claims Processing Manual (CLM), chapter 3, section 190.4.3, 190.6.1 and 190.7.2.2.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/190/4.3/Annual Update
R	3/190/6.1/Wage Index
R	3/190/7.2.2/Determining the Cost-to-Charge Ratio

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 4406	Date: October 1, 2019	Change Request: 11420

Transmittal 4357, dated August 9, 2019, is being rescinded and replaced by Transmittal 4406 dated, October 1, 2019, to revise business requirement 11420.2 to show an October 1, 2019 effective date instead of a September 30, 2019 effective date. All other information remains the same.

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

I. GENERAL INFORMATION

A. Background: On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule that established the Prospective Payment System (PPS) for Inpatient Psychiatric Facilities (IPF) under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a federal per diem base rate which includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this IPF PPS annually.

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update established in the "**Medicare Program; FY 2020 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2019 (FY 2020) Final Rule**". These changes are applicable to discharges occurring from October 1, 2019 through September 30, 2020 (FY 2020).

B. Policy: Fiscal Year 2020 Update to the IPF PPS

1. Market Basket Update:

Since the IPF PPS inception, the Office of the Actuary periodically revises and rebases the IPF market basket to reflect more recent data on IPF cost structures. We last rebased and revised the market basket applicable to IPFs in the FY 2016 IPF PPS final rule, when we adopted a 2012-based IPF-specific market-basket. For FY 2020, CMS is using the 2016-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and Electroconvulsive Therapy (ECT) payment per treatment). The 2016-based IPF market basket update for FY 2020 is 2.9 percent. However, this 2.9 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an "other adjustment" that reduces any update to the IPF market basket update by percentages specified in section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the RY beginning in 2019. For the FY beginning in 2019 (that is, FY 2020), section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage point. CMS implemented that provision in the FY 2020 IPF PPS and Quality Reporting Updates Final Rule.

In addition, section 1886(s)(2)(A)(i) of the Act requires the application of the "productivity adjustment" described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, an RY that coincides with an FY), and each subsequent RY. For the FY beginning in 2019 (that is, FY 2020), the reduction is 0.4 percentage point. CMS implemented that provision in the FY 2020 IPF PPS and Quality Reporting Updates Final Rule.

Therefore, CMS updated the IPF PPS base rate for FY 2020 by applying the adjusted market basket update of 1.75 percent (which includes the 2016-based IPF market basket update of 2.9 percent, an ACA required 0.75 percentage point reduction to the market basket update, and a required productivity adjustment reduction of .4 percentage point) and the wage index budget neutrality factor of 1.0026 to the FY 2019 Federal per diem base rate of $782.78, yielding an FY 2020 Federal per diem base rate of $798.55. Similarly, applying the adjusted market basket update of 1.75 percent and the wage index budget neutrality factor of 1.0026 to the FY 2019 ECT payment per treatment of $337.00 yields an ECT payment per treatment of $343.79 for FY 2020.

2. FY 2020 Wage Index Update

CMS finalized a policy to remove the one-year lag of the wage index data by updating the IPF PPS wage index for FY 2020 with the concurrent wage data from the FY 2020 inpatient prospective payment system wage index before reclassifications and other adjustments are taken into account, instead of using the FY 2019 inpatient prospective payment system wage index data. We implement changes to the wage index in a budget-neutral manner. Thus, there will not be an impact on aggregate Medicare payments to IPFs.

In addition, on August 15, 2017, OMB announced in OMB Bulletin No. 17–01 that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. The new urban CBSA is as follows:

• Twin Falls, Idaho (CBSA 46300).

This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho. Prior to this re-designation, Jerome County and Twin Falls County, Idaho were classified as rural. Currently, there is a single IPF in new CBSA 46300 (provider 13S002), which will lose its 17 percent rural adjustment as a result of being re-designated as urban.

The FY 2020 final IPF PPS wage index is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

3. Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary shall reduce any annual update to a standard Federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied when calculating the Federal per diem base rate and the ECT payment per treatment as follows:

- The adjusted market basket update of 1.75 percent (which includes the 2016-based IPF market basket update of 2.9 percent, an ACA required 0.75 percentage point reduction to the market basket update, and a required productivity adjustment reduction of .4 percentage point) is reduced by 2.0

percentage points, for a negative update of -0.25 percent for IPFs that failed to meet quality reporting requirements.

- For IPFs that failed to submit quality reporting data under the IPFQR program for FY 2020, the -0.25 percent update and the wage index budget neutrality factor of 1.0026 are applied to the FY 2019 Federal per diem base rate of $782.78, yielding a Federal per diem base rate of $782.85.

- Similarly, for IPFs that failed to submit quality reporting data under the IPFQR program for FY 2020, the -0.25 percent update and the wage index budget neutrality factor of 1.0026 are applied to the FY 2019 ECT payment per treatment of $337.00, yielding a per treatment ECT payment of $337.03 for FY 2020.

4. PRICER Updates: IPF PPS Fiscal Year 2020 (October 1, 2019 – September 30, 2020):

- The Federal per diem base rate is $798.55 for IPFs that complied with quality data submission requirements.
- The Federal per diem base rate is $782.85, when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.
- The fixed dollar loss threshold amount is $14,960.
- The IPF PPS wage index is based on the FY 2020 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 76.9 percent.
- The non-labor related share is 23.1 percent.
- The ECT payment per treatment is $343.79 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $337.03 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

5. Provider Specific File (PSF) Updates:

The FY 2020 IPF PPS wage index uses the most recent OMB statistical area delineations to identify a facility's urban or rural status for the purpose of determining if a rural adjustment will apply to the facility. As noted in section 2 above, provider 13S002 is newly designated as urban instead of as rural and is in a new CBSA 46300.

For FY 2020, no IPFs should have any special pay indicators or receive any wage index value other than those given in the FY 2020 IPF PPS wage index.

Medicare Administrative Contractors (MACs) shall update the PSF as necessary.

6. The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2020

See Attachment One: “National Cost to Charge Ratios (CCRs)”

7. ICD-10 CM/PCS Updates

For FY 2020, the IPF PPS adjustment factors are unchanged from those used in FY 2019. However, CMS updated the ICD-10-CM/PCS code set, effective October 1, 2019. These updates affect the ICD-10-CM/PCS codes that underlie the IPF PPS MS-DRGs and the IPF PPS comorbidity categories. The updated FY 2020 MS-DRG code lists are available on the IPPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html , and the updated FY 2020 IPF PPS comorbidity categories are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html . There were no changes from FY 2019 to FY 2020 to the IPF Code First list or the IPF Electroconvulsive Therapy procedure code list.

8. COLA Adjustment

The IPF PPS Cost of Living Adjustment (COLA) factors list for FY 2020 was unchanged from FY 2019. See **Attachment One**: "Cost of Living Adjustments (COLAs)."

9. Rural Adjustment

For FY 2020, IPFs designated as "rural" continue to receive a 17 percent rural adjustment.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11420.1	FISS shall install and pay claims with the FY 2020 IPF PPS Pricer for discharges occurring on or after October 1, 2019.					X				
11420.2	Medicare Contractors shall perform the updates as outlined in the policy section, item 5 "Provider Specific File (PSF) Updates" of this notification. Medicare Contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 1, 2019.	X								
11420.3	CMS shall ensure that the IPF PPS Pricer includes all FY 2020 IPF PPS updates.									CMS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11420.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Katherine Lucas, 410-786-7723 or katherine.lucas@cms.hhs.gov (back-up) , Sherlene Jacques, 410-786-0510 or sherlene.jacques@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

190.4.3 - Annual Update

(Rev.4406, Issued: 10-01-19, Effective: 10-01-19, Implementation: 10-07-19)

Prior to rate year (RY) 2012, the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) was on a July 1st - June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006 and every July 1*st* thereafter.

Effective with RY 2012, the IPF PPS payment rate update period switched from a rate year that began on July 1st ending on June 30th to a period that coincides with a fiscal year (FY). To transition from a RY to a FY, the IPF PPS RY 2012 covered the15 month period from July 1st -September 30th. This change to the payment update period will allow one consolidated annual update to both the rates and the ICD-10-CM/PCS coding changes (MS-DRG, comorbidities, and code first). Coding and rate changes will continue to be effective October 1st-September 30th of each year thereafter.

In accordance with 42 CFR 412.428, the annual update includes revisions to the Federal per diem base rate, the hospital wage index, ICD-10-CM coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) payment per treatment, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

Below are the Change Requests (CRs) for the applicable Rate Years (RYs) and Fiscal Years (FYs), which are issued via a Recurring Update Notification.

RY 2009 - CR 6077
RY 2010 - CR 6461
RY 2011 - CR 6986
RY 2012 - CR 7367
FY 2013 - CR 8000
FY 2014 - CR 8395
FY 2015 - CR 8889
FY 2016 - CR 9305
FY 2017 - CR 9732
FY 2018 - CR 10214
FY 2019 - CR 10880
FY 2020 - CR 11420

Change Requests can be accessed through the following CMS Transmittals Website:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Inpatient-Psychiatric-Facility-PPS-Transmittals.html

190.6.1 - Wage Index

(Rev.4406, Issued: 10-01-19, Effective: 10-01-19, Implementation: 10-07-19)

The wage index accounts for the geographic differences in labor costs. *Prior to Fiscal Year 2020, the IPF PPS used the unadjusted, pre-floor, pre-reclassified hospital wage index from the prior year as the basis for the IPF wage index. Beginning with Fiscal Year 2020, t*he IPF PPS uses the *concurrent* unadjusted, pre-floor, pre-reclassified hospital wage index *as the basis for the IPF wage index*. The wage index is applied to the labor-related share of the Federal per diem base rate.

Core-Based Statistical Area (CBSA) designations are used for assigning a wage index value for discharges occurring on or after *October 1*. Updates to the IPF PPS wage index are made in a budget neutral manner. CMS calculates a budget-neutral wage index adjustment factor by comparing estimated payments under the previous wage index to estimated payments under the updated wage index. This factor is applied in the update to the Federal per diem base rate.

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev.4406, Issued: 10-01-19, Effective: 10-01-19, Implementation: 10-07-19)

For discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine the IPF's CCR. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals:

1) Identify total Medicare costs from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

Distinct Part Units

For IPFs that are distinct part psychiatric units:

1) Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IPF unit that has the letter "S" or "M" in the third position of the Medicare provider number.

A. - Use of Alternative Data in Determining CCRs For IPFs Subject to the IPF PPS

Under 42 CFR 412.424(d)(3)(i,), for discharges in cost reporting periods beginning on or after January 1, 2005, CMS may direct Medicare contractors to use an alternative CCR to the CCRs from the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data.

B. - Request by the IPF for use of a Different CCR

For discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may request that an alternative CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request after evaluation by the Medicare contractor of the evidence presented by the IPF. Revised CCRs are applied prospectively to all IPF claims. Medicare contractors shall send notification to the CMS Central Office via the following address and e-mail address:

CMS
C/O Division of Chronic Care Management-IPF Outlier Team
7500 Security Blvd.
Mail Stop C5-05-27
Baltimore, MD. 21244
outliersipf@cms.hhs.gov

C. - Application of National *Median* CCRs for IPFs

For discharges in cost reporting periods occurring on or after January 1, 2005, the Medicare contractor may use the national CCRs for an IPF in one of the following circumstances:
1. New IPFs that have not yet submitted their first Medicare cost report.
2. IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
3. Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using the national *median* CCRs until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

NOTE: IPF PPS provides two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.

The policies in section E below can be applied as an alternative to the national *median* CCR.
For those IPFs assigned the national *median* CCR, the CCR must be updated every *October* 1st based on the latest national *median* CCRs published in each year's IPF *PPS notice or final rule* until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D. - Notification to IPFs Under the IPF PPS of a Change in the CCR

The Medicare contractor shall notify an IPF whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to an IPF about a change to their CCR(s).

E. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Entities Subject to the IPF PPS

For discharges beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentatively settled cost report (whichever is from the later period) to determine the IPF's CCR. Under the IPF PPS, Medicare contractors must update the IPFs CCR on the Provider Specific File to reflect the IPFs CCR from the most recent tentative settlements or final settled cost reports, (whichever is the later period). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

Subject to the approval of CMS, an IPF's CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all IPF PPS claims processed after the update.

F. - Alternative CCRs

Effective for discharges in cost reporting periods beginning on or after January 1, 2005, the CMS Central Office may direct Medicare contractors to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office and CMS Central Office must approve any such request after evaluation by the Medicare contractor of the evidence presented by the IPF.

G. - IPF Mergers, Ownership Changes, and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IPF with the surviving provider number. If a new provider number (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement) is issued the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact CMS Central Office to seek guidance. Medicare contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Contractors shall contact the CMS regional and Central Office for further instructions. Contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

H. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 - Operating Cost to Charge Ratio and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

Attachment 1
FY 2020 Final IPF PPS Rates and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$798.55
Labor Share (76.9%)	$614.08
Non-Labor Share (23.1%)	$184.47

Per Diem Rate Applying the 2 Percentage Point Reduction

Federal Per Diem Base Rate	$782.85
Labor Share (76.9%)	$602.01
Non-Labor Share (23.1%)	$180.84

Fixed Dollar Loss Threshold Amount:

$14,960

Wage Index Budget-Neutrality Factor:

1.0026

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	FY 2020 Pre-floor, Pre-reclass IPPS Hospital Wage Index

Cost of Living Adjustments (COLAs):

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25

Area	Cost of Living Adjustment Factor
County of Maui and County of Kalawao	1.25

Patient Adjustments:

ECT – Per Treatment	$343.79
ECT – Per Treatment Applying the 2 Percentage Point Reduction	$337.03

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a Qualifying Emergency Department	1.19
Day 1 -- Facility With a Qualifying Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

DRG Adjustments:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficit	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13
Drug/Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings – Digestive & Urinary	1.08
Severe Musculoskeletal & Connective Tissue Diseases	1.09
Poisoning	1.11

National Median and Ceiling Cost-to-Charge Ratios (CCRs)

CCRs	Rural	Urban
National Median	0.5720	0.4370
National Ceiling	2.0239	1.7263