

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 14000	Date: October 8, 2026
	Change Request 14591

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet.

Transmittal 13920 issued September 11, 2026, is being rescinded and replaced by Transmittal 14000, dated October 8, 2026, to clarify language regarding calculation of an IPF's FTE resident cap if slots were awarded under section 4122 of the Consolidated Appropriations Act of 2023 by updating the IOM. All other information remains the same.

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2027

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to identify changes that are required as part of the annual IPF PPS update established in IPF Final Rule titled, “**Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update**” and “**Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System–Rate Update; Correction.**” These changes are applicable to discharges occurring from October 1, 2026, through September 30, 2027 (FY 2027). This recurring CR applies to the Claims Processing Manual (CPM), chapter 3, section 190.

EFFECTIVE DATE: October 1, 2026

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 5, 2026

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	190.4.3 - Annual Update
R	3/190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap
R	3/190.7.2.1 - How to Calculate Outlier Payments
R	3/190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

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: 14000	Date: October 8, 2026	Change Request: 14591
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II. 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.

In addition, section 4125 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328), which amended section 1886(s) of the Act, requires CMS to revise the Medicare PPS for psychiatric hospitals and psychiatric units. Specifically, section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 requires that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for rate year 2025 (FY 2025).

This CR identifies changes that are required as part of the annual IPF PPS update established in IPF Final Rule titled, "**Medicare Program; FY 2027 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update.**" These changes are applicable to discharges occurring from October 1, 2026, through September 30, 2027 (FY 2027).

B. Policy: Fiscal Year 2027 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. In the FY 2024 IPF PPS final rule, CMS rebased and revised the market basket applicable to IPFs and adopted a 2021-based IPF-specific market basket. For FY 2027, CMS is using the 2021-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 2021-based IPF market basket update for FY 2027 is 3.2 percent. However, this 3.2 percent is subject to one reduction required by the Social Security Act (the Act), as described below.

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 Rate Year (RY) beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent RY. For the FY beginning in 2026 (that is, FY 2027), the reduction is 0.9 percentage point. CMS implemented that provision in the FY 2027 IPF PPS Final Rule.

Therefore, CMS updated the IPF PPS base rate for FY 2027 by applying the adjusted market basket update of 2.3 percent (which includes the 2021-based IPF market basket update of 3.2 percent and a productivity adjustment reduction of 0.9 percentage point), and the wage index budget neutrality factor of 0.9986 to the FY 2026 Federal per diem base rate of \$892.87, yielding an FY 2027 Federal per diem base rate of \$912.13.

Similarly, applying the adjusted market basket update of 2.3 percent, and the wage index budget neutrality factor of 0.9986 to the FY 2026 ECT payment per treatment of \$673.85 yields an ECT payment per treatment of \$688.38 for FY 2027.

2. FY 2027 Wage Index Update

CMS continued its policy from the prior FY of updating the IPF PPS wage index for FY 2027, with the concurrent wage data from the FY 2027 inpatient PPS wage index before reclassifications and other adjustments are considered.

The FY 2027 final IPF PPS wage index is available online at:

<https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/wage-index>.

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 FY 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 FY, 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 2.3 percent (which includes the 2021-based IPF market basket update of 3.2 percent and a required productivity adjustment reduction of 0.9 percentage point) is reduced by 2.0 percentage points, for an update of 0.3 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 2027, the 0.3 percent update, and the wage index budget neutrality factor of 0.9986 are applied to the FY 2026 Federal per diem base rate of \$892.87, yielding a Federal per diem base rate of \$894.29.

- Similarly, for IPFs that failed to submit quality reporting data under the IPFQR program for FY 2027, the 0.3 percent update, and the wage index budget neutrality factor of 0.9986 are applied to the FY 2026 ECT payment per treatment of \$673.85, yielding a per treatment ECT payment of \$674.93 for FY 2027.

4. PRICER Updates: IPF PPS Fiscal Year 2027 (October 1, 2026 – September 30, 2027):

- The Federal per diem base rate is \$912.13 for IPFs that complied with quality data submission requirements.
- The Federal per diem base rate is \$894.29, 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 \$40,750.
- The IPF PPS wage index is based on the FY 2027 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 78.9 percent.
- The non-labor related share is 21.1 percent.
- The ECT payment per treatment is \$688.38 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is \$674.93 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

5. Provider Specific File (PSF) Updates

Effective beginning FY 2023, a permanent five percent cap was adopted and applied to all IPF providers on any decrease to a provider's final wage index from that provider's final wage index of the prior FY. Under the five percent cap policy, a new IPF that opens during FY 2027 would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied, because a new IPF would not have a wage index in the prior FY.

In addition, we are continuing our policy to phase out the rural adjustment for IPFs that became urban in FY 2025, because of the adoption of the revised Core-Based Statistical Area (CBSA) delineations based on Office of Management and Budget (OMB) Bulletin 23–01. Under this transition policy, these IPFs will not receive a rural adjustment for FY 2027.

To implement these policies for FY 2027, the following fields will be updated in the PSF:

- **Supplemental Wage Index** - used for the prior fiscal year wage index value
- **Supplemental Wage Index Indicator** - used to indicate the value in the "Supplemental Wage Index" field is the prior fiscal year wage index.

Medicare administrative contractors must update the "Supplemental Wage Index" and "Supplemental Wage Index Indicator" for all providers that were active in FY 2026.

Medicare administrative contractors must follow the steps below to ensure the appropriate values are applied in the Supplemental Wage Index and Supplemental Wage Indicator fields:

1. If the provider was not active for FY 2026, then skip all of the below steps and leave the "Supplemental Wage Index" and "Supplemental Wage Index Indicator" fields blank. If the provider was active for FY 2026, then follow the steps below.
2. Validate the accuracy of the provider's FIPS state and county codes.
3. Identify the FY 2026 IPF wage index calculated by the pricer software and used to pay claims for each provider in FY 2026, and add this wage index value to "Supplemental Wage Index" field.
4. If the provider's "Supplemental Wage Index Indicator" for FY 2026 was "3", then update the value of "Supplemental Wage Index Indicator" to be "1". For all other providers that were active for FY 2026, update the value of "Supplemental Wage Index Indicator" to be "1".

6. The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2027

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

7. International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System (ICD-10 CM/PCS) Updates

For FY 2027, CMS updated the ICD-10-CM/PCS code set, effective October 1, 2026. These updates affect the ICD-10-CM/PCS codes that underlie the IPF PPS Medicare Severity Diagnosis-Related Groups (MS-DRGs) and the IPF PPS comorbidity categories. The updated FY 2027 MS-DRG code lists are available on the IPPS website at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps>, and the updated FY 2027 IPF PPS comorbidity categories are available at <https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility-pps/inpatient-psychiatric-facilities-pps-files>.

There were no changes for FY 2027 to the IPF ECT procedure code list.

8. Cost of Living Adjustment (COLA) Adjustment

The IPF PPS COLA factors for FY 2027 were updated consistent with those applied under the IPPS in FY 2027.

- See **Addendum A** section titled, “Cost of Living Adjustments (COLAs).”

9. Rural Adjustment

For FY 2027, IPFs designated as “rural” will receive an 18 percent rural adjustment. In addition, as discussed in the FY 2025 IPF PPS Final Rule, we phased out the rural adjustment for IPFs that became urban in FY 2025 because of the adoption of the revised CBSA delineations based on OMB Bulletin 23–01. Affected providers will not receive a rural adjustment for FY 2027.

III. 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	
14591.1	Medicare contractors shall perform the updates as outlined in the policy section, item 6 “PSF Updates” of this notification.	X								
14591.1.1	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 1, 2026.	X								
14591.2	As specified in publication 100-04, Medicare Claims Processing Manual, chapter 3, section 20.2.3.1, Medicare contractors shall maintain the	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	accuracy of the data and update the PSF file as changes occur in data element values.									
14591.3	CMS shall ensure that the IPF PPS Pricer includes all FY 2027 IPF PPS updates.									IPF Pricer, PCS
14591.4	Contractors shall access the IPF PPS Pricer via the Cloud to pay FY 2027 payment rates on claims with discharge dates on or after October 1, 2026.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors:

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Amy Miller, 410-786-8213 or amy.miller@cms.hhs.gov , Nick Brock, 410-786-5148 or nicolas.brock@cms.hhs.gov

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

VII. 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. 14000; Issued: 10-08-2026; Effective: 10-01-26; Implementation: 10-05-26)

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 1st 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 the 15 month period from July 1st -September 30th. This change to the payment update period allowed 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
FY 2021 – CR 11949
FY 2022- CR 12417
FY 2023 – CR 12859
FY 2024 – CR 13335
FY 2025 – CR 13766
FY 2026 – CR *14206*
FY 2027 – CR 14591

Change Requests can be accessed through the following CMS Transmittals Website:
<https://www.cms.gov/medicare/regulations-guidance/transmittals>

190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap

(Rev. 14000; Issued: 10-08-2026; Effective: 10-01-26; Implementation: 10-05-26)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. There is no limit to the number of residents teaching institutions can hire or train. There is only a limit to the number of residents who may be counted in calculation of the IPF PPS teaching adjustment. The cap is the number of FTE residents that trained in the IPF during a base year. The cap may be increased by the number of FTE residents awarded to the IPF under section 4122 of the CAA, 2023.

An IPF's FTE resident cap is determined based on the IPF's most recently filed cost report, filed prior to November 15, 2004. IPFs that first began training residents after November 15, 2004, will initially receive an FTE cap of zero. The FTE caps for new IPFs (as well as existing IPFs) that start training residents in a new DGME program (as defined in 42 CFR 413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in 42 CFR 412.424(d)(1)(iii)(B)(2)). *In addition, effective beginning July 1, 2026*, an IPF's FTE resident cap may also be increased by the number of resident FTE slots awarded *by CMS* under section 4122 of the *Consolidated Appropriations Act of 2023 (Pub. L. 117-328)*, either to an IPF hospital or to an IPPS hospital for resident FTEs that are allocated to the IPF subunit paid under the IPF PPS.

IPFs are not permitted to aggregate the FTE resident caps used to compute the IPF PPS teaching status adjustment through affiliation agreements. Residents with less than fulltime status and residents rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IPF (for example, a resident on a full-time, 3-month rotation to the IPF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS Indirect Medical Education (IME) adjustment is allowed to be counted for purposes of the teaching status adjustment under the IPF PPS.

The denominator used to calculate the teaching status adjustment under the IPF PPS is the IPF's ADC from the current cost reporting period. If IPFs have more FTE residents in a given year than their FTE resident cap, payments are based on the lower number (the cap amount) in that year. If an IPF were to have fewer FTE residents in a given year than its FTE resident cap, an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility trains).

190.7.2.1 - How to Calculate Outlier Payments

(Rev. 14000; Issued: 10-08-2026; Effective: 10-01-26; Implementation: 10-05-26)

1 - Calculate the Adjusted Fixed Dollar Loss Threshold Amount

- Multiply the threshold amount by the labor share and the area wage index;
- Multiply the threshold amount by the non-labor share and any applicable COLA (Alaska or Hawaii);
- Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural); and
- Add this amount to the sum of the Federal per diem payment and ECT payment to obtain the adjusted threshold amount.

2 - Calculate Eligible Outlier Costs

- Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.

- Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.
- Divide this amount by the length of stay to calculate the per diem outlier amount.
- For days 1 through 9, multiply this per diem outlier amount by 0.80. For day 10 and thereafter, multiply the per diem outlier amount by 0.60. The sum of these amounts is the total outlier payment *for claims with discharges before October 1, 2027. For claims with discharges on or after October 1, 2027, the sum of these amounts is the total outlier payment before application of the outlier cap.*

3 - Calculate Outlier Cap

- *For claims with discharges on or after October 1, 2027, determine the number of IPF PPS stays during the facility's cost reporting period.*
- *If the facility's number of IPF PPS stays is less than 50, the outlier cap does not apply. The outlier payment is the amount calculated in Step 2 above.*
- *If the number of stays is greater than or equal to 50, calculate the facility's outlier cap following the instructions in this step (Step 3).*
- *For claims with discharges on or after October 1, 2027, calculate the facility's total IPF PPS payments excluding outlier payments for all discharges occurring during the cost reporting year.*
- *Divide the facility's total IPF PPS non-outlier payments by 80 percent (0.8) to determine the maximum allowable total IPF PPS payment amount (including outlier payments and non-outlier payments).*
- *Subtract the facility's maximum allowable total IPF PPS payments from its actual total IPF PPS payment amount. If the result of this calculation is greater than 0, then the facility's total outlier payments exceed 20 percent of its total IPF PPS payments. The result of this calculation is the outlier cap.*

4 - Calculate Outlier Payment

- *For claims with discharges on or after October 1, 2027, if the facility has 50 or more stays in the cost reporting period and the facility's total outlier payments exceed the 20 percent cap, reduce the total outlier payment calculated in Step 2 by the result of the calculation in Step 3.*
- *If the outlier cap does not apply to the facility according to the determination in Step 3, the outlier payment is the payment calculated in Step 2.*

190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 14000; Issued: 10-08-2026; Effective: 10-01-26; Implementation: 10-05-26)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IPF is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §190.7.2.2 (B), and CMS Regional Office that a hospital has met the criteria for reconciliation.

Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, *the number of IPF PPS stays, and* the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

- 2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE:** Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.
- 3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §190.7.2.2 (B)) that the hospital's outlier claims are to be reconciled.
- 4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.
- *NOTE:** The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).
- 5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.
- 6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:
- Type of Bill (TOB) equals 11X
 - Previous claim is in a paid status (P location) within FISS
 - Cancel date is 'blank'
- 7) The Medicare contractor reconciles the claims through the IPF Pricer software and not through any editing or grouping software.
- 8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE:** The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).
- 9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.
- 10) For hospitals paid under the IPF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider.
- 11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §190.7.2.4. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is

also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE:** The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 255296, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.09, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 5053, of Worksheet E-3, Part 1 of the cost report (**NOTE:** the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines please see § 3633.1 of the Provider Reimbursement Manual, Part II.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part II line 2, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 5053, of Worksheet E-3, Part II of the cost report (**NOTE:** the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 29 of Worksheet E-3, Part II.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPF PPS, Medicare contractors shall enter the original CCR in PSF field 25 Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §190.7.2.2 (B) with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract	
Provider #	
Health Insurance Claim (HIC) Number	
Document Control Number (DCN)	
Type of Bill	
Original Paid Date	
Statement From Date	

Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
List of Data Elements for FISS Extract
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts

Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP)
Reason Code
HMO-IME Indicator
Filler

Addendum A
FY 2027 IPF PPS Final Rates and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	\$912.13
Labor Share (78.9%)	\$719.67
Non-Labor Share (21.1%)	\$192.46

Per Diem Rate Applying the 2 Percentage Point Reduction:

Federal Per Diem Base Rate	\$894.29
Labor Share (78.9%)	\$705.59
Non-Labor Share (21.1%)	\$188.70

Fixed Dollar Loss Threshold Amount:

\$40,750

Wage Index Budget-Neutrality Factor:

0.9986

Facility Adjustments:

Rural Adjustment Factor	1.18
Teaching Adjustment Factor	0.7957
Wage Index	FY 2027 Pre-floor, Pre-reclassified IPFS 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	1.28
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.32
City of Juneau and 80-kilometer (50-mile) radius by road	1.36
Rest of Alaska	1.44
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.32
County of Kauai	1.26
County of Maui and County of Kalawao	1.25

Patient Adjustments:

ECT – Per Treatment	\$688.38
ECT – Per Treatment Applying the 2 Percentage Point Reduction	\$674.93

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a Qualifying Emergency Department	1.28
Day 1 -- Facility With a Qualifying Emergency Department	1.54
Day 2	1.20
Day 3	1.15
Day 4	1.12
Day 5	1.08
Day 6	1.06
Day 7	1.03
Day 8	1.02
Day 9	1.01
Day 10 and After	1.00

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 55	1.02
55 and under 60	1.05
60 and under 65	1.06
65 and under 70	1.09
70 and under 80	1.11
80 and over	1.13

DRG Adjustments:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.12
057	Degenerative nervous system disorders w/o MCC	1.11
876	OR procedure w principal diagnoses of mental illness	1.29
880	Acute adjustment reaction & psychosocial dysfunction	1.08
881	Depressive neuroses	1.06
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.17
884	Organic disturbances & intellectual disabilities	1.08
885	Psychoses	1.00
886	Behavioral & developmental disorders	1.07
887	Other mental disorder diagnoses	1.00
894	Alcohol/drug abuse or dependence, left AMA	0.86
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.90
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.00
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.95
917	Poisoning and toxic effects of drugs w MCC	1.19
918	Poisoning and toxic effects of drugs w/out MCC	1.12
947	Signs and Symptoms w MCC	1.12
948	Signs and Symptoms w/out MCC	1.09

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Tracheostomy	1.09
Eating Disorders	1.09
Renal Failure, Acute	1.06
Renal Failure, Chronic	1.08
Oncology Treatment	1.44
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.17
Cardiac Conditions	1.04
Gangrene	1.12
Chronic Obstructive Pulmonary Disease and Sleep Apnea	1.09
Artificial Openings – Digestive & Urinary	1.07
Severe Musculoskeletal & Connective Tissue Diseases	1.05
Poisoning	1.16
Intensive Management for High-Risk Behavior	1.07

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

CCRs	Rural	Urban
National Median	0.5720	0.4200
National Ceiling	2.4179	1.8699