DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, and 489

[CMS–1655–F; CMS–1664–F; CMS–1632–F2]

RIN 0938–AS77; 0938–AS88; 0938–AS41

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals; Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correction.

SUMMARY: This document corrects technical and typographical errors in the final rule that appeared in the August 22, 2016 **Federal Register** titled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals.''

DATES: This correction is effective October 1, 2016.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2016–18476 of August 22, 2016 (81 FR 56761) there were a number of technical and typographical errors identified and corrected in the Correction of Errors section of this correcting document. The provisions in this correcting document are effective as if they had been included in the document that appeared in the August 22, 2016 **Federal Register**. Accordingly, the corrections are effective October 1, 2016.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 56775, we made a typographical error in stating the cost reduction.

On page 56796, we are correcting errors and inadvertent omissions in the summary and response to a comment on the assignment of 18 additional diagnosis codes.

On page 56797, we erroneously referred to the wrong table.

On page 56801, we are correcting errors and inadvertent omissions in our response to comments on our proposal to redesignate four ICD–10–PCS procedure codes.

On page 56803 and in the table on page 56804 describing ICD–10–PCS Endovascular Thrombectomy Procedure Codes Reassigned to MS–DRGs 270, 271, and 272 for FY 2017, we are correcting technical errors in our discussion in response to comments to remove 34 ICD–10–PCS procedure codes describing endovascular thrombectomy of non-lower limbs from the proposed list of codes to be reassigned to MS–DRGs 270, 271 and 272. In this response, we erroneously referred to 34 procedure codes describing non-lower limb procedures (as included in the list submitted by the commenter) rather than 32 non-lower limb procedure codes. Two of the 34 procedure codes identified by the commenter, ICD–10–PCS procedure codes 04CT3ZZ (Extirpation of matter from right peroneal artery, percutaneous approach) and 04CU3ZZ (Extirpation of matter from left peroneal artery, percutaneous approach), describe endovascular thrombectomy of lower limbs. These codes are assigned to MS–DRGs 270, 271 and 272, accurately replicating the logic of ICD–9–CM MS–DRGs Version 32 and supporting clinical and resource use homogeneity as originally proposed and in accordance with the finalized policy to add procedures describing endovascular thrombectomy of lower limbs to ICD–10 Version 34 MS–DRGS 270, 271 and 272.

On page 56804, as a result of our correction of the MS–DRG assignment in Table 6B—New Procedure Codes for 13 ICD–10–PCS procedure codes that describe endovascular thrombectomy procedures of the lower limb, as described in section II.D. of this correction document, we are making additional conforming corrections to the table describing ICD–10–PCS Endovascular Thrombectomy Procedure Codes Reassigned to MS–DRGs 270, 271, and 272 for FY 2017.

On pages 56821 and 56823, we erroneously stated there were 58 additional combination codes for removal and replacement of knee joints. There were 57 additional combination codes.

On pages 56822 and 56823, we erroneously listed the code number for (Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach) as code 0SRU0JA three times within the table. The correct code number should be 0SRU0J9 (Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach).

As a result of the corrections to pages 56803, 56804, 56821, 56822, and 56823, we have made conforming changes to the ICD–10 MS–DRG Definitions Manual Version 34 and ICD–10 MS–DRG Grouper Software Version 34 for FY 2017.

On page 56858, we erroneously omitted MS–DRG 265 from the table of MS–DRGs subject to the policy for replaced devices offered without cost or with a credit.

On pages 56895 and 56897, we inadvertently made an error to the title of ICD–10–PCS procedure code XW03331 and omitted an additional procedure code that describes Idarucizumab. Cases involving Idarucizumab that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure codes XW03331 (Introduction of Idarucizumab, Dabigatran reversal agent into peripheral vein, percutaneous approach, New Technology Group 1) and XW04331 (Introduction of Idarucizumab, Dabigatran reversal agent into central vein, percutaneous approach, New Technology Group 1).

On page 56927, as a result of the correction of the technical errors described in section II.B of this correction document, we have made conforming changes to the following: The number of hospitals approved for wage index reclassifications by the Medicare Geographic Classification Review Board (MGCRB) starting in FY 2017 and the number of hospitals in a

MGCRB reclassification status for FY 2017.

On page 57002 in the table titled, ''Previously Adopted and Newly Finalized Baseline and Performance Periods for the FY 2021 Program Year'' we erroneously repeated the same information three times, and in the first instance provided incorrect performance period years for the Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–COPD) and THA/TKA measures.

On page 57033, we made a typographical error and omitted a dash within the web link address creating a non-functional link.

On pages 57195, 57196, 57199, 57211, 57213, 57218, and 57220 through 57223 we inadvertently made technical and typographical errors to the Long-Term Care Hospital Quality Reporting Program section and have corrected those errors for clarification.

B. Summary of Errors in the Addendum

As discussed in section II.D. of this correcting document, we made technical errors with regard to the calculation of Factor 3 of the uncompensated care payment methodology. The revisions made to address some of these errors directly affected and required the recalculation of all the budget neutrality factors and final outlier threshold. Factor 3 is used to determine the amount of total uncompensated care payment a hospital is eligible to receive as well as the amount of the uncompensated care payment a hospital receives per discharge. Per discharge uncompensated care payments are then included when determining total payments for purposes of all of the budget neutrality factors and the final outlier threshold. Therefore, we made conforming changes to pages 57278 through 57280, 57286, and 57291 to take into account the updated per-discharge uncompensated care payments determined using revised Factor 3 amounts. We made further conforming corrections to the national outlier adjustment factors on page 57286 and the table on page 57288 as a result of these changes. Finally, we made conforming corrections to the national operating standardized amounts.

We made inadvertent errors related to the MGCRB reclassification status of one provider as well as the status of three providers reclassified as urban to rural under section 1886(d)(8)(E) of the Act (codified in the regulations under § 412.103 and hereinafter referred to as § 412.103).

Specifically, the reclassification status in the FY 2017 IPPS/LTCH PPS final rule did not properly reflect the following:

- Withdrawal of a MGCRB reclassification for FY 2017 for one provider.
- Application of urban to rural reclassification under § 412.103 for three providers.

Therefore, on page 57279, we recalculated the reclassification hospital budget neutrality adjustment.

The reclassification errors also required the recalculation of additional budget neutrality adjustment factors, the fixed-loss cost threshold, the final wage indexes, and the national operating standardized amounts. Therefore, we made conforming changes to the following:

- On page 57280, the rural floor budget neutrality adjustment and the wage index transition budget neutrality adjustment.
- On page 57286, the calculation of the outlier fixed-loss cost threshold and the national outlier adjustment factors.
- On page 57288, the table titled ''Change of FY 2016 Standardized Amounts to the FY 2017 Standardized Amounts''.

On pages 57291 and 57293 through 57295, in our discussion of the determination of the Federal hospital inpatient capital related prospective payment rate update, we have made conforming corrections to the increase in the capital Federal rate, the incremental and cumulative budget neutrality adjustment factors for changes in the GAFs and the MS–DRG relative weights, the GAF/MS–DRG budget neutrality adjustment factor (due to the errors in our calculation of the GAFs, which are computed from the wage index), the capital Federal rate, and the outlier threshold (as discussed previously).

Also, as a result of these errors, on pages 57294 and 57295, we have made conforming corrections in the tables showing the comparison of factors and adjustments for the FY 2016 capital Federal rate and FY 2017 capital Federal rate and the proposed FY 2017 capital Federal rate and final FY 2017 capital Federal rate.

On page 57307, we are making conforming corrections the fixed-loss amount for site neutral discharges due to corrections in the IPPS rates and factors discussed previously.

On page 57312, we have made conforming corrections to the national operating standardized amounts and capital standard Federal payment rate (which also include the rates payable to hospitals located in Puerto Rico) in Tables 1A, 1B, 1C, and 1D as a result of the conforming corrections to certain budget neutrality factors and the outlier threshold (as described previously).

C. Summary of Errors in the Appendices

On pages 57312, 57315 through 57317, 57319 through 57323, 57330 through 57332 in our regulatory impact analyses, we made conforming corrections to the factors, values, and tables and accompanying discussion of the changes in operating and capital IPPS payments for FY 2017 and the effects of certain budget neutrality factors as a result of the technical errors that lead to conforming changes in our calculation of the operating and capital IPPS budget neutrality factors, outlier threshold, final wage indexes, operating standardized amounts, and capital Federal rate (as described in section II.B. of this correction document).

On pages 57324 through 57326, in the table titled ''Modeled Disproportionate Share Hospital Payments for Estimated FY 2017 DSHs by Hospital Type: Model DSH $ (In Millions) From FY 2016 To FY 2017'' and the accompanying discussion, we made corrections to address technical and formatting errors in the estimated impacts resulting from inadvertent errors in the calculation of Factor 3 for certain hospitals.

On pages 57331 through 57332, we made conforming corrections to Table III—Comparison of Total Payments Per Case [FY 2016 Payments Compared to FY 2017 Payments].

On page 57342, we made conforming corrections to the discussion of the estimated changes in operating and capital IPPS payments and the accounting statement and table for acute care hospitals that arose from the corrections of errors and conforming changes as described in sections II.B. and II.D. of this correcting document.

D. Summary of Errors in and Corrections to Files and Tables Posted on the CMS Web Site

We are correcting the errors in the following IPPS tables that are listed on page 57311 of the FY 2017 IPPS/LTCH PPS final rule and are available on the Internet on the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html.* The tables that are available on the Internet have been updated to reflect the revisions discussed in this correcting document.

Table 2—Case-Mix Index and Wage Index Table—FY 2017. Because the uncompensated care and reclassification errors discussed in section II.B. of this correction document required that we recalculate the rural and imputed floor budget neutrality factor, we are

correcting the values in the column titled FY 2017 Wage Index for all providers. For the three providers for which we are applying urban to rural reclassification under § 412.103, we are correcting the values in the column titled ''FY 2017 Wage Index'', inserting the rural reclassified CBSA in the column titled ''Reclassified/Redesignated CBSA'', and inserting a ''Y'' in the column titled ''Hospital Reclassified as Rural Under Section 1886(d)(8)(E) of the Act (§ 412.103)''. For the provider that withdrew its MGCRB reclassification for FY 2017, we are revising the wage index in the column titled FY 2017 Wage Index, and we are removing the MGCRB flag in the column titled MGCRB Reclass.

Table 3—Wage Index Table by CBSA—FY 2017. Because the uncompensated care and reclassification errors discussed in section II.B. of this correction document required that we recalculate the rural and imputed floor budget neutrality factor, we are making corresponding changes to the wage indexes and GAFs of all CBSAs listed in Table 3. Specifically, we are correcting the values and flags in the columns titled ''Wage Index'', ''Reclassified Wage Index'', ''GAF'', ''Reclassified GAF'', ''Pre-Frontier and/or Pre-Rural Floor Wage Index'' and ''Eligible for Rural Floor Wage Index''.

Table 6B—New Procedure Codes for FY 2017. In Table 6B—New Procedure Codes, we inadvertently listed the incorrect MS–DRG assignment for 13 ICD–10–PCS procedure codes that describe endovascular thrombectomy procedures of the lower limb involving a bifurcation. We are correcting the MS–DRG assignment of these 13 ICD–10–PCS codes in Table 6B.

Table 10—New Technology Add-On Payment Thresholds for Applications for FY 2018. We are correcting the thresholds in this table as a result of the corrections to the operating standardized amounts discussed in section II.B. of this correcting document.

Table 18—FY 2017 Medicare DSH Uncompensated Care Payment Factor 3 and Projected DSH Eligibility. For the FY 2017 IPPS/LTCH PPS final rule, we published a list of hospitals that we identified to be subsection (d) hospitals and subsection (d) Puerto Rico hospitals eligible to receive empirically justified Medicare DSH payment adjustments and uncompensated care payments for FY 2017. We also published, in the Supplemental Medicare DSH File located in the FY 2017 IPPS/LTCH PPS final rule data files page at *https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-FinalRule-Home-Page-Items/FY2017-IPPSFinal-Rule-Data-Files.html*, the data used to calculate each hospital's Factor 3, total uncompensated care payment, and estimated uncompensated care payment per discharge.

Shortly after the publication of the FY2017 IPPS/LTCH PPS final rule, we discovered that, in calculating Factor 3 of the uncompensated care payment methodology, we had understated the low-income insured days of hospitals that merged after 2011 with one surviving provider number because we inadvertently excluded the low income insured days of acquired hospitals from the low income insured days used in the Factor 3 calculation of surviving hospitals that were projected to receive Medicare DSH in FY 2017. In addition, we discovered that we had calculated a Factor 3 for hospitals that have ceased operations and erroneously calculated Factor 3 using Medicaid days reported on Worksheet S–3 instead of Worksheet S–2 of certain hospitals' FY 2013 cost reports. We are revising Factor 3 for all hospitals to correct these errors. These corrections to the uncompensated care payments impacted the calculation of all the budget neutrality factors as well as the outlier fixed-loss cost threshold for outlier payments.

In addition, we discovered that we had inadvertently excluded the Medicaid days from the 2011 cost report for a provider as well as the Medicaid days from the 2012 cost report for another provider from the calculation of Factor 3. Due to technical errors by our Medicare Administrative Contractors the Medicaid days from these cost reports were not included in the March 2016 update of HCRIS. We projected that both providers would be eligible to receive Medicare DSH in FY 2017. Accordingly, we are revising Factor 3 for all hospitals to reflect these Medicaid days; however, the impact of these revisions is too small to affect other aspects of the IPPS ratesetting, such as the calculation of the fixed-loss threshold for outlier payments.

We are also correcting the errors in the following LTCH PPS table that is listed on page 57311 of the FY 2017 IPPS/LTCH PPS final rule and is available on the Internet on the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html* under the list item for regulation number CMS–1655–F. The table that is available on the Internet has been updated to reflect the revisions discussed in this correcting document.

Table 11—MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, Short Stay Outlier (SSO) Threshold, and ''IPPS Comparable Threshold'' for LTCH PPS Discharges Occurring from October 1, 2016 through September 30, 2017. We are correcting this table by correcting typographical errors for MS–LTC–DRGs 627 and 658 in the columns titled ''Relative Weight,'' ''Geometric Average Length of Stay,'' ''Short-Stay Outlier (SSO) Threshold,'' and ''IPPS Comparable Threshold.''

III. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

We believe that this correcting document does not constitute a rule that would be subject to the APA notice and comment or delayed effective date requirements. This correcting document corrects technical and typographic errors in the preamble, addendum, payment rates, tables, and appendices included or referenced in the FY 2017 IPPS/LTCH PPS final rule but does not make substantive changes to the policies or payment methodologies that were adopted in the final rule. As a result, this correcting document is intended to ensure that the information in the FY 2017 IPPS/LTCH PPS final rule accurately reflects the policies adopted in that final rule.

In addition, even if this were a rule to which the notice and comment procedures and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the final rule or delaying the effective date would be contrary to the public interest because it is in the public's interest for providers to receive

appropriate payments in as timely a manner as possible, and to ensure that the FY 2017 IPPS/LTCH PPS final rule accurately reflects our policies. Furthermore, such procedures would be unnecessary, as we are not altering our payment methodologies or policies, but rather, we are simply implementing correctly the policies that we previously proposed, received comment on, and subsequently finalized. This correcting document is intended solely to ensure that the FY 2017 IPPS/LTCH PPS final rule accurately reflects these payment methodologies and policies. Therefore, we believe we have good cause to waive the notice and comment and effective date requirements.

IV. Correction of Errors

In FR Doc. 2016–18476 of August 22, 2016 (81 FR 56761), we are making the following corrections:

A. Corrections of Errors in the Preamble

1. On page 56775, third column, second bulleted paragraph, line 25, the figure ''$50.4 million'' is corrected to read ''$56.4 million''.

2. On page 56796—

a. Top half of the page, third column, third full paragraph,

(1) Lines 4 and 5, the phrase ''describing similar conditions'' is corrected to read ''displayed in Table 6A—New Diagnosis Codes associated with the proposed rule (which is available via the Internet on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*) that describe similar conditions''.

(2) Lines 9 and 10, the phrase, ''18 ICD–10–CN diagnosis codes in the following table be reassigned'' is corrected to read ''18 ICD–10–CM diagnosis codes in the following table also be reassigned''.

b. Lower half of the page, first column, last paragraph—

(1) Lines 6 and 7, the phrase ''describing procedures performed on'' is corrected to read ''describing conditions affecting''.

(2) Line 14, the phrase ''MS DRGs 091, 092 and 093.'' is corrected to read ''MS–DRGs 091, 092, and 093 because they are also nervous system codes.''

3. On page 56797, first column, first paragraph, lines 15 and 16, the phrase ''These 18 codes also are reflected in Table 6E'' is corrected to read ''These 18 codes are reflected in Table 6A''.

4. On page 56801, second column, second full paragraph—

a. Lines 11 and 12, the phrase ''performing such procedures because loop'' is corrected to read ''performing such procedures because, as noted in the FY 2017 IPPS/LTCH PPS proposed rule, loop''.

b. Lines 25 and 26, the phrase ''were not able to finalize that specific request.'' is corrected to read ''were not able to replicate that specific request in the ICD–9–CM based MS–DRGs.''.

c. Lines 26 through 29, the sentence ''Rather, we finalized an alternative option, which was to change the designation for four of the six codes requested.'' is corrected to read ''Rather, we proposed an alternative option, which was to change the designation for four of the six codes requested, because we believed that if we limited the change in designation to these four codes, the change would not have any impact.''.

d. Lines 40 through 41, the phrase ''not finalizing the proposal to change the two'' is corrected to read ''not changing the designation of the two''.

5. On page 56803, bottom of the page—

a. First column, last paragraph, lines 7 and 8, the phrase ''removing the 34 codes'' is corrected to read ''removing 32 of the 34 codes''.

b. Second column, first partial paragraph—

(1) Lines 5 and 6, the phrase ''34 non-lower'' is corrected to read ''32 non-lower''.

(2) Lines 8 and 9, the phrase ''These 34 non-lower'' is corrected to read ''These 32 non-lower''.

(3) Line 13, after the phrase ''for FY 2017.'' the paragraph is corrected by adding sentences to read as follows:

''Two of the procedure codes identified by the commenter, ICD–10–PCS procedure codes 04CT3ZZ (Extirpation of matter from right peroneal artery, percutaneous approach) and 04CU3ZZ (Extirpation of matter from left peroneal artery, percutaneous approach) describe endovascular thrombectomy of lower limbs and are not non-lower limb procedure codes.''.

c. Third column, first full paragraph, line 11, the phrase ''34 procedure'' is corrected to read ''32 procedure''.

6. On page 56804, top of page, the table titled ''ICD–10–PCS ENDOVASCULAR THROMBECTOMY PROCEDURE CODES REASSIGNED TO MS–DRGs 270, 271, AND 272 FOR FY 2017'' is corrected by adding the following entries:

04CK3Z6	Extirpation of Matter from Right Femoral Artery, Bifurcation, Percutaneous Approach.
04CL3Z6	Extirpation of Matter from Left Femoral Artery, Bifurcation, Percutaneous Approach.
04CM3Z6	Extirpation of Matter from Right Popliteal Artery, Bifurcation, Percutaneous Approach.
04CN3Z6	Extirpation of Matter from Left Popliteal Artery, Bifurcation, Percutaneous Approach.
04CP3Z6	Extirpation of Matter from Right Anterior Tibial Artery, Bifurcation, Percutaneous Approach.
04CQ3Z6	Extirpation of Matter from Left Anterior Tibial Artery, Bifurcation, Percutaneous Approach.
04CR3Z6	Extirpation of Matter from Right Posterior Tibial Artery, Bifurcation, Percutaneous Approach.
04CS3Z6	Extirpation of Matter from Left Posterior Tibial Artery, Bifurcation, Percutaneous Approach.
04CT3Z6	Extirpation of Matter from Right Peroneal Artery, Bifurcation, Percutaneous Approach.
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach.
04CU3Z6	Extirpation of Matter from Left Peroneal Artery, Bifurcation, Percutaneous Approach.
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach.
04CV3Z6	Extirpation of Matter from Right Foot Artery, Bifurcation, Percutaneous Approach.
04CW3Z6	Extirpation of Matter from Left Foot Artery, Bifurcation, Percutaneous Approach.
04CY3Z6	Extirpation of Matter from Lower Artery, Bifurcation, Percutaneous Approach.

7. On page 56821, middle of the page—

a. Second column, first partial paragraph, line 2, the phrase ''identified 58'' is corrected to read ''identified 57''.

b. Third column, first partial paragraph, line 3, the phrase ''following 58'' is corrected to read ''following 57''.

8. On pages 56821 through 56823, in the table titled ''ICD–10–PCS CODE PAIRS PROPOSED TO BE ADDED TO VERSION 34 ICD–10 MS–DRGs 466, 467, and 468: PROPOSED NEW KNEE REVISION ICD–10–PCS COMBINATIONS'', the codes (in the 4th column) for the following entries are corrected to read as follows:

ICD–10–PCS CODE PAIRS PROPOSED TO BE ADDED TO VERSION 34 ICD–10 MS–DRGS 466, 467, AND 468: PROPOSED NEW KNEE REVISION ICD–10–PCS COMBINATIONS

Code	Code description		Code	Code description
0SPD08Z	Removal of Spacer from Left Knee Joint, Open Approach.	and	0SRU0J9	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach.
0SPD38Z	Removal of Spacer from Left Knee Joint, Percutaneous Approach.	and	0SRU0J9	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach.
0SPD48Z	Removal of Spacer from Left Knee Joint, Percutaneous Endoscopic Approach.	and	0SRU0J9	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach.

9. On page 56823, lower half of the page—

a. First column, second paragraph, line 10, the phrase ''58 new'' is corrected to read ''57 new''.

b. Second column—

(1) First partial paragraph, line 11, the phrase ''58 new'' is corrected to read '' new''.

(2) First full paragraph, lines 3 and 4, the phrase ''58 new'' is corrected to read ''57 new''.

10. On page 56858, top of the page, the untitled table is corrected by adding the following entry after line 34 (which is the entry for MDC 5, MS–DRG 262):

MDC	MS–DRG	MS–DRG Title
5	265	AICD Lead Procedures.

11. On page 56895, third column, first partial paragraph—

a. Lines 8 and 9, the phrase ''a unique ICD–10–PCS procedure code'' is corrected to read ''two unique ICD–10–PCS procedure codes''.

b. Lines 10 through 15, the sentence ''The approved procedure code is XW0331 (Introduction of Idarucizumab, Dabigatran reversal agent into central vein, percutaneous approach, New Technology Group 1).'' is corrected to read ''The approved procedure codes are XW0331 (Introduction of Idarucizumab, Dabigatran reversal agent into peripheral vein, percutaneous approach, New Technology Group 1) and XW04331 (Introduction of Idarucizumab, Dabigatran reversal agent into central vein, percutaneous approach, New Technology Group 1).''.

12. On page 56897, third column, third full paragraph, line 11, the phrase ''procedure code XW03331.'' is corrected to read ''procedure codes XW03331 and XW04331.''.

13. On page 56927—

a. Second column, last partial paragraph, line 5 the phrase ''265 hospitals'' is corrected to read ''264 hospitals''.

b. Third column, first partial paragraph, line 12, the phrase ''817 hospitals'' is corrected to read ''816 hospitals''.

14. On page 57002, bottom of the page, the table titled ''PREVIOUSLY ADOPTED AND NEWLY FINALIZED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2021 PROGRAM YEAR'' is corrected to read as follows:

PREVIOUSLY ADOPTED AND NEWLY FINALIZED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2021 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care		
• Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–COPD) *	• July 1, 2011–June 30, 2014	• July 1, 2016–June 30, 2019
• THA/TKA *	• April 1, 2011–March 31, 2014	• April 1, 2016–March 31, 2019
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2019
Efficiency and Cost Reduction		
• MSPB	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 2019
• Payment (AMI Payment and HF Payment)	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2019

* Previously adopted baseline and performance periods that remain unchanged (80 FR 49562 through 49563).

15. On page 57033, first column, last paragraph, lines 2 through 4, the web link ''*http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/dgme.html*'' is corrected to read ''*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html.*''

16. On page 57195—

a. First column, last partial paragraph, lines 4 and 5, the phrase ''it recommended'' is corrected to read ''the commenters recommended''.

b. Third column, third full paragraph—

(1). Line 14, the phrase ''This measure'' is corrected to read ''The Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC LTCH QRP quality measure''.

(2) Lines 23 through 25, the phrase '' and Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP,'' is corrected to read '', Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP and Medicare Spending Per Beneficiary-PAC LTCH QRP,''.

17. On page 57196, third column, first full paragraph, lines 13 through 16, the phrase ''with information more frequently, such as unadjusted counts of potentially preventable readmissions (PPRs) and discharge data.'' is corrected to read ''with information, such as unadjusted counts of potentially preventable readmissions (PPRs) and discharge data, more frequently.''

18. On page 57199, first column, second full paragraph, lines 3 and 4, the phrase ''SES or SDS status.'' is corrected to read ''SES or SDS.''

19. On page 57211, third column, second full paragraph, line 16, the phrase ''to discharge'' is corrected to read ''to be discharged''.

20. On page 57213—

a. Second column, last partial paragraph, lines 6 through 8, the phrase

"and a SNF stay within a 30-day window, the SNF stay is a candidate to for" is corrected to read "and then a SNF stay within a 30-day window, the SNF stay is a candidate for".

b. Third column, after the last paragraph, Footnote 280, lines 1 and 2, the measure name "Hospital-Wide All-Cause Readmission Measure (HWR) (CMS/Yale)." is corrected to read "Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (CMS/Yale)."

21. On page 57218, third column, first full paragraph, lines 4 and 5, the phrase "The commenter was correct in its interpretation of" is corrected to read "The commenter's interpretation was correct regarding".

22. On page 57220, second column, second footnoted full paragraph (Footnote 311), lines 1 through 6, the footnote "[311]Greenwald, J.L., Halasyamani, L., Greene, J., LaCivita, C., *et al.* (2010). Making inpatient medication reconciliation patient centered, clinically relevant and implementable: A consensus statement on key principles and necessary first steps. Journal of Hospital Medicine, 5(8), 477–485." is corrected to read "[311]Institute of Medicine. Preventing Medication Errors. Washington, DC: National Academies Press; 2006."

23. On page 57221, second column, second full paragraph, lines 3 and 4, the phrase "cross-setting and quality measure" is corrected to read "cross-setting quality measure".

24. On page 57222—

a. Second column, first full paragraph, lines 11 and 12, the phrase "however, the adoption of the measure" is corrected to read "however, the measure".

b. Third column, first full paragraph—

(1) Line 4, the word "facilities" is corrected to read "facility's".

(2) Line 22, the phrase "collected admission" is corrected to read "collected at admission".

25. On page 57223—

a. First column, second paragraph—

(1) Lines 1 through 4, the phrase "Since the time of the MAP consideration, with our measure contractor, we tested this measure in a pilot test involving twelve PAC facilities," is corrected to read "Since the time of the NQF-convened MAP consideration we have further tested this measure in a pilot test involving twelve PAC facilities".

(2) Lines 7 and 8, the phrase, "record collection system" is corrected to read "records system".

b. Second column, third full paragraph, lines 9 and 10, the phrase "PAC facility." is corrected to read "PAC facility. We appreciate MedPAC and other commenters' recommendation for a quality measure that assesses post-discharge medication communication with primary care providers for patients discharged to home."

B. Correction of Errors in the Addendum

1. On page 57278, third column, fifth full paragraph,

a. Line 3, the figure "0.999079" is corrected to read "0.999078".

b. Line 9, the figure "0.999079" is corrected to read "0.999078".

2. On page 57279—

a. Second column, first full paragraph, line 9, the figure "1.000209" is corrected to read "1.00021".

b. Third column, third full paragraph, line 12, the figure "0.988224" is corrected to read "0.988136".

3. On page 57280—

a. First column, fifth full paragraph, line 4, the figure "0.993200" is corrected to read "0.991987".

b. Third column, second full paragraph,

(1) Line 3, the figure "0.999994" is corrected to read "0.999997".

(2) Line 6, the figure "0.999994" is corrected to read "0.999997".

4. On page 57286—

a. Second column, last paragraph—

(1) Line 6, the figure "$23,570" is corrected to read "$23,573".

(2) Line 8, the figure "$83,347,416,971" is corrected to read "$83,364,479,923".

(3) Line 9, the figure "$4,479,256,519" is corrected to read "$4,479,256,368".

b. Third column—

(1) First partial paragraph, line 11, the figure "$23,570" is corrected to read "$23,573".

(2) Following the third full paragraph, the untitled table is corrected to read as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948998	0.938602

5. On page 57288, middle of the page, the table titled "CHANGE OF FY 2016 STANDARDIZED AMOUNTS TO THE FY 2017 STANDARDIZED AMOUNTS", is corrected to read as follows:

CHANGE OF FY 2016 STANDARDIZED AMOUNTS TO THE FY 2017 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2016 Base Rate after removing: 1. FY 2016 Geographic Reclassification Budget Neutrality (0.988169). 2. FY 2016 Rural Community Hospital Demonstration Program Budget Neutrality (0.999837).	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09. Nonlabor (30.4 percent): $1,919.26.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09. Nonlabor (30.4 percent): $1,919.26.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09. Nonlabor (30.4 percent): $1,919.26.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09. Nonlabor (30.4 percent): $1,919.26.

CHANGE OF FY 2016 STANDARDIZED AMOUNTS TO THE FY 2017 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015 and FY 2016 Documentation and Coding Adjustments as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012 (0.9255). 4. FY 2016 Operating Outlier Offset (0.948998). 5. FY 2016 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.999998). 6. FY 2017 2-Midnight Rule Permanent Adjustment (1/0.998).	If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28. Nonlabor (38 percent): $2,399.07.	If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28. Nonlabor (38 percent): $2,399.07.	If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28. Nonlabor (38 percent): $2,399.07.	If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28. Nonlabor (38 percent): $2,399.07.
FY 2017 Update Factor	1.0165	0.99625	1.00975	0.9895.
FY 2017 MS-DRG Recalibration Budget Neutrality Factor.	0.999078	0.999078	0.999078	0.999078.
FY 2017 Wage Index Budget Neutrality Factor.	1.00021	1.00021	1.00021	1.00021.
FY 2017 Reclassification Budget Neutrality Factor.	0.988136	0.988136	0.988136	0.988136.
FY 2017 Operating Outlier Factor.	0.948998	0.948998	0.948998	0.98998.
Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015, FY 2016 and FY 2017 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012.	0.9118	0.9118	0.9118	0.9118.
FY 2017 New Labor Market Delineation Wage Index 3-Year Hold Harmless Transition Budget Neutrality Factor.	0.999997	0.999997	0.999997	0.999997.
FY 2017 2-Midnight Rule One-Time Prospective Increase.	1.006	1.006	1.006	1.006.
National Standardized Amount for FY 2017 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4).	Labor: $3,839.23 Nonlabor: $1,676.91	Labor: $3,762.75 Nonlabor: $1,643.50	Labor: $3,8143.74 Nonlabor: $1,665.77	Labor: $3,737.25. Nonlabor: $1,632.37.

CHANGE OF FY 2016 STANDARDIZED AMOUNTS TO THE FY 2017 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,420.01 Nonlabor: $2,096.13	Labor: $3,351.88 Nonlabor: $2,054.37	Labor: $3,397.30 Nonlabor: $2,082.21	Labor: $3,329.16. Nonlabor: $2,040.46.

6. On page 57291—

a. First column, second full paragraph, line 15, the figure ''0.999079'' is corrected to read ''0.999078''.

b. Third column, first full paragraph line 6, the figure ''1.84'' is corrected to read ''1.83''.

7. On page 57293, third column—

a. First partial paragraph—

(1) Line 1, the figure ''0.9995'' is corrected to read ''0.9994''.

(2) Line 4, ''0.9855'' is corrected to read ''0.9854''.

b. First full paragraph, line 16, the figure ''0.9851'' is corrected to read ''0.9850''.

c. Last paragraph—

(1) Line 2, the figure ''0.9991''is corrected to read ''0.9990''.

(2) Line 4, ''0.9995'' is corrected to read ''0.9994''.

8. On page 57294—

a. Top of the page—

(1) Second column—

(a) First full paragraph, line 17, the figure ''$446.81'' is corrected to read ''$446.79''.

(b) Second bulleted paragraph, line 6, the figure ''0.9991'' is corrected to read ''0.9990''.

(2) Third column, second full paragraph—

(a) Line 13, the figure, ''0.09'' is corrected to read ''0.10''.

(b) Line 26, the figure, ''1.84'' is corrected to read ''1.832''.

b. Bottom of the page, the table titled ''COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2016 CAPITAL FEDERAL RATE AND FY 2017 CAPITAL FEDERAL RATE'' is corrected to read as follows:

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2016 CAPITAL FEDERAL RATE AND FY 2017 CAPITAL FEDERAL RATE

	FY 2016	FY 2017	Change	Percent change [3]
Update Factor [1]	1.0130	1.009	1.009	0.9
GAF/DRG Adjustment Factor [1]	0.9976	0.9990	0.9990	−0.10
Outlier Adjustment Factor [2]	0.9365	0.9386	1.0022	0.22
Permanent 2-midnight Policy Adjustment Factor	N/A	1.002	1.002	0.2
One-Time 2-midnight Policy Adjustment Factor	N/A	1.006	1.006	0.6
Capital Federal Rate	$438.75	$446.79	1.0183	1.83

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2016 to FY 2017 resulting from the application of the 0.9990 GAF/DRG budget neutrality adjustment factor for FY 2017 is a net change of 0.9990 (or −0.10 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2017 outlier adjustment factor is 0.9386/0.9365, or 1.0022 (or 0.22 percent).

[3] Sum of individual changes may not match percent change in capital rate due to rounding.

9. On page 57295—

a. The top of the page, the table titled ''COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2017 CAPITAL FEDERAL RATE AND FINAL FY 2017 CAPITAL FEDERAL RATE'' is corrected to read as follows:

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2017 CAPITAL FEDERAL RATE AND FINAL FY 2017 CAPITAL FEDERAL RATE

	Proposed FY 2017	Final FY 2017	Change	Percent change
Update Factor [1]	1.0090	1.0090	1.0000	0.00
GAF/DRG Adjustment Factor [1]	0.9993	0.9990	0.9997	−0.03
Outlier Adjustment Factor [2]	0.9374	0.9386	1.0013	0.13
Permanent 2-midnight Policy Adjustment Factor	1.002	1.002	1.000	0.00
One-Time 2-midnight Policy Adjustment Factor	1.006	1.006	1.000	0.00
Capital Federal Rate	$446.35	$446.79	1.0010	0.10

b. Lower three-fourths of the page, first column, second paragraph, line 21, the figure, ''$23,570.'' is corrected to read ''$23,573.''

10. On page 57307, second column, first full paragraph—

a. Line 15, the figure ''$23,570'' is corrected to read ''$23,573''.

b. Line 35, the figure ''$23,570'' is corrected to read ''$23,573''.

11. On page 57312—

a. Top of the page—

(1) Table 1A titled ''NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2017'' is corrected to read as follows:

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2017

Hospital submitted quality data and is a meaningful EHR user (update = 1.65 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = −0.375 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 0.975 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = −1.05 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,839.23	$1,677.91	$3,762.75	$1,643.50	$3,813.74	$1,665.77	$3,737.25	$1,632.37

(2) Table 1B titled ''NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2017'' is corrected to read as follows:

TABLE 1B—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2017

Hospital submitted quality data and is a meaningful EHR user (update = 1.65 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = −0.375 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 0.975 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = −1.05 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,420.01	$2,096.13	$3,351.88	$2,054.37	$3,397.30	$2,082.21	$3,329.16	$2,040.46

b. Middle of the page—

(1) Table 1C titled ''ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1);—FY 2017'' is corrected to read as follows:

TABLE 1C—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2017

Standardized amount	Rates if wage index is greater than 1		Rates if wage index is less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National [1]	Not Applicable	Not Applicable	$3,420.01	$2,096.13

[1] For FY 2017, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

(2) Table 1D titled ''CAPITAL STANDARD FEDERAL PAYMENT RATE—FY 2017'' is corrected as follows:

TABLE 1D—CAPITAL STANDARD FEDERAL PAYMENT RATE—FY 2017

	Rate
National	$446.79

C. Corrections of Errors in the Appendices

1. On page 57312, bottom of the page, third column, first partial paragraph,

a. Line 8, the figure ''$987'' is corrected to read ''$990''.

b. Line 10, the figure ''$66'' is corrected to read ''$72''.

2. On page 57315, upper three-fourths of the page—

a. Second column, third full paragraph,

(1) Line 7, the figure ''1,380'' is corrected to read ''1,369''.

(2) Line 9, the figure ''1,135'' is corrected to read ''1,146''.

b. Third column, first full paragraph, line 13—

(1) The figure ''1,372'' is corrected to read ''1,369''.

(2) The figure ''1,150'' is corrected to read ''1,153''.

3. On pages 57315 through 57317, the table titled ''TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017'' is corrected to read as follows:

TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017

	Number of hospitals[1]	Hospital rate update and documentation and coding adjustment (1)[2]	FY 2017 weights and DRG changes with application of recalibration budget neutrality (2)[3]	FY 2017 Wage data under new CBSA designations with application of wage budget neutrality (3)[4]	FY 2017 MGCRB reclassifications (4)[5]	Rural and imputed floor with application of national rural and imputed floor budget neutrality (5)[6]	Application of the frontier wage index and out-migration adjustment (6)[7]	All FY 2017 changes (7)[8]
All Hospitals	3,330	1.0	0.0	0.0	0.0	0.0	0.1	0.9
By Geographic Location:								
Urban hospitals	2,515	0.9	0.0	0.0	−0.1	0.0	0.1	0.9
Large urban areas	1,369	0.9	0.1	0.0	−0.3	−0.1	0.0	0.9
Other urban areas	1,146	1.0	0.0	0.0	0.1	0.2	0.2	1.0
Rural hospitals	815	1.6	−0.4	0.1	1.3	−0.2	0.1	1.2
Bed Size (Urban):								
0–99 beds	659	0.9	−0.2	0.2	−0.5	0.1	0.2	0.9
100–199 beds	767	1.0	−0.1	0.0	0.0	0.3	0.2	0.7
200–299 beds	446	1.0	−0.1	−0.1	0.1	0.0	0.1	0.8
300–499 beds	431	1.0	0.1	0.0	−0.2	0.1	0.2	0.9
500 or more beds	212	0.9	0.2	0.0	−0.2	−0.2	0.0	1.1
Bed Size (Rural):								
0–49 beds	317	1.5	−0.5	0.1	0.2	−0.2	0.3	1.0
50–99 beds	292	1.8	−0.6	0.1	0.8	−0.2	0.1	1.2
100–149 beds	120	1.6	−0.4	0.0	1.5	−0.2	0.2	1.0
150–199 beds	46	1.7	−0.2	0.2	1.7	−0.3	0.0	1.3
200 or more beds	40	1.6	−0.1	0.2	2.5	−0.3	0.0	1.5
Urban by Region:								
New England	116	0.8	0.0	−0.5	1.1	0.9	0.1	−0.4
Middle Atlantic	315	0.9	0.1	−0.1	0.8	−0.2	0.1	0.9
South Atlantic	407	1.0	0.0	−0.2	−0.5	−0.3	0.1	0.9
East North Central	390	0.9	0.0	−0.1	−0.2	−0.4	0.0	1.0
East South Central	147	1.0	0.0	−0.1	−0.4	−0.3	0.0	1.2
West North Central	163	1.1	0.1	−0.1	−0.8	−0.4	0.7	1.0
West South Central	385	0.9	0.0	0.2	−0.5	−0.4	0.0	1.2
Mountain	163	1.1	0.0	0.1	−0.3	1.2	0.2	2.2
Pacific	378	0.9	0.0	0.4	−0.4	1.0	0.1	0.5
Puerto Rico	51	0.9	0.1	−0.5	−1.0	0.1	0.1	0.3
Rural by Region:								
New England	21	1.3	−0.2	0.3	1.4	−0.3	0.2	1.6
Middle Atlantic	54	1.7	−0.4	0.1	0.8	−0.2	0.1	1.6
South Atlantic	128	1.7	−0.5	−0.1	2.3	−0.3	0.1	1.0
East North Central	115	1.7	−0.4	0.0	1.0	−0.2	0.1	1.2
East South Central	155	1.1	−0.3	0.4	2.2	−0.4	0.1	1.0
West North Central	98	2.2	−0.4	0.0	0.2	−0.1	0.3	1.5
West South Central	160	1.5	−0.4	0.4	1.3	−0.3	0.1	1.2
Mountain	60	1.7	−0.4	0.1	0.2	−0.1	0.2	1.3
Pacific	24	1.9	−0.4	−0.3	1.3	−0.1	0.0	1.3
By Payment Classification:	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Urban hospitals	2,522	0.9	0.0	0.0	−0.1	0.0	0.1	0.9
Large urban areas	1,369	0.9	0.1	0.0	−0.3	−0.1	0.0	0.9
Other urban areas	1,153	1.0	0.0	0.0	0.1	0.2	0.2	1.0
Rural areas	808	1.6	−0.4	0.1	1.4	−0.2	0.1	1.2
Teaching Status:								
Nonteaching	2,266	1.1	−0.2	0.0	0.1	0.2	0.1	0.8
Fewer than 100 residents	815	1.0	0.0	0.0	−0.1	0.0	0.2	0.9
100 or more residents	249	0.9	0.2	0.0	−0.1	−0.2	0.0	1.1
Urban DSH:								
Non-DSH	589	0.9	−0.1	−0.2	0.2	0.0	0.2	0.8
100 or more beds	1,642	0.9	0.1	0.0	−0.1	0.0	0.1	0.9
Less than 100 beds	363	1.0	−0.3	0.0	−0.5	0.1	0.1	0.7
Rural DSH:								
SCH	240	2.0	−0.6	0.1	0.1	−0.1	0.0	1.4
RRC	325	1.7	−0.3	0.1	1.8	−0.2	0.0	1.3
100 or more beds	29	0.9	−0.4	0.1	2.9	−0.4	0.1	0.5
Less than 100 beds	142	0.8	−0.4	0.2	1.3	−0.4	0.7	0.2
Urban teaching and DSH:								
Both teaching and DSH	898	0.9	0.1	0.0	−0.2	−0.1	0.1	1.0
Teaching and no DSH	109	0.9	0.0	−0.1	1.1	0.0	0.0	0.7
No teaching and DSH	1,107	1.0	−0.1	0.1	−0.1	0.3	0.1	0.8
No teaching and no DSH	408	0.9	−0.1	−0.2	−0.4	0.0	0.2	0.9
Special Hospital Types:								
RRC	189	0.8	−0.1	0.1	1.9	0.0	0.5	1.2
SCH	324	2.1	−0.3	−0.1	0.0	0.0	0.0	1.7
MDH	148	1.7	−0.6	0.0	0.6	−0.1	0.1	1.3
SCH and RRC	126	2.2	−0.3	0.1	0.4	−0.1	0.0	1.8
MDH and RRC	12	2.1	−0.6	−0.1	1.3	−0.2	0.0	2.2
Type of Ownership:								
Voluntary	1,927	1.0	0.0	0.0	0.0	0.0	0.1	0.9
Proprietary	881	1.0	0.0	0.1	0.0	0.0	0.1	0.9
Government	522	1.0	0.0	−0.1	−0.2	0.0	0.1	0.9

TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017—Continued

	Number of hospitals[1]	Hospital rate update and documentation and coding adjustment (1)[2]	FY 2017 weights and DRG changes with application of recalibration budget neutrality (2)[3]	FY 2017 Wage data under new CBSA designations with application of wage budget neutrality (3)[4]	FY 2017 MGCRB reclassifications (4)[5]	Rural and imputed floor with application of national rural and imputed floor budget neutrality (5)[6]	Application of the frontier wage index and out-migration adjustment (6)[7]	All FY 2017 changes (7)[8]
Medicare Utilization as a Percent of Inpatient Days:								
0–25	523	0.8	0.1	0.1	−0.3	0.2	0.0	1.1
25–50	2,122	1.0	0.0	0.0	0.0	−0.1	0.1	0.9
50–65	545	1.2	−0.2	−0.1	0.6	0.0	0.1	0.9
Over 65	89	1.2	−0.3	0.3	−0.4	0.2	0.2	1.0
FY 2017 Reclassifications by the Medicare Geographic Classification Review Board:								
All Reclassified Hospitals	791	1.1	−0.1	0.0	2.3	−0.2	0.0	0.9
Non−Reclassified Hospitals	2,539	1.0	0.0	0.0	−0.8	0.1	0.1	0.9
Urban Hospitals Reclassified	532	1.0	0.0	−0.1	2.3	−0.1	0.0	0.9
Urban Nonreclassified Hospitals	1,936	0.9	0.1	0.0	−0.9	0.1	0.1	0.9
Rural Hospitals Reclassified Full Year	277	1.7	−0.3	0.1	2.2	−0.2	0.0	1.3
Rural Nonreclassified Hospitals Full Year	489	1.6	−0.4	0.2	−0.2	−0.2	0.3	1.1
All Section 401 Reclassified Hospitals:	72	1.7	−0.2	0.0	0.3	−0.1	0.9	1.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	48	1.2	−0.4	0.1	3.1	−0.4	0.0	0.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2015, and hospital cost report data are from reporting periods beginning in FY 2012 and FY 2013.

[2] This column displays the payment impact of the hospital rate update and other adjustments including the 1.65 percent adjustment to the national standardized amount and hospital-specific rate (the estimated 2.7 percent market basket update reduced by 0.3 percentage points for the multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the −1.5 percent documentation and coding adjustment to the national standardized amount and the adjustment of (1/0.998) to permanently remove the −0.2 percent reduction, and the 1.006 temporary adjustment to address the effects of the 0.2 percent reduction in effect for FYs 2014 through 2016 related to the 2-midnight policy.

[3] This column displays the payment impact of the changes to the Version 34 GROUPER, the changes to the relative weights and the recalibration of the MS DRG weights based on FY 2015 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the recalibration budget neutrality factor of 0.999078 in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the update to wage index data using FY 2013 cost report data and the OMB labor market area delineations based on 2010 Decennial Census data. This column displays the payment impact of the application of the wage budget neutrality factor, which is calculated separately from the recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The wage budget neutrality factor is 1.000210.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) along with the effects of the continued implementation of the new OMB labor market area delineations on these reclassifications. The effects demonstrate the FY 2017 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2017. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.988136.

[6] This column displays the effects of the rural and imputed floor based on the continued implementation of the new OMB labor market area delineations. The Affordable Care Act requires the rural floor budget neutrality adjustment to be 100 percent national level adjustment. The rural floor budget neutrality factor (which includes the imputed floor) applied to the wage index is 0.991987. This column also shows the effect of the 3-year transition for hospitals that were located in urban counties that became rural under the new OMB delineations or hospitals deemed urban where the urban area became rural under the new OMB delineations, with a budget neutrality factor of 0.999997.

[7] This column shows the combined impact of the policy required under section 10324 of the Affordable Care Act that hospitals located in frontier States have a wage index no less than 1.0 and of section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if a threshold percentage of residents of the county where the hospital is located commute to work at hospitals in counties with higher wage indexes. These are not budget neutral policies.

[8] This column shows the estimated change in payments from FY 2016 to FY 2017.

4. On page 57319,

a. First column, second full paragraph,

(1) Line 6, the figure ''0.988224'' is corrected to read ''0.988136''.

(2) Line 13, the figure ''1.4'' is corrected to read ''1.3''.

b. Second column—

(1) First full paragraph—

(a) Line 8, the figure ''0.9930'' is corrected to read ''0.991987''.

(b) Line 9, the figure ''0.7'' is corrected to read ''0.8''.

(2) Third full paragraph—

(a) Line 1, the figure ''397'' is corrected to read ''436''.

(b) Line 5—

(1) The figure ''0.9930'' is corrected to read ''0.991987''.

(2) The figure ''0.7'' is corrected to read ''0.8''.

(c) Line 23, the figure ''1.0'' is corrected to read ''0.9''.

(d) Line 31, the figure ''$24'' is corrected to read ''$22''.

(e) Line 33, the figure ''0.7'' is corrected to read ''0.6''.

c. Third column—

(1) First full paragraph,

(a) Line 7, the figure ''$10'' is corrected to read ''$6.4''.

(b) Line 18, the figure ''$17'' is corrected to read ''$18''.

(2) Second full paragraph, line 28, the figure ''0.999994'' is corrected to read ''0.999997''.

5. On page 57320, the table titled ''FY 2017 IPPS Estimated Payments Due to Rural Floor and Imputed Floor with National Budget Neutrality'' is corrected to read as follows:

FY 2017 IPPS ESTIMATED PAYMENTS DUE TO RURAL AND IMPUTED FLOOR WITH NATIONAL BUDGET NEUTRALITY

State	Number of hospitals (1)	Number of hospitals that will receive the rural floor or imputed floor (2)	Percent change in payments due to application of rural floor and imputed floor with budget neutrality (3)	Difference (in $ millions) (4)
Alabama	83	6	−0.3	−6
Alaska	6	4	2.1	4
Arizona	57	46	3.5	63
Arkansas	44	0	−0.4	−4
California	301	186	1.3	131
Colorado	48	3	0.2	3
Connecticut	31	8	0.2	4
Delaware	6	2	0	0
Washington, DC	7	0	−0.4	−1
Florida	171	16	−0.3	−2
Georgia	105	0	−0.4	−18
Hawaii	12	0	−0.3	−10
Idaho	14	0	−0.3	−1
Illinois	126	3	−0.4	−1
Indiana	89	0	−0.4	−19
Iowa	35	0	−0.4	−11
Kansas	53	0	−0.3	−4
Kentucky	65	0	−0.4	−3
Louisiana	95	2	−0.4	−6
Maine	18	0	−0.4	−5
Massachusetts	58	15	0.6	−2
Michigan	95	0	−0.4	22
Minnesota	49	0	−0.3	−18
Mississippi	62	0	−0.4	−6
Missouri	74	2	−0.3	−4
Montana	12	4	0.3	−8
Nebraska	26	0	−0.3	1
Nevada	24	3	−0.2	−2
New Hampshire	13	9	2.2	−2
New Jersey	64	18	0.2	11
New Mexico	25	0	−0.3	6
New York	154	21	−0.3	−1
North Carolina	84	1	−0.4	−20
North Dakota	6	1	−0.3	−12
Ohio	130	10	−0.4	−1
Oklahoma	86	2	−0.3	−13
Oregon	34	2	−0.4	−4
Pennsylvania	151	5	−0.4	−4
Puerto Rico	51	12	0.1	−20
Rhode Island	11	10	4.7	0
South Carolina	57	5	−0.1	18
South Dakota	18	0	−0.2	−2
Tennessee	92	20	−0.3	−1
Texas	320	3	−0.4	−7
Utah	33	1	−0.3	−26
Vermont	6	0	−0.2	−2
Virginia	76	1	−0.3	−1
Washington	49	6	−0.1	−8
West Virginia	29	3	−0.2	−1
Wisconsin	65	6	−0.3	−5
Wyoming	10	0	−0.1	0

6. On page 57321, second column, first partial paragraph —

a Line 1, the figure ''277'' is corrected to read ''278''.

b Line 7, the figure ''1.0'' is corrected to read ''0.9''.

7. On pages 57321 through 57323, the table titled ''TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2017 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM [PAYMENTS PER DISCHARGE]'' is corrected to read as follows:

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2017 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per discharge]

	Number of hospitals (1)	Estimated average FY 2016 payment per discharge (2)	Estimated average FY 2017 payment per discharge (3)	FY 2017 changes (4)
All Hospitals	3,330	$11,542	$11,649	0.9
By Geographic Location:				
Urban hospitals	2,515	11,890	11,997	0.9
Large urban areas	1,369	12,690	12,799	0.9
Other urban areas	1,146	10,946	11,051	1.0
Rural hospitals	815	8,602	8,707	1.2
Bed Size (Urban):				
0–99 beds	659	9,392	9,478	0.9
100–199 beds	767	10,050	10,117	0.7
200–299 beds	446	10,757	10,840	0.8
300–499 beds	431	12,092	12,202	0.9
500 or more beds	212	14,613	14,772	1.1
Bed Size (Rural):				
0–49 beds	317	7,208	7,279	1.0
50–99 beds	292	8,192	8,292	1.2
100–149 beds	120	8,434	8,519	1.0
150–199 beds	46	9,243	9,367	1.3
200 or more beds	40	10,171	10,320	1.5
Urban by Region:				
New England	116	12,957	12,901	−0.4
Middle Atlantic	315	13,471	13,593	0.9
South Atlantic	407	10,498	10,595	0.9
East North Central	390	11,190	11,303	1.0
East South Central	147	10,042	10,160	1.2
West North Central	163	11,578	11,692	1.0
West South Central	385	10,693	10,820	1.2
Mountain	163	12,279	12,549	2.2
Pacific	378	15,372	15,452	0.5
Puerto Rico	51	8,491	8,513	0.3
Rural by Region:				
New England	21	11,818	12,009	1.6
Middle Atlantic	54	8,655	8,791	1.6
South Atlantic	128	8,043	8,122	1.0
East North Central	115	8,918	9,023	1.2
East South Central	155	7,639	7,716	1.0
West North Central	98	9,420	9,560	1.5
West South Central	160	7,243	7,328	1.2
Mountain	60	10,100	10,228	1.3
Pacific	24	12,045	12,197	1.3
By Payment Classification:				
Urban hospitals	2,522	11,886	11,993	0.9
Large urban areas	1,369	12,690	12,799	0.9
Other urban areas	1,153	10,940	11,046	1.0
Rural areas	808	8,602	8,706	1.2
Teaching Status:				
Nonteaching	2,266	9,600	9,680	0.8
Fewer than 100 residents	815	11,133	11,231	0.9
100 or more residents	249	16,764	16,949	1.1
Urban DSH:				
Non-DSH	589	10,055	10,140	0.8
100 or more beds	1,642	12,247	12,359	0.9
Less than 100 beds	363	8,853	8,914	0.7
Rural DSH:				
SCH	240	8,584	8,702	1.4
RRC	325	9,006	9,123	1.3
100 or more beds	29	7,018	7,054	0.5
Less than 100 beds	142	6,823	6,838	0.2
Urban teaching and DSH:				
Both teaching and DSH	898	13,344	13,474	1.0
Teaching and no DSH	109	11,361	11,442	0.7
No teaching and DSH	1,107	10,047	10,124	0.8
No teaching and no DSH	408	9,455	9,539	0.9
Special Hospital Types:				
RRC	189	9,709	9,824	1.2

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2017 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per discharge]

	Number of hospitals (1)	Estimated average FY 2016 payment per discharge (2)	Estimated average FY 2017 payment per discharge (3)	FY 2017 changes (4)
SCH	324	10,344	10,516	1.7
MDH	148	7,321	7,415	1.3
SCH and RRC	126	10,767	10,957	1.8
MDH and RRC	12	8,822	9,019	2.2
Type of Ownership:				
Voluntary	1,927	11,719	11,830	0.9
Proprietary	881	10,130	10,218	0.9
Government	522	12,485	12,596	0.9
Medicare Utilization as a Percent of Inpatient Days:				
0–25	523	14,996	15,160	1.1
25–50	2,122	11,460	11,562	0.9
50–65	545	9,343	9,431	0.9
Over 65	89	6,948	7,019	1.0
FY 2017 Reclassifications by the Medicare Geographic Classification Review Board:				
All Reclassified Hospitals	791	11,399	11,507	0.9
Non-Reclassified Hospitals	2,539	11,595	11,701	0.9
Urban Hospitals Reclassified	532	12,008	12,115	0.9
Urban Nonreclassified Hospitals	1,936	11,849	11,955	0.9
Rural Hospitals Reclassified Full Year	277	8,984	9,101	1.3
Rural Nonreclassified Hospitals Full Year	489	8,173	8,266	1.1
All Section 401 Reclassified Hospitals	72	11,307	11,474	1.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	48	7,889	7,954	0.8

7. On page 57324, top of the page, third column, last paragraph, line 1, the figure ''2,426'' is corrected to read ''2,419''.

8. On pages 57324 and 57325, the table titled ''Modeled Disproportionate Share Hospital Payments for Estimated FY 2017 DSHs by Hospital Type: Model DSH $ (In Millions) From FY 2016 to FY 2017'' is corrected to read as follows:

MODELED DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR ESTIMATED FY 2017 DSHS BY HOSPITAL TYPE: MODEL DSH $ (IN MILLIONS) FROM FY 2016 TO FY 2017

	Number of DSHs (FY 2017) (1)	FY 2016 final rule estimated DSH $ * (in millions) (2)	FY 2017 final rule estimated DSH $ * (in millions) (3)	Dollar difference: FY 2017–FY 2016 (in millions) (4)	Percent change ** (5)
Total	2,419	$9,767	$9,551	−$216	−2.2
By Geographic Location:					
Urban Hospitals	1,921	9,294	9,106	−188	−2.0
Large Urban Areas	1,045	5,885	5,765	−120	−2.0
Other Urban Areas	876	3,408	3,341	−68	−2.0
Rural Hospitals	498	473	445	−28	−5.9
Bed Size (Urban):					
0 to 99 Beds	336	189	185	−4	−2.2
100 to 249 Beds	837	2,211	2,154	−57	−2.6
250+ Beds	748	6,894	6,767	−127	−1.8
Bed Size (Rural):					
0 to 99 Beds	368	206	190	−16	−7.8
100 to 249 Beds	116	211	199	−12	−5.5
250+ Beds	14	56	56	0	−0.2
Urban by Region:					
East North Central	322	1,273	1,252	−22	−1.7
East South Central	129	574	566	−8	−1.4
Middle Atlantic	232	1,614	1,570	−44	−2.7
Mountain	125	448	448	0	−0.1
New England	90	394	385	−9	−2.4
Pacific	312	1,459	1,448	−10	−0.7
Puerto Rico	41	104	116	12	11.3

MODELED DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR ESTIMATED FY 2017 DSHS BY HOSPITAL TYPE: MODEL DSH $ (IN MILLIONS) FROM FY 2016 TO FY 2017—Continued

	Number of DSHs (FY 2017) (1)	FY 2016 final rule estimated DSH $ * (in millions) (2)	FY 2017 final rule estimated DSH $ * (in millions) (3)	Dollar difference: FY 2017–FY 2016 (in millions) (4)	Percent change ** (5)
South Atlantic	314	1,777	1,721	−56	−3.2
West North Central	104	451	439	−11	−2.5
West South Central	252	1,200	1,161	−39	−3.2
Rural by Region:					
East North Central	64	49	44	−4	−8.3
East South Central	141	149	141	−8	−5.3
Middle Atlantic	28	34	33	−1	−2.4
Mountain	21	16	15	0	−0.2
New England	11	15	16	1	7.2
Pacific	7	9	7	−3	−27.4
South Atlantic	86	98	92	−6	−6.4
West North Central	31	20	19	−1	−6.3
West South Central	109	83	78	−6	−7.0
By Payment Classification:					
Urban Hospitals	1,886	9,243	9,055	−188	−2.0
Large Urban Areas	1,043	5,884	5,764	−120	−2.0
Other Urban Areas	843	3,359	3,292	−68	−2.0
Rural Hospitals	533	523	496	−28	−5.3
Teaching Status:					
Nonteaching	1,544	3,117	3,053	−64	−2.1
Fewer than 100 residents	637	3,213	3,132	−81	−2.5
100 or more residents	238	3,437	3,366	−71	−2.1
Type of Ownership:					
Voluntary	1,405	6,044	5,913	−131	−2.2
Proprietary	541	1,672	1,629	−43	−2.6
Government	471	2,023	1,983	−40	−2.0
Unknown	2	27	25	−2	−6.1
Medicare Utilization Percent:					
Missing or Unknown	4	1	1	0	0.9
0 to 25	428	3,013	2,974	−39	−1.3
25 to 50	1,617	6,356	6,189	−166	−2.6
50 to 65	319	385	375	−10	−2.5
Greater than 65	51	12	11	−1	−8.2

Source: Dobson | DaVanzo analysis of 2011–2013 Hospital Cost Reports.

* Dollar DSH calculated by [0.25 * estimated section 1886(d)(5)(F) payments] + [0.75 * estimated section 1886(d)(5)(F) payments * Factor 2 * Factor 3]. When summed across all hospitals projected to receive DSH payments, DSH payments are estimated to be $9,767 million in FY 2016 and $9,551 million in FY 2017.

** Percentage change is determined as the difference between Medicare DSH payments modeled for the FY 2017 IPPS/LTCH PPS final rule (column 3) and Medicare DSH payments modeled for the FY 2016 IPPS/LTCH PPS final rule (column 2) divided by Medicare DSH payments modeled for the FY 2016 final rule (column 2) times 100 percent.

9. On page 57325, bottom of the page, third column, last paragraph, line 8, the figure ‘‘6.4’’ is corrected to read ‘‘5.9’’.

10. On page 57326, first column—

a. First partial paragraph—

(1) Line 7 the figure ‘‘5.2’’ is corrected to read ‘‘5.5’’.

(2) Line 8, the figure ‘‘5.9’’ is corrected to read ‘‘0.2’’.

b. First full paragraph, line 12, the figure ‘‘11.4’’ is corrected to read ‘‘11.3’’.

c. Third full paragraph (last paragraph)—

(1) Line 12, the figure ‘‘11.4’’ is corrected to read ‘‘11.3’’.

(2) Line 18, the figure ‘‘$9.5 million’’ is corrected to read ‘‘$9.4 million’’.

11. On page 57330, third column—

a. Fourth bulleted paragraph, line 4, the figure ‘‘0.9991’’ is corrected to read ‘‘0.9990’’.

b. Last paragraph, line 6, the figure ‘‘1.84’’ is corrected to read ‘‘1.83’’.

12. On page 57331, top half of the page—

a. First column—

(1) First partial paragraph—

(a) Line 1, the phrase ‘‘Less than half of the hospitals’’ is corrected to read ‘‘Most of the hospitals’’.

(b) Lines 4 through 6, the phrase ‘‘the effects of changes to the GAFs, while the remainder of these urban area hospitals would experience no change or a decrease in’’ is corrected to read ‘‘the effects of changes to the GAFs, while hospitals in one urban area are expected to experience a decrease in’’.

(c) Line 11, the phrase ‘‘except for two rural areas where changes in’’ is corrected to read, ‘‘except for one rural area where changes in’’.

(2) Third paragraph, lines 8 and line 9, the phrase ‘‘0.7 percent, while hospitals in rural areas, on average, are expected to experience a 0.8’’ is corrected to read ‘‘0.7 percent, and hospitals in rural areas, on average, are also expected to experience a 0.7’’.

b. Second column—

(1) First partial paragraph, lines 2 through 6, the sentence ‘‘The primary factor contributing to the small difference in the projected increase in capital IPPS payments per case for urban hospitals as compared to rural hospitals is the changes to the GAFs.’’ is corrected by deleting the sentence.

(2) First full paragraph—

(a) Lines 4 through 8, ‘‘range from a 4.2 percent increase for the Puerto Rico urban hospitals, and a 1.4 percent

increase for the West South Central urban region to a 0.7 percent increase for the Mountain urban region.'' is corrected to read ''range from a 4.1 percent increase for the Puerto Rico urban hospitals, and a 2.1 percent increase for the Mountain urban region to a 0.7 percent increase for several other urban regions.''.

(b) Line 13, the figure ''4.2'' is corrected to read ''4.1''.

(c) Line 23, the figure ''1.6'' is corrected to read ''2.1''.

(d) Line 26, the figure ''0.4'' should read ''0.1''.

c. Third column—

(1) First full paragraph, line 9, the figure ''0.7'' is corrected to read ''0.6''.

(2) Second full paragraph—

(a) Line 13, the figure ''1.0'' is corrected to read ''0.9''.

(b) Line 17, the figure ''1.0'' is corrected to read ''0.9''.

(c) Line 20, the figure ''0.2'' is corrected to read ''0.3''.

13. On pages 57331 and 57332, the table titled ''Table III.—Comparison of Total Payments Per Case [FY 2016 Payments Compared To FY 2017 Payments]'' is corrected to read as follows:

TABLE III—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2016 payments compared to FY 2017 payments]

	Number of hospitals	Average FY 2016 payments/case	Average FY 2017 payments/case	Change
By Geographic Location:				
All hospitals	3,330	912	920	0.8
Large urban areas (populations over 1 million)	1,369	1,011	1,019	0.7
Other urban areas (populations of 1 million of fewer)	1,146	871	879	0.9
Rural areas	815	618	623	0.7
Urban hospitals	2,515	947	955	0.8
0–99 beds	659	768	774	0.8
100–199 beds	767	824	829	0.6
200–299 beds	446	865	871	0.7
300–499 beds	431	958	967	0.9
500 or more beds	212	1,139	1,149	0.9
Rural hospitals	815	618	623	0.7
0–49 beds	317	520	524	0.7
50–99 beds	292	577	582	0.8
100–149 beds	120	610	614	0.6
150–199 beds	46	669	673	0.6
200 or more beds	40	738	745	0.9
By Region:				
Urban by Region	2,515	947	955	0.8
New England	116	1,031	1,024	−0.6
Middle Atlantic	315	1,056	1,064	0.7
South Atlantic	407	840	847	0.8
East North Central	390	908	915	0.8
East South Central	147	793	804	1.3
West North Central	163	923	930	0.7
West South Central	385	858	868	1.1
Mountain	163	977	998	2.1
Pacific	378	1,219	1,227	0.7
Puerto Rico	51	435	453	4.1
Rural by Region	815	618	623	0.7
New England	21	868	878	1.1
Middle Atlantic	54	591	603	2.1
South Atlantic	128	584	584	0.0
East North Central	115	638	643	0.9
East South Central	155	562	566	0.9
West North Central	98	666	668	0.4
West South Central	160	536	542	1.2
Mountain	60	718	717	−0.1
Pacific	24	804	812	1.0
By Payment Classification:				
All hospitals	3,330	912	920	0.8
Large urban areas (populations over 1 million)	1,369	1,011	1,019	0.7
Other urban areas (populations of 1 million of fewer)	1,153	870	878	0.9
Rural areas	808	619	623	0.7
Teaching Status:				
Non-teaching	2,266	771	776	0.7
Fewer than 100 Residents	815	885	892	0.8
100 or more Residents	249	1,287	1,298	0.9
Urban DSH:				
100 or more beds	1,642	968	976	0.8
Less than 100 beds	363	696	702	0.8
Rural DSH:				
Sole Community (SCH/EACH)	240	575	581	1.0
Referral Center (RRC/EACH)	325	649	654	0.7
Other Rural:				
100 or more beds	29	538	540	0.4

TABLE III—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2016 payments compared to FY 2017 payments]

	Number of hospitals	Average FY 2016 payments/case	Average FY 2017 payments/case	Change
Less than 100 beds	142	526	528	0.3
Urban teaching and DSH:				
Both teaching and DSH	898	1,043	1,052	0.9
Teaching and no DSH	109	942	948	0.6
No teaching and DSH	1,107	813	820	0.8
No teaching and no DSH	408	815	820	0.6
Rural Hospital Types:				
Non special status hospitals	2,529	948	955	0.7
RRC/EACH	189	772	782	1.4
SCH/EACH	324	706	716	1.4
SCH, RRC and EACH	126	748	756	1.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2017 Reclassifications:				
All Urban Reclassified	532	953	962	0.9
All Urban Non-Reclassified	1,936	948	955	0.7
All Rural Reclassified	277	650	655	0.9
All Rural Non-Reclassified	489	578	580	0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	42	599	602	0.5
Type of Ownership:				
Voluntary	1,927	926	934	0.8
Proprietary	881	820	827	0.8
Government	522	963	969	0.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	523	1,103	1,114	1.0
25–50	2,122	916	923	0.8
50–65	545	745	750	0.7
Over 65	89	529	531	0.4

14. On page 57342—

a. Top of the page—

(1) First column, first full paragraph—

(a) Line 11, the figure ''987'' is corrected to read ''990''.

(b) Line 23, the figure ''809'' is corrected to read ''811''.

(2) Second column, first partial paragraph—

(a) Line 12, the figure ''809'' is corrected to read ''811''.

(b) Line 14, the figure''680'' is corrected to read ''683''.

(c) Line 19, the figure ''66'' is corrected to read ''72''.

(d) Line 23, the figure ''746'' is corrected to read ''755''.

b. Middle of the page, the table titled ''TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2016 TO FY 2017'' is corrected to read as follows:

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2016 TO FY 2017

Category	Transfers
Annualized Monetized Transfers	$755 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.

Dated: September 29, 2016.

Madhura Valverde,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2016–24042 Filed 9–30–16; 11:15 am]

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–R4–ES–2015–0132; 4500030113]

RIN 1018–AZ09

Endangered and Threatened Wildlife and Plants; Threatened Species Status for Kentucky Arrow Darter With 4(d) Rule

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), determine threatened species status under the Endangered Species Act of 1973 (Act), as amended, for Kentucky arrow darter (*Etheostoma spilotum*), a fish species from the upper Kentucky River basin in Kentucky. The effect of this regulation will be to add this species to the List of Endangered and Threatened Wildlife. We are also adopting a rule under section 4(d) of the Act (a ''4(d) rule'') to further provide for the conservation of the Kentucky arrow darter.