307 of the CAA as amended (42 U.S.C. 7410, 7426 and 7607).

V. Judicial Review

Under section 307(b)(1) of the CAA, judicial review of this final rule is available only by the filing of a petition for review in the U.S. Court of Appeals for the appropriate circuit by March 6, 2017. Under section 307(b)(2) of the CAA, the requirements that are the subject of this final rule may not be challenged later in civil or criminal proceedings brought by us to enforce these requirements.

List of Subjects in 40 CFR Part 52

Environmental protection, Administrative practices and procedures, Air pollution control, Electric utilities, Incorporation by reference, Intergovernmental relations, Nitrogen oxides, Ozone.

Dated: December 15, 2016.

Gina McCarthy,

Administrator.

[FR Doc. 2016–31258 Filed 12–30–16; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 414, 416, 419, 482, 486, 488, and 495

[CMS–1656–CN]

RIN 0938–AS82

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital; Correction and Extension of Comment Period

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

ACTION: Correction and extension of comment period for final rule and interim final rule.

SUMMARY: This document corrects technical errors that appeared in the final rule with comment period and interim final rule with comment period published in the **Federal Register** on November 14, 2016, entitled ''Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital.''

This document extends the comment period to January 3, 2017 for both the final rule with comment period and the interim final rule with comment period.

DATES: *Effective date:* This correction is effective January 1, 2017.

Comment period: The comment period for the final rule and interim final rule, published November 14, 2016 (81 FR 79562), is extended to 5 p.m. E.S.T. on January 3, 2017.

FOR FURTHER INFORMATION CONTACT:

Hospital Outpatient Prospective Payment System (OPPS), contact Lela Strong (410) 786–3213.

Electronic Health Record (EHR) Incentive Programs, contact Kathleen Johnson (410) 786–3295 or Steven Johnson (410) 786–3332.

Hospital Outpatient Quality Reporting (OQR) Program Administration, Validation, and Reconsideration Issues, contact Elizabeth Bainger at (410) 786–0529

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2016–26515 of November 14, 2016 (81 FR 79562), titled ''Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital'' (hereinafter referred to as the CY 2017 OPPS/ASC final rule), there were a number of technical errors that are identified and corrected in the Correction of Errors section below. The provisions in this correction document are effective as if they had been included in the document published November 14, 2016. Accordingly, the corrections are effective January 1, 2017.

II. Extension of Comment Period

We are extending the comment period. We inadvertently scheduled the comment period to end on December 31, 2016, a Saturday. We ordinarily do not end the comment period on a weekend or federal holiday. Therefore, we are extending the comment period for the final rule and interim final rule to end on the next business day, January 3, 2017.

III. Summary of Errors

A. Errors in the Preamble

1. Hospital Outpatient Prospective Payment System (OPPS) Corrections

On page 79566, in the Table of Contents, we inadvertently included a title that referred to the CY 2017 OPPS/ASC proposed rule instead of the final rule with comment period. We are correcting the title in this correcting document. On the same page, in the table of contents, we made a typographical error in the title of the sixth item, which we are correcting to match the title in the preamble of the document.

On page 79569, we incorrectly stated estimated total payments to OPPS providers as $773 million. We have corrected this figure to be $64 billion.

On page 79582, we incorrectly stated that status indicator ''J1'' procedure claims with modifier ''50'' were included in the C–APC claims accounting and the complexity adjustment evaluations as of January 1, 2015.'' Instead, these claims were included in the C–APC complexity adjustment evaluations presented in the CY 2017 OPPS/ASC final rule with comment period. The results of these evaluations were included in the C–APC complexity adjustment evaluations tab of Addendum J to the CY 2017 OPPS/ASC final rule with comment period.

On pages 79584, we inadvertently omitted discussion of one of the recommendations from the August 2016 meeting of the Advisory Panel on

Hospital Outpatient Payment (HOP Panel). The HOP Panel recommended that, ''CMS provide further information and data for stakeholders to review on how comprehensive APCs are created and their effects; and CMS provide more time for the public to review the information and make proposals to the Panel.'' In this correcting document, we address this recommendation.

On page 79587, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rate listed for C–APC 5244 (Level 4 Blood Product Exchange and Related Services).

On page 79595, we made technical errors by inadvertently excluding the wage index data for 6 providers in Alaska, Virginia, Ohio, Mississippi, and Puerto Rico when calculating the weight scaler for budget neutrality. We have corrected the weight scaler for budget neutrality to include the wage index data for those 6 providers, which results in a change of the weight scaler from 1.4208 to 1.4214. This revised weight scaler affects all payments that are scaled for budget neutrality. As a result we are also providing corrected addenda as described in the ''Summary of Errors and Corrections to the OPPS and ASC Addenda Posted on the CMS Web site'' section below.

On pages 79607 through 79608, we use the payment rates available in Addenda A and B to display calculation of adjusted payment and copayment. Due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment and copayment numbers used in the example to reflect the corrections.

On page 79621, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 13—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Auditory Osseointegrated Procedures (81 FR 79621) for CPT codes 69714, 69715, 69717, and 69718.

On page 79622, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 14—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for CPT Codes 28297 and 28740.

On page 79624, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 16—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Percutaneous Vertebral Augmentation/Kyphoplasty Procedures.

On page 79627, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 18—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Transcranial Magnetic Stimulation (TMS) Therapy Codes.

On page 79629, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are updating the payment rates for CPT code 75571 to $59.86, for CPT code 77080 to $112.73, and for APC 5822 (Level 2 Health and Behavior Services) to $70.26 for CY 2017.

On pages 79636 through 79637, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 23—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Transprostatic Urethral Implant Procedures.

On pages 79638 through 79639, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 25—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates Certain Cryoablation Procedures.

On page 79641, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 28—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Dialysis Circuit Procedures.

On page 79643, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rate for CPT code 77371 to $7,455.99 as well as the payment rates in Table 30—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Procedures.

On page 79645, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 32—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Smoking and Tobacco Use Cessation Counseling Services.

On page 79647, we used imprecise language in describing HCPCS codes G0237, G0238, and G0239. Specifically, we stated that ''we believe that we should reassign HCPCS codes G0237, G0238, and G0239 to status indictor ''S'' because these codes also describe pulmonary rehabilitation services.'' We are clarifying that these codes describe respiratory treatment services. We acknowledge that the original language could be interpreted to mean that these codes describe pulmonary rehabilitation services, which was not our intent.

On page 79648, due to the change in OPPS payment rates as a result of the updated OPPS weight scaler, we are also updating the payment rates in Table 34—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Pulmonary Rehabilitation Services.

On page 79662, we incorrectly made certain Status Indicator (SI) and APC assignments in Table 35—Drugs and Biologicals For Which Pass-Through Payment Status Expires December 31, 2016. Specifically, we incorrectly assigned a SI of ''N'' (Items and Services Packaged into APC Rates) to a number of drugs that should have been assigned a SI of ''K'' (Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals). These drugs have also been assigned to APCs for CY 2017. Additionally, on page 79662, we incorrectly described two Long Descriptors (for HCPCS codes J7181 and 7201) that were displayed in Table 35. These Long Descriptors have been revised for CY 2017.

On page 79664, we incorrectly described two Long Descriptors (for HCPCS codes A9587 and A9588) that were displayed in Table 36—Drugs and Biologicals With Pass-Through Payment Status in CY 2017. These Long Descriptors have been revised for CY 2017.

On page 79671, we made technical errors to the description of certain Healthcare Common Procedure Coding System (HCPCS) codes that appeared in Table 37—Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2017. Specifically, we are removing HCPCS codes Q4119, Q4120, and Q4129 to accurately show that these codes were deleted on December 31, 2016, and should not have appeared in Table 37. These codes were correctly assigned to OPPS SI ''D'' in the OPPS Addendum B that was released with the CY 2017 OPPS/ASC final rule.

On page 79708, we used imprecise language in the summary of final policy on how we would apply the ''billing .–. . prior to November 2, 2015,'' statutory language in determining whether an off-campus PBD is excepted or not. Specifically, we stated in the preamble that ''off campus PBDs would be eligible to receive OPPS payment as excepted off- campus PBDs for services that were furnished prior to November 2, 2015, and billed under the OPPS in accordance with timely filing limits.'' We are clarifying that the policy is not specific to services, but rather so long as an off-campus PBD furnished a covered

OPD service prior to November 2, 2015 and billed the OPPS within timely filing limits for that service that the off-campus PBD would be excepted from payment adjustment under the final section 603 payment policy for the items and services the off-campus PBD furnishes on or after January 1, 2017. As noted in the sentence prior (81 FR 79708), we agreed with the commenters that an interpretation of the ''billing under this subsection with respect to covered OPD services furnished prior to [November 2, 2015]'' statutory language could allow for an exception for off-campus PBDs that furnished a covered OPD service prior to November 2, 2015, but had not submitted a bill to Medicare for such service prior to November 2, 2015.

On page 79719, we described the changes to regulation and incorrectly stated the effective date to implement section 603 of Public Law 114–74 is effective January 1, 2017, for cost reporting periods beginning January 1, 2017. The effective date is for items and services furnished on or after January 1, 2017, regardless of when the cost reporting period begins. We have corrected this language to delete the reference to cost reporting periods.

On pages 79869 through 79870, we provided and described Table 52—Estimated Impact of the CY 2017 Changes for the Hospital Outpatient Prospective Payment System, based on rates which applied the incorrect scaler. We have updated the impact table and the description of the table to reflect these corrections.

On Page 79877, we incorrectly described implementation of Section 603 of the Bipartisan Budget Act of 2015 as reducing OPPS payments by $500 million in 2017. We have corrected this estimate to be a reduction of total Part B payments by $50 million in 2017.

2. Ambulatory Surgical Center (ASC) Payment System Corrections

On pages 79741 through 79742, in the discussion of additions to the list of ASC covered surgical procedures, we incorrectly stated that CPT code 22851 (Application of intervertebral biomechanical device(s) (*e.g.,* synthetic cage(s), methlmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)) was deleted effective April 13, 2016. This code was deleted effective December 31, 2016.

On page 79743 in Table 51—Additions to the List of ASC Covered Surgical Procedures for CY 2017 (81 FR 79743), we inadvertently excluded CPT code 22585 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)). This code has a CY 2017 ASC payment indicator of N1.

On pages 79752 through 79753, we inadvertently published an incorrect ASC conversion factor of $45.030 for ASCs that meet the quality reporting requirements. Also, on pages 79752 through 79753, we inadvertently published an incorrect ASC wage index budget neutrality adjustment of 0.9996 that is being corrected to 0.9997. For ASCs that do not meet the quality reporting requirements, we finalized an ASC conversion factor of $44.330. The ASC conversion factor for ASCs that meet the quality reporting requirements is the product of the CY 2016 conversion factor multiplied by the wage index budget neutrality adjustment of 0.9997 and the MFP-adjusted CPI–U payment update (81 FR 79752 to 79753). We have since determined that the 2016 conversion factor of $44.190 used to calculate the CY 2017 conversion factor is incorrect. The corrected 2016 ASC conversion factor for ASCs that meet the quality reporting requirements is $44.177, as finalized in the CY 2016 final rule with comment period (80 FR 70501). Using the correct 2016 ASC conversion factor of $44.177, we have recalculated the 2017 ASC conversion factor to be $45.003 for ASCs that meet quality reporting requirements and a conversion factor of $44.120 for ASCs that do not meet quality reporting requirements. The corrected conversion factor will slightly change payment for some ASC services; therefore we have revised payment rates in ASC addendum AA and addendum BB.

3. Interim Final Rule with Comment Period Corrections

On page 79725, we referenced table X.B.2, but did not include the table in the interim final rule with comment period. This table, Payment for Nonexcepted Items and Services by OPPS Status Indicator, has been posted to the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1656-FC-2017-OPPS-Status-Indicator.zip.*

4. Hospital Outpatient Quality Reporting Program Correction

On page 79784, there was a typographical error in the table entitled ''Previously Finalized and Newly Finalized Hospital OQR Program Measure Set for the CY 2020 Payment Determination and Subsequent Years''. As listed in the table, the measure OP–30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use incorrectly included three asterisks after the name Three asterisks indicates that a measure is voluntary. This measure should have had only two asterisks to indicate that the measure name was updated to reflect the National Quality Forum title, not three, as it is not a voluntary measure. Accordingly, we are correcting the table and updating the number of asterisks next to OP–30 from three to two asterisks.

B. Regulation Text Corrections

1. OPPS Corrections

To implement the provisions of section 1833(t) of the Act, as amended by section 603 of Public Law 114–74, in the CY 2017 OPPS/ASC final rule with comment period, we amended the Medicare regulations by (1) adding a new paragraph (v) to § 419.22 to specify that, effective January 1, 2017, for cost reporting periods beginning January 1, 2017, excluded from payment under the OPPS are items and services that are furnished by an off-campus provider-based department that do not meet the definition of excepted items and services; and (2) adding a new § 419.48 that sets forth the definition of excepted items and services, and also the definition of ''excepted off-campus provider-based department''. On page 79879, we incorrectly stated that the effective date was based on cost reporting periods and are striking that language. Also, on page 79880, we incorrectly implied that on-campus provider-based departments that furnish services after November 2, 2015, could no longer bill under the OPPS in the regulation text at 419.48(b). In addition, on page 79880, in the regulation text at 419.48(b), the definition of an ''excepted off-campus provider-based department'' does not accurately state that the department of a provider must also have billed within timely filing limits. The revised regulation text corrects these technical errors.

2. Electronic Health Record (EHR) Incentive Programs Corrections

In the CY 2017 OPPS/ASC final rule, we inadvertently omitted amendments to § 495.40 that were included in an earlier-published final rule with comment period titled ''Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria

for Physician-Focused Payment Models'' (referred to as the Quality Payment Program (QPP) final rule) (81 FR 77008, 77556–77557, November 4, 2016). We are making the corrections to § 495.40 described below in order to preserve the earlier amendments to that section as finalized in the QPP final rule.

On page 79892, in § 495.40, ''Demonstration of meaningful use criteria,'' paragraph (a), ''Demonstration by EPs,'' we inadvertently omitted a reference to § 495.22 in the introductory text. We are correcting the introductory text to state that an EP must demonstrate that he or she satisfies each of the applicable objectives and associated measures under § 495.20, § 495.22, or § 495.24. Additionally, we are correcting the introductory text to include the phrase ''supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT:'' as finalized in the QPP final rule (81 FR 77556), which updates requirements for demonstration of meaningful use to include activities related to health information technology.

On page 79892, in § 495.40, ''Demonstration of meaningful use criteria,'' we are correcting the inadvertent omission of § 495.40(a)(2)(i)(H) and (I) as finalized in the QPP final rule (81 FR 77556), which revise attestation requirements and require EPs to attest their cooperation with certain authorized health IT surveillance and direct review activities as part of demonstrating meaningful use under the Medicare and Medicaid EHR Incentive Programs.

On page 79892, in § 495.40, ''Demonstration of meaningful use criteria,'' paragraph (b), ''Demonstration by eligible hospitals and CAHs,'' we inadvertently omitted a cross reference to § 495.22 in the introductory text. We are correcting the introductory text to state that an eligible hospital or CAH must demonstrate that it satisfies each of the applicable objectives and associated measures under § 495.20, § 495.22, or § 495.24. Additionally, we are correcting the introductory text to include the phrase ''supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT:'' as finalized in the QPP (81 FR 77556), which updates the requirements for demonstration of meaningful use to include activities related to health information technology.

On page 79892, in § 495.40 (b), ''Demonstration by eligible hospitals and CAHs,'' we are correcting the inadvertent omission of § 495.40 (b)(2)(i)(H) and (I) as finalized in the QPP final rule (81 FR 77556 through 77557), which revises attestation requirements and requires eligible hospitals and CAHs to attest their cooperation with certain authorized health IT surveillance and direct review activities as part of demonstrating meaningful use under the Medicare and Medicaid EHR Incentive Programs.

C. Summary of Errors and Corrections to the OPPS and ASC Addenda Posted on the CMS Web site

In Addendum J, on the Complexity Adjustment tab, CPT code 36908—Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure) was incorrectly written as 368x8. Also, CPT code 24200 (Removal of foreign body, upper arm or elbow; subcutaneous) was incorrectly excluded from Addendum J. The revised version of Addendum J is available via the Internet on the CMS Web site.

The payment and copayment rates in Addendum A (Final OPPS APCs for CY 2017), Addendum B (Final OPPS Payment by HCPCS Code for CY 2017), Addendum C (Final HCPCS Codes Payable Under the 2017 OPPS by APC), ASC Addendum AA (Final ASC Covered Surgical Procedures for CY 2016 (Including Surgical Procedures for Which Payment is Packaged)), ASC Addendum BB (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2016 (Including Ancillary Services for Which Payment is Packaged)) and the payment rates in the 2017 Drug, Blood, Brachytherapy Costs Statistics file that were published on the CMS Web site in conjunction with the CY 2017 OPPS/ASC Final Rule with comment period have been updated to reflect corrections to the weight scaler. The payment rates included in the corrected versions of the Addenda have also been corrected within the text of the CY 2017 OPPS/ASC Final Rule with comment period, as well as under the columns titled ''Final CY 2017 OPPS Payment Rate'' in Tables 13, 14, 16, 18, 23, 25, 28, 30, 32, and 34.

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the notice and comment and delay in effective date APA requirements; in cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and 60-day comment period and delay in effective date requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process are impracticable, unnecessary, or contrary to the public interest. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and an agency includes a statement of support.

We believe that this correcting document does not constitute a rulemaking that would be subject to these requirements. This correcting document corrects technical and typographic errors in the preamble, addenda, payment rates, tables, and appendices included or referenced in the CY 2017 OPPS/ASC final rule with comment period and interim final rule with comment period but does not make substantive changes to the policies or payment methodologies that were adopted in the final rule with comment period and interim final rule with comment period. As a result, the corrections made through this correcting document are intended to ensure that the information in the CY 2017 OPPS/ASC final rule with comment period and interim final rule with comment period accurately reflects the policies adopted in those rules.

In addition, even if this were a rulemaking 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 with comment period and interim final rule with comment period 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 CY 2017 OPPS/ASC final rule with comment period and interim final rule with comment period accurately reflect our policies as of the date they take effect and are applicable.

Furthermore, such procedures would be unnecessary, as we are not altering our payment methodologies or policies, but rather, we are simply correctly implementing the policies that we previously proposed, received comment on, and subsequently finalized. This correcting document is intended solely to ensure that the CY 2017 OPPS/ASC final rule with comment period and interim final rule with comment period accurately reflects these payment methodologies and policies. For these reasons, we believe we have good cause to waive the notice and comment and effective date requirements.

V. Correction of Errors

In FR Doc. 2016–26515 of November 14, 2016 (81 FR 79562), make the following corrections:

Preamble Corrections

1. On page 79566, third column,

a. In line 44, Table of Contents, the title ''5. Summary of Proposals'' is corrected to read ''5. Summary of Final Policies''.

b. In line 45, Table of Contents, the title ''6. Final Changes to Regulations'' is corrected to read ''6. Changes to Regulations''.

2. On page 79569, second column, second full paragraph, under the bulleted item, ''OPPS Update,'' in line 20, replace ''$773 million'' with ''$64 billion''.

3. On page 79582, third column, second full paragraph, under a response to public comment, in lines 29 through 34, the last sentence of the paragraph is corrected to read ''Status indicator ''J1'' procedure claims with modifier ''50'' will be included in the complexity adjustment evaluation for CY 2017. This evaluation can be found in Addendum J to the CY 2017 OPPS/ASC final rule with comment period.''

4. On page 79584, first column, first partial paragraph, in line 21, the following language is inserted after ''. . . analyses of the C–APC payment policy.'' and before ''Regarding the comment about creating. . . .'': We are accepting the recommendation that the HOP Panel made at the August 22, 2016 meeting to ''provide further information and data for stakeholders to review on how comprehensive APCs are created and their effects and to provide more time for the public to review the information and make proposals to the Panel.'' We plan to provide the results of an analysis of our comprehensive packaging policies in CY 2017. In addition, we will consider scheduling future HOP Panel meetings on a date that allows stakeholders as much time as is practicable subsequent to display of the proposed rule to analyze and review our proposed policies and other data prior to the meeting.

5. On page 79587, third column, first full paragraph, in line 16, replace ''$27,752'' with ''$27,764''.

6. On page 79595, third column, third paragraph, replace ''1.4208'' with ''1.4214.''

7. On page 79607,

a. First column, bottom half of the page, last full paragraph—

(1) In line 17, replace ''$538.88'' with ''$539.11.''

(2) In line 21, replace ''$528.10'' with ''$528.33.''

b. In the second column, first partial paragraph,

(1) In lines 1 and 2, replace ''$418.26 (.60 * $538.88 * 1.2936).'' with ''$418.44 (.60 * $539.11 * 1.2936).''

(2) In line 5, replace ''$409.89 (.60 * $528.10 * 1.2936).'' with ''$410.07 (.60 * $528.33 * 1.2936).''

(3) In line 8, replace ''$215.55 (.40 * $538.88).'' with ''$215.64 (.40 * $539.11).''

(4) In line, replace ''$211.24 (.40 * $528.10).'' with ''$211.33 (.40 * $528.33).''

(5) In lines 15 and 16, replace ''$633.81 ($418.26 +$215.55).'' with ''$634.08 ($418.44 +$215.64).''

(6) In lines 18 and 19, replace ''$621.13 ($409.89 + $211.24).'' with ''$621.40 ($410.07 + $211.33).''

8. On page 79608, second column, third full paragraph, under ''Step 1,'' in lines 5 and 8, replace ''$107.78'' with $107.83'' and ''$538.88'' with ''$539.11.''

9. On page 79621, Table 13—Final CY 2017 Status Indicator (SI), APC, and Payment Rates for the Auditory Osseointegrated Procedures, is corrected to read as follows:

TABLE 13—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE AUDITORY OSSEOINTEGRATED PROCEDURES

CPT code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy.	J1	5125	$10,537.90	J1	5115	$9,561.23
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy.	J1	5125	10,537.90	J1	5116	14,704.13
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy.	J1	5123	4,969.26	J1	5114	5,221.57

TABLE 13—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE AUDITORY OSSEOINTEGRATED PROCEDURES—Continued

CPT code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy.	J1	5124	7,064.07	J1	5115	9,561.23

10. On page 79622, Table 14—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for CPT Codes 28297 and 28740, is corrected to read as follows:

TABLE 14—FINAL CY 2017 STAUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR CPT CODES 28297 AND 28740

CPT code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
28297	Correction, hallux valgus (bunion), with or without sesamoidectomy; lapidus-type procedure.	J1	5124	$7,064.07	J1	5114	$5,221.57
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint.	J1	5124	7,064.07	J1	5114	5,221.57

11. On page 79624, Table 16—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Percutaneous Vertebral Augmentation/Kyphoplasty Procedures, is corrected to read as follows:

TABLE 16—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE PERCUTANEOUS VERTEBRAL AUGMENTATION/KYPHOPLASTY PROCEDURES

CPT code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic.	J1	5124	$7,064.07	J1	5114	$5,221.57
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar.	J1	5124	7,064.07	J1	5114	5,221.57
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure).	N	N/A	Packaged	N	N/A	Packaged

12. On page 79627, Table 18—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Transcranial Magnetic Stimulation (TMS) Therapy Codes, is corrected to read as follows:

TABLE 18—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE TRANSCRANIAL MAGNETIC STIMULATION (TMS) THERAPY CODES

CPT code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
90867	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; initial, including cortical mapping, motor threshold determination, delivery and management.	S	5722	$220.35	S	5722	$232.31
90868	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session.	S	5722	220.35	S	5722	232.31
90869	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent motor threshold re-determination with delivery and management.	S	5722	$220.35	S	5721	$127.10

13. On page 79629,

a. Second column,

1. First partial paragraph, last sentence, in line 19, replace ''$59.84'' with $59.86

2. Second full paragraph, last sentence, in line 27, replace ''$112.69'' with ''$112.73''.

b. Third column, first full paragraph, in line 16, replace ''70.23.'' with ''$70.26.''

14. On pages 79636 through 79637, Table 23—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Transprostatic Urethral Implant Procedures, is corrected to read as follows:

TABLE 23—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS AND PAYMENT RATES FOR THE TRANSPROSTATIC URETHRAL IMPLANT PROCEDURES

CPT/HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants.	J1	5375	$3,393.73	J1	5375	$3,484.01
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants.	T	1565	5,250.00	J1	5376	7,452.66
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant.	B	N/A	N/A	B	N/A	N/A
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure).	B	N/A	N/A	B	N/A	N/A

15. On pages 79638 through 79639, Table 25—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates Certain Cryoablation Procedures, is corrected to read as follows:

TABLE 25—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR CERTAIN CRYOABLATION PROCEDURES

CPT/HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation.	T	5352	$4,118.23	J1	5114	$5,221.57
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation.	T	5352	4,118.23	J1	5361	4,199.13
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy.	T	5352	4,118.23	J1	5362	6,969.84
0340T	Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance.	T	5352	4,118.23	J1	5361	4,199.13
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve.	J1	5361	4,001.15	J1	5432	4,151.86
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve.	J1	5361	4,001.15	J1	5432	4,151.86
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve).	T	5352	4,118.23	J1	5432	4,151.86

16. On page 79641, Table 28—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Dialysis Circuit Procedures, is corrected to read as follows:

TABLE 28—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE DIALYSIS CIRCUIT PROCEDURES

Proposed CY 2017 CPT code	Final CY 2017 CPT code	Short descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
36147	36147	Access av dial grft for eval	T	5181	$862.51	D		
36148	36148	Access av dial grft for proc	N			D		
369X1	36901	Intro cath dialysis circuit				T	5181	$684.13
369X2	36902	Intro cath dialysis circuit				J1	5192	4,825.20
369X3	36903	Intro cath dialysis circuit				J1	5193	9,752.43
369X4	36904	Thrmbc/nfs dialysis circuit				J1	5192	4,825.20
369X5	36905	Thrmbc/nfs dialysis circuit				J1	5193	9,752.43
369X6	36906	Thrmbc/nfs dialysis circuit				J1	5194	14,782.14
369X7	36907	Balo angiop ctr dialysis seg				N	N/A	N/A
369X8	36908	Stent plmt ctr dialysis seg				N	N/A	N/A
369X9	36909	Dialysis circuit embolj				N	N/A	N/A

17. On page 79643,

a. First column, first partial paragraph, in line 14, replace ''$7, 453.'' with ''$7,456.''

b. Table 30—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) Procedures, is corrected to read as follows:

TABLE 30—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE MAGNETIC RESONANCE IMAGE GUIDED HIGH INTENSITY FOCUSED ULTRASOUND (MRgFUS) PROCEDURES

CPT/HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	T	5414	$1,861.18	J1	5414	$2,085.47

TABLE 30—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE MAGNETIC RESONANCE IMAGE GUIDED HIGH INTENSITY FOCUSED ULTRASOUND (MRgFUS) PROCEDURES—Continued

CPT/ HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	T	5414	1,861.18	J1	5414	2,085.47
0398T	Magnetic resonance image guided high intensity focused ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.	E	N/A	N/A	S	1537	9,750.50
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	T	5122	2,395.59	J1	5114	2,085.47

18. On page 79645, Table 32—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Smoking and Tobacco Use Cessation Counseling Services, is corrected to read as follows:

TABLE 32—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENT, AND PAYMENT RATE FOR THE SMOKING AND TOBACCO USE CESSATION COUNSELING SERVICES

CPT/ HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment rate	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment rate
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.	S	5821	$27.12	S	5821	$25.23
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.	S	5821	27.12	S	5821	25.23
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.	S	5821	27.12	D	N/A	N/A
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.	S	5822	69.65	D	N/A	N/A

19. On page 79647, first column, second full paragraph, under a response to public comment, the last two sentences of the paragraph are corrected to read ''However, the rationale for this modification of the proposal for these codes is not related to the statutory provision of section 144 of the Medicare Improvements for Patients and Providers Act of 2008. We believe that pulmonary rehabilitation (and the related respiratory treatment services) are not typically ancillary to the other HOPD services that may be furnished to beneficiaries. These services are typically part of a course of treatment that is prescribed after a diagnosis is made and often after other treatments are initiated or completed.''

20. On page 79648, Table 34—Final CY 2017 Status Indicator (SI), APC Assignments, and Payment Rates for the Pulmonary Rehabilitation Services, is corrected to read as follows:

TABLE 34—FINAL CY 2017 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE PULMONARY REHABILITATION SERVICES

HCPCS code	Long descriptors	CY 2016 OPPS SI	CY 2016 OPPS APC	CY 2016 OPPS payment	Final CY 2017 OPPS SI	Final CY 2017 OPPS APC	Final CY 2017 OPPS payment
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring).	Q1	5734	$91.18	S	5732	$28.38
G0238	Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring).	Q1	5733	55.94	S	5732	28.38
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).	Q1	5732	30.51	S	5732	28.38
G0424	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day.	Q1	5733	55.94	S	5733	54.55

21. On page 79662, Table 35—Drugs and Biologicals for Which Pass-Through Payment Status Expires December 31, 2016, is corrected to read as follows:

TABLE 35—DRUGS AND BIOLOGICALS FOR WHICH PASS–THROUGH PAYMENT STATUS EXPIRES DECEMBER 31, 2016

CY 2017 HCPCS code	CY 2017 Long descriptor	Final CY 2017 status indicator	Final CY 2017 APC
C9497	Loxapine, inhalation powder, 10 mg	K	9497
J1322	Injection, elosulfase alfa, 1mg	K	1480
J1439	Injection, ferric carboxymaltose, 1 mg	K	9441
J1447	Injection, TBO-Filgrastim, 1 micrograms	K	1748
J3145	Injection, testosterone undecanoate, 1 mg	N	N/A
J3380	Injection, vedolizumab, 1 mg	K	1489
J7181	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u	K	1746
J7200	Factor ix (antihemophilic factor, recombinant), Rixubus, per i.u	K	1467
J7201	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u	K	1486
J7205	Injection, factor viii, fc fusion protein, (recombinant), per i.u	K	1656
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	N	N/A
J9301	Injection, obinutuzumab, 10 mg	K	1476
J9308	Injection, ramucirumab, 5 mg	K	1488
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	K	1466
Q4121	Theraskin, per square centimeter	N	N/A

22. On page 79664, Table 36—Drugs and Biologicals with Pass-Through Payment Status in CY 2017, the Long Descriptors for CY HCPCS codes A9588 and A9587 are revised to read as follows:

CORRECTIONS TO TABLE 36—DRUGS AND BIOLOGICALS WITH PASS–THROUGH PAYMENT STATUS IN CY 2017

CY 2016 HCPCS code	CY 2017 HCPCS code	CY 2017 Long descriptor	CY 2017 status indicator	CY 2017 APC
N/A	A9588	Fluciclovine f-18, diagnostic, 1 mCi	G	9052
N/A	A9587	Gallium Ga-68, dotatate, diagnostic, 0.1 mCi	G	9056

23. On page 79671, in Table 37—Assignments to High Cost and Low Cost Groups for CY 2017, remove HCPCS codes Q4119, Q4120, and Q4129.

24. On page 79708, third column, in lines 28 through 31, the words ''for services that were furnished prior to November 2, 2015, and billed under the OPPS in accordance with timely filing limits.'' are corrected to read ''if the PBD furnished a covered OPD service prior to November 2, 2015 and billed the OPPS within timely filing limits for that service.''

25. On page 79719, third column, first partial paragraph, in lines 6 and 7, remove the words ''for cost reporting periods beginning January 1, 2017,''.

26. On page 79741, third column, fourth full paragraph, in lines 10 and 11, the words ''was deleted by the AMA Editorial Panel in April 2016.'' are corrected to read ''will be deleted effective December 31, 2016.''

27. On page 79742, first column, first full paragraph, in lines 2 and 3, the words ''was deleted effective April 13, 2016,'' are corrected to read ''will be deleted effective December 31, 2016,''.

28. On page 79743, Table 51—Additions To The List of ASC Covered Surgical Procedures For CY 2017, CPT code 22585 is added in numerical order to read as follows:

CORRECTIONS TO TABLE 51—ADDITIONS TO THE LIST OF ASC COVERED SURGICAL PROCEDURES FOR CY 2017

CY 2017 CPT code	CY 2017 long descriptor	CY 2017 ASC payment indicator
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure).	N1

29. On page 79752, third column, bottom half of the page, first full paragraph,

a. In line 11, replace ''0.9996'' with ''0.9997.''

b. In line 27, replace ''$45.030'' with ''$45.003.''

c. In line 30, replace ''$44.190'' with ''$44.177.''

d. In line 32, replace ''0.9996'' with ''0.9997.''

30. On page 79753,

a. First column, first partial paragraph,

(1) In line 9, replace ''$44.330'' with ''$44.120.''

(2) In line 12, replace ''$44.190'' with ''$44.177.''

(3) In line 14, replace ''0.9996'' with ''0.9997.''

b. Second column, second full paragraph, in line 7, replace ''$45.030'' with ''$45.003.''

31. On page 79784, the un-numbered table—PREVIOUSLY FINALIZED AND NEWLY FINALIZED HOSPITAL OQR PROGRAM MEASURE SET FOR THE CY 2020 PAYMENT DETERMINATION AND SUBSEQUENT YEARS, is corrected by removing the three asterisks, ''***'' after the OP–30 measure name and adding in its place two asterisks, ''**'' to read as follows:

0659	OP–30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.**

32. On page 79868,

a. Second column, first full paragraph, in line 3, replace ''1.7'' with ''1.8.''

b. Third column, first paragraph, in lines 15 and 16, ''an increase of 0.1 percent to 0.3 percent'' is corrected to read ''no change to an increase of 0.3 percent.''

33. On page 79869,

a. Second column, first full paragraph, in line 11, replace ''1.7'' with ''1.8.''

b. Third column, first full paragraph, in line 2, replace ''1.7'' with ''1.8.''

34. On pages 79869 through 79870, Table 52—Estimated Impact of the CY 2017

Changes for the Hospital Outpatient Prospective Payment System, is corrected to read as follows:

TABLE 52—IMPACT OF CHANGES FOR FINAL CY 2017 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	APC recalibration (all changes) (2)	New wage index and provider adjustments (3)	All budget neutral changes (combined cols 2,3) with market basket update (4)	All changes (5)
All Providers*	3906	0.0	0.0	1.7	1.8
All Hospitals (excludes hospitals held harmless and CMHCs)	3789	0.0	0.0	1.8	1.8
Urban Hospitals	2958	0.0	0.0	1.7	1.8
Large Urban (GT 1 Mill.)	1616	0.0	−0.1	1.6	1.7
Other Urban (LE 1 Mill.)	1342	0.1	0.1	1.8	1.8
Rural Hospitals	831	0.2	0.3	2.2	2.2
Sole Community	376	0.2	0.4	2.3	2.2
Other Rural	455	0.2	0.2	2.1	2.1
Beds (Urban):					
0–99 Beds	1045	−0.3	0.2	1.6	1.7
100–199 Beds	834	0.2	−0.1	1.8	1.8
200–299 Beds	465	0.2	0.0	1.9	1.9
300–499 Beds	405	0.1	0.0	1.8	1.9
500 + Beds	209	−0.2	0.0	1.4	1.5
Beds (Rural):					
0–49 Beds	340	0.3	0.5	2.6	2.5
50–100 Beds	299	0.2	0.4	2.4	2.3
101–149 Beds	108	0.1	−0.2	1.6	1.7
150–199 Beds	45	0.0	0.4	2.2	2.1
200 + Beds	39	0.2	0.2	2.1	2.1

TABLE 52—IMPACT OF CHANGES FOR FINAL CY 2017 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals (1)	APC recalibration (all changes) (2)	New wage index and provider adjustments (3)	All budget neutral changes (combined cols 2,3) with market basket update (4)	All changes (5)
Region (Urban):					
New England	146	0.0	−1.1	0.6	0.6
Middle Atlantic	350	0.0	0.1	1.7	1.7
South Atlantic	465	0.1	0.0	1.7	1.8
East North Cent	473	0.1	0.1	1.8	1.9
East South Cent	177	−0.4	0.3	1.6	1.7
West North Cent	182	−0.1	0.0	1.6	1.5
West South Cent	527	−0.2	0.3	1.8	1.9
Mountain	206	0.2	1.0	2.9	3.0
Pacific	383	0.4	−0.3	1.7	1.8
Puerto Rico	49	0.5	−0.3	1.8	1.8
Region (Rural):					
New England	21	0.9	0.5	3.1	3.0
Middle Atlantic	55	0.1	1.2	3.0	3.0
South Atlantic	126	0.3	−0.3	1.7	1.7
East North Cent	121	0.2	0.3	2.2	2.2
East South Cent	158	0.0	0.2	1.9	1.9
West North Cent	100	0.0	0.4	2.1	2.0
West South Cent	168	0.2	0.7	2.6	2.6
Mountain	58	0.2	−0.1	1.9	1.8
Pacific	24	0.3	−0.1	1.9	1.9
Teaching Status:					
Non-Teaching	2712	0.1	0.1	1.9	2.0
Minor	731	0.1	0.0	1.9	1.9
Major	346	−0.2	−0.1	1.4	1.5
DSH Patient Percent:					
0	10	−1.7	−0.2	−0.2	−0.1
GT 0–0.10	305	−0.4	0.0	1.2	1.3
0.10–0.16	270	0.1	0.1	1.8	1.8
0.16–0.23	600	0.1	0.1	2.0	2.0
0.23–0.35	1135	0.1	0.1	1.9	1.9
GE 0.35	895	0.1	−0.1	1.7	1.7
DSH not Available **	574	−1.4	−0.2	0.1	0.2
Urban Teaching/DSH:					
Teaching & DSH	975	0.0	0.0	1.6	1.7
No Teaching/DSH	1425	0.1	0.1	1.9	1.9
No Teaching/No DSH	10	−1.7	−0.2	−0.2	−0.1
DSH Not Available2	548	−1.4	−0.3	0.0	0.1
Type of Ownership:					
Voluntary	1983	0.1	0.1	1.8	1.9
Proprietary	1306	0.0	0.1	1.7	1.8
Government	500	−0.1	−0.1	1.5	1.6
CMHCs	50	−15.0	−0.4	−13.9	−13.7

Column (1) shows total hospitals and/or CMHCs.
Column (2) includes all final CY 2017 OPPS policies and compares those to the CY 2016 OPPS.
Column (3) shows the budget neutral impact of updating the wage index by applying the final FY 2017 hospital inpatient wage index, including all hold harmless policies and transitional wages. The rural adjustment continues our current policy of 7.1 percent so the budget neutrality factor is 1. The budget neutrality adjustment for the cancer hospital adjustment is 1.003 because the payment-to-cost ratio target changes from 0.92 in CY 2016 to 0.91 in CY 2017.
Column (4) shows the impact of all budget neutrality adjustments and the addition of the final 1.65 percent OPD fee schedule update factor (2.7 percent reduced by 0.3 percentage points for the final productivity adjustment and further reduced by 0.75 percentage point in order to satisfy statutory requirements set forth in the Affordable Care Act). It also includes the impact of the additional adjustment of 1.0004 for Lab services with L1 Modifiers packaged into the OPPS.
Column (5) shows the additional adjustments to the conversion factor resulting from the frontier adjustment, a change in the pass-through estimate, and adding estimated outlier payments.
These 3,906 providers include children and cancer hospitals, which are held harmless to pre-BBA amounts, and CMHCs.
** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

■ 35. On page 79871, third column, first partial paragraph, in the last line, replace ''$45.016'' with ''$45.003.''

■ 36. On page 79877, third column, last paragraph, in lines 2 and 3, the phrase ''OPPS payments by $500 million'' is corrected to read ''Part B payments by $50 million.''

Regulations Text Corrections

§ 419.22 [Corrected]

■ 37. On page 79879, second column, in § 419.22, ''Hospital services excluded

from payment under the hospital outpatient prospective payment system,'' the words ''for cost reporting periods beginning on or after January 1, 2017,'' are removed.

■ 38. On page 79880, first column, in § 419.48, paragraph (b) is corrected to read as follows:

§ 419.48, ''Definition of excepted items and services

* * * * *

(b) For the purpose of this section, ''excepted off-campus provider-based department'' means a ''department of a provider'' (as defined at § 413.65(a)(2) of this chapter) that is located on the campus (as defined in § 413.65(a)(2) of this chapter) or within the distance described in such definition from a ''remote location of a hospital'' (as defined in § 413.65(a)(2) of this chapter) that meets the requirements for provider-based status under § 413.65 of this chapter. This definition also includes an off-campus department of a provider that was furnishing services prior to November 2, 2015 that were billed under the OPPS in accordance with timely filing limits.

* * * * *

■ 39. Section 495.40 is corrected as follows:

■ a. On page 79892, in the first column, in amendment 27, redesignate instructions d through f as instructions e through g respectively and add a new instruction d to read ''d. Adding paragraphs (a)(2)(i)(H) and (I).''

■ b. On page 79892, in the second column, in amendment 27, correct redesignated instruction g to read ''g. Adding new paragraphs (b)(2)(i)(G), (H), and (I).''

■ c. On page 79892, in the second column, paragraph (a) introductory text is correctly revised.

■ d. On page 79892, in the second column, paragraphs (a)(2)(i)(H) and (I) are added.

■ e. On page 79892, in the second column, paragraph (b) introductory text is correctly revised.

■ f. On page 79892, in the third column paragraphs (b)(2)(i)(H) and (I) are added.

The revisions and additions read as follows:

§ 495.40 Demonstration of meaningful use criteria.

(a) Demonstration by EPs. An EP must demonstrate that he or she satisfies each of the applicable objectives and associated measures under § 495.20, § 495.22 or § 495.24, supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT:

* * * * *

(2) * * *

(i) * * *

(H) *Supporting providers with the performance of CEHRT (SPPC).* To engage in activities related to supporting providers with the performance of CEHRT, the EP—

(*1*) Must attest that he or she:

(*i*) Acknowledges the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

(*ii*) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.

(*2*) Optionally, may also attest that he or she:

(*i*) Acknowledges the option to cooperate in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC–ACB surveillance is received; and

(*ii*) If requested, cooperated in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by the EP in the field.

(I) *Support for health information exchange and the prevention of information blocking.* For an EHR reporting period in CY 2017 and subsequent years, the EP must attest that he or she—

(*1*) Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

(*2*) Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times—

(*i*) Connected in accordance with applicable law;

(*ii*) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;

(*iii*) Implemented in a manner that allowed for timely access by patients to their electronic health information; and

(*iv*) Implemented in a manner that allowed for the timely, secure, and trusted bidirectional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate Certified EHR technology and vendors.

(*3*) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.''

* * * * *

(b) Demonstration by eligible hospitals and CAHs. An eligible hospital or CAH must demonstrate that it satisfies each of the applicable objectives and associated measures under § 495.20, § 495.22, or § 495.24, supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT:

* * * * *

(2) * * *

(i) * * *

(H) *Supporting providers with the performance of CEHRT (SPPC).* To engage in activities related to supporting providers with the performance of CEHRT, the eligible hospital or CAH—

(*1*) Must attest that it:

(*i*) Acknowledges the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

(*ii*) If requested, cooperated in good faith with ONC direct review of its health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the eligible hospital or CAH in the field.

(*2*) Optionally, may attest that it:

(*i*) Acknowledges the option to cooperate in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC–ACB surveillance is received; and

(*ii*) If requested, cooperated in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the eligible hospital or CAH in the field.

(I) *Support for health information exchange and the prevention of information blocking.* For an EHR reporting period in CY 2017 and subsequent years, the eligible hospital or CAH must attest that it—

(*1*) Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

(*2*) Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times—

(*i*) Connected in accordance with applicable law;

(*ii*) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;

(*iii*) Implemented in a manner that allowed for timely access by patients to their electronic health information; and

(*iv*) Implemented in a manner that allowed for the timely, secure, and trusted bidirectional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.

(*3*) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.''.

* * * * *

Dated: *December 27, 2016.*

Madhura Valverde,

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

[FR Doc. 2016–31774 Filed 12–30–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 433, 438, 440, 457, and 495

[CMS–2390–F3]

RIN–0938–AS25

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Corrections

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

ACTION: Final rule; correcting amendment.

SUMMARY: This document corrects technical errors that appeared in the final rule published in the May 6, 2016 **Federal Register** (81 FR 27498 through 27901) entitled, ''Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability.'' The effective date for the rule was July 5, 2016.

DATES: *Effective Date:* This correcting document is effective December 30, 2016.

Applicability Date: The corrections indicated in this document are applicable beginning immediately.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2016–09581 (81 FR 27498 through 27901), the final rule entitled, ''Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability'' there were technical errors that are identified and corrected in this correcting document. These corrections are applicable immediately.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 27560 we made a technical error in the response to comments of § 438.6(e). In this response, we inadvertently identified the effective date and the date by which we would enforce compliance for the regulation, which is correctly identified in the Compliance section on page 27499.

On page 27679 we made a technical error in the preamble text of § 438.330 (Quality Assessment and Performance Improvement Program) in a response to comment. We stated, ''Note that standards for risk adjustment are provided in §§ 438.5(g) and 438.7(b)(5).'' We inadvertently omitted the words ''for payment purposes'' after ''risk adjustment'' in this sentence to clarify that these cross-referenced sections are related to risk adjustment for payment purposes.

On page 27708 we made a technical error in the preamble text of § 438.358 (Activities Related to External Quality Review) in a response to comment about § 438.358(b)(iv) (Validation of MCO, PIHP, or PAHP validation of network adequacy). We inadvertently included PIHPs and PAHPs in a statement about the match rate for this EQR-related activity for MCOs. We stated, ''. . . the validation of MCOs, PIHPs, and PAHPs would be eligible for the 75 percent match rate under § 438.370(a).'' This was in error, as it conflicts with § 438.370 of the final rule and the preamble discussion of that section on pages 27715 through 27717.

On page 27712 we made a technical error in the preamble text of § 438.360 (Nonduplication of mandatory activities with Medicare or accreditation review) in a response to comment about updating the EQR protocols to incorporate data from a Medicare or private accrediting entity review. We referenced three of the mandatory EQR-related activities using the citation from the proposed rule (§ 438.358(b)(1) to (b)(3)), rather than the citation from the final rule (§ 438.358(b)(1)(i) to (b)(1)(iii)).

On page 27738 we made a technical error in the response to comments of § 438.242(b)(2). In this response, we inadvertently mistyped ''T–MSIS.''

On page 27766 we made a technical error in the preamble text of § 457.1233. We inadvertently did not note that CHIP is also adopting the changes discussed in the Medicaid preamble to include PCCM entities as subject to § 438.230 in