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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495

[CMS–1677–CN]

RIN–0938–AS98

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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; 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 14, 2017, issue of the **Federal Register**, which will amend the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2018.

DATES: This correction is effective October 1, 2017.

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

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2017–16434 of August 14, 2017 (82 FR 37990) there were a number of technical and typographical errors that are identified and corrected by 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 14, 2017 **Federal Register**. Accordingly, the corrections are effective October 1, 2017.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 37990, we are making a conforming correction, removal of the reference to part 488, based on the removal of the regulations text for § 488.5 described in section II.B. of this correcting document.

On pages 38067 and 38068, we are correcting technical errors in our discussion and summary of and response to public comment regarding ICD–10–PCS procedure codes describing procedures involving percutaneous insertion of intraluminal or monitoring device. Specifically, we erroneously referred to a count of 28 procedure codes describing procedures involving the percutaneous insertion of intraluminal and monitoring devices into central nervous system and other cardiovascular body parts rather than 18 procedure codes. Of the 28 codes listed in Table 6P.4b associated with the proposed rule, 10 procedure codes were duplicative, and erroneously included in the table and in the total number of codes referenced in the preamble. As indicated in the final rule, after consideration of the public comments we received, we maintained the designation of 15 procedure codes identified by the commenters. For this reason, we are also correcting Table 6P.4b associated with the final rule (as discussed in section II.E. of this correcting document) to reflect the 3 distinct procedure codes for which we finalized a change in designation, including to remove the listings of ICD–10–PCS procedure codes 00H032Z (Insertion of Monitoring Device into Brain, Percutaneous Approach) and 00H632Z (Insertion of Monitoring Device into Cerebral Ventricle, Percutaneous Approach), which we finalized to maintain as O.R. procedures for FY 2018, and are making conforming changes to the corresponding count of codes listed in that table as indicated on page 38068. Consistent with these corrections, we are also correcting the description of the proposal on page 38067 of the final rule. As a result of the corrections to Table 6P.4b associated with the final rule and the conforming corrections on pages 38067 and 38068, we have made conforming changes to the ICD–10 MS–DRG Definitions Manual Version 35 and ICD–10 MS–DRG Grouper Software Version 35 for FY 2018 to reflect the O.R. designation of ICD–10–PCS procedure codes 00H032Z (Insertion of Monitoring Device into Brain, Percutaneous Approach) and 00H632Z (Insertion of Monitoring Device into Cerebral Ventricle, Percutaneous Approach), as finalized on page 38068 of the final rule for FY 2018.

In addition, after publication of the FY 2018 IPPS/LTCH PPS final rule, we became aware that the logic for the ICD–10 MS–DRG Definitions Manual Version 35 and the ICD–10 MS–DRG Grouper and Medicare Code Editor (MCE) Version 35 Software erroneously designated the following ICD–10–PCS procedure code as a non-O.R. procedure rather than as an O.R. procedure as finalized on page 38072 of the final rule for FY 2018: 0BCC8ZZ (Extirpation of matter from right upper lung lobe, via natural or artificial opening endoscopic). Therefore, we also made changes to the ICD–10 MS–DRG Definitions Manual Version 35 and the ICD–10 MS–DRG Grouper and MCE Version 35 Software to correctly reflect the O.R. designation for this procedure code for FY 2018.

We recalculated the FY 2018 MS–DRG relative weights (and associated statistics, such as average length of stay (ALOS)) as a result of the corrections to the logic for the ICD–10 MS–DRG Grouper Version 35 Software discussed above. In addition, since the MS–LTC–DRGs used under the LTCH PPS for FY 2018 are the same as the MS DRGs used under the IPPS for FY 2018 (and as such use the same ICD–10 MS–DRG Grouper Version 35 Software), we also recalculated the FY 2018 MS–LTC–DRG relative weights (and associated statistics, such as geometric ALOS) for the same reasons.

On page 38119, we made a technical error in describing which ICD–10–PCS procedure codes will be used to identify cases involving ZINPLAVA™ that are eligible for new technology add-on payments in FY 2018. Specifically, cases involving ZINPLAVA™ that are eligible for new technology add-on payments will be identified by either of the ICD–10–PCS procedure codes listed in the final rule (XW033A3 or XW043A3) (rather than requiring the combination of both ICD–10–PCS procedure codes).

On pages 38132 and 38137, in our discussion of the wage indexes, we provided incorrect values for the FY 2018 national average hourly wage (unadjusted for occupational mix) and the FY 2018 occupational mix adjusted national average hourly wage due to inadvertent errors related to the wage data collected from the Medicare cost reports of six hospitals (CMS Certification Numbers (CCNs) 240010, 420033, 420037, 420038, 420078, and 420102).

On page 38144, we made an inadvertent error in the mailing address

for the Medicare Geographic Review Board (MGCRB).

On page 38195, in our discussion regarding disproportionate share hospitals (DSHs), we made errors in the June 2017 Office of the Actuary's estimate for FY 2018 Medicare DSH payments.

On page 38225, we made typographical errors in our description of several Hospital Readmissions Reduction Program (HRRP) measures.

On page 38249, in our response to a comment, we advertently referenced the MORT–30–PN measure, instead of the PN Payment measure.

On page 38257 through 38259, in our discussion of the Hospital Value-Based Purchasing (HVBP) Program, we made several typographical and technical errors to references and dates.

On pages 38309 and 38310, we are correcting the MS–LTC–DRG normalization factor and the MS–LTC DRG budget neutrality factor based on the recalculation of the MS–LTC–DRG relative weights due to the corrections to the MS–DRG Grouper Software Version 35 described previously. (Because the MS–LTC–DRGs used under the LTCH PPS are the same as the MS–DRGs used under the IPPS, the corrections to the MS–DRG Grouper Software Version 35 described previously affect the MS–LTC–DRGs groupings by extension.)

On pages 38426, 38434, 38440, and 38458, in our discussion of the LTCH Quality Reporting Program (QRP), we made technical and typographical errors including an error in our description of a quality measure.

B. Summary of Errors in the Regulations Text

On page 38516, we inadvertently retained regulations language from the proposed rule at § 488.5(a)(21), regarding accrediting organizations, after stating in the preamble of the final rule that we had decided not to adopt such language. In addition, on page 38509, we inadvertently retained a description of subjects set out in 42 CFR part 488 in the ''List of Subjects.'' We are correcting these errors by removing the description of subjects, amendatory instructions, and regulations text for part 488.

On page 38516, in the regulations text provisions for § 495.4 (definitions for the Electronic Health Record (EHR) Incentive Program), we inadvertently omitted the definition of certified electronic health record technology (CEHRT) for 2018.

On page 38517, in the regulations text provisions for § 495.24, we inadvertently omitted an EHR measure change for eligible professionals (EPs) in § 495.24(d)(6)(i)(B)(*1*)(*iv*).

C. Summary of Errors in the Addendum

As discussed in section II.A. of this correcting document, we are making corrections to the logic for the ICD–10 MS–DRG Grouper Version 35 Software for three ICD–10–PCS procedure codes (0BCC8ZZ, 00H032Z and 00H632Z) that had been erroneously designated as non-O.R. procedures rather than as O.R. procedures as finalized for FY 2018. As a result, we have recalculated the FY 2018 MS–DRG relative weights after applying the changes in the Version 35 MS–DRG groupings to the FY 2016 MedPAR data used for the final rule.

The FY 2018 MS–DRG relative weights are used to calculate the MS–DRG reclassification and recalibration budget neutrality factor when comparing total payments using FY 2017 MS–DRG relative weights to total payments using the FY 2018 MS–DRG relative weights. Additionally, the FY 2018 MS–DRG relative weights are used when determining total payments for purposes of all other budget neutrality factors and the final outlier threshold, which are discussed in this section II.C. of this correcting document.

As discussed in section II.E. of this correcting document, we made several technical errors with regard to the calculation of Factor 3 of the uncompensated care payment methodology. Factor 3 is used to determine the total amount of the uncompensated care payment a hospital is eligible to receive for a fiscal year. This amount is then used to calculate the amount of the interim uncompensated care payments a hospital receives per discharge. Per discharge uncompensated care payments are included when determining total payments for purposes of all of the budget neutrality factors and the final outlier threshold.

As a result, the revisions made to address these technical errors regarding the calculation of Factor 3 directly affected the calculation of total payments and required the recalculation of all the budget neutrality factors and the final outlier threshold.

Because of the errors in the wage data for the six hospitals (CCNs 240010, 420033, 420037, 420038, 420078, and 420102), as discussed in section II.A. of this correcting document, we recalculated the FY 2018 national average hourly wages unadjusted for occupational mix and adjusted for occupational mix which resulted in the recalculation of the final FY 2018 IPPS wage indexes and the geographic adjustment factors (GAFs) (which are computed from the wage index). The final FY 2018 IPPS wage data are used in the calculation of the wage index budget neutrality adjustment when comparing total payments using the final FY 2017 IPPS wage index data to total payments using the final FY 2018 IPPS wage index data. Additionally, the final FY 2018 IPPS wage index data are used when determining total payments for purposes of the rest of the budget neutrality factors (except for the MS–DRG reclassification and recalibration budget neutrality factor) and the final outlier threshold. In addition, the final FY 2018 IPPS wage index data are used to calculate the FY 2018 LTCH PPS wage index values, certain budget neutrality factors, and the LTCH PPS standard Federal payment rate in the FY 2018 IPPS/LTCH PPS final rule.

Due to the correction of the combination of errors listed previously (recalculation of the MS–DRG relative weights, revisions to Factor 3 of the uncompensated care methodology and correction to the final FY 2018 IPPS wage index data), we recalculated all IPPS budget neutrality adjustment factors, the fixed-loss cost threshold, the final wage indexes (and GAFs), and the national operating standardized amounts and capital Federal rate. Therefore, we made conforming changes to the following:

- On page 38522 and 38532, the MS–DRG reclassification and recalibration budget neutrality factor.
- On page 38522, the wage index budget neutrality adjustment.
- On page 38522, the reclassification hospital budget neutrality adjustment.
- On page 38523, the rural and imputed floor budget neutrality adjustment.
- On page 38527, the calculation of the outlier fixed-loss cost threshold, the national outlier adjustment factors, total operating Federal payments, total operating outlier payments, and percentage of capital outlier payments.
- On page 38529, the table titled ''Changes From FY 2017 Standardized Amounts to the FY 2018 Standardized Amounts''.

On pages 38532 and 38534 through 38535, in our discussion of the determination of the Federal hospital inpatient capital related prospective payment rate update, due to the recalculation of the MS–DRG relative weights and GAFs we have made conforming corrections to the increase in the capital Federal rate, the capital outlier payment adjustment (budget neutrality) factor, the GAF/DRG budget neutrality adjustment factors, the capital Federal rate, and the outlier threshold (as discussed previously), along with

certain statistical figures (for example, percent change) in the accompanying discussions.

Also, as a result of these errors, on page 38535, we have made conforming corrections in the tables showing the comparison of factors and adjustments for the FY 2017 capital Federal rate and FY 2018 capital Federal rate and the proposed FY 2018 capital Federal rate and final FY 2018 capital Federal rate.

On pages 38537 and 38539, we are correcting the area wage level budget neutrality factor and making a conforming change to the FY 2018 LTCH PPS standard Federal payment rate due to corrections to the wage data discussed previously.

On page 38544, we are making conforming corrections to the fixed-loss amount for FY 2018 LTCH PPS standard Federal payment rate discharges and the high-cost outlier (HCO) threshold determined in absence of the required changes under the 21st Century Cures Act due to corrections in the MS–LTC–DRG data discussed previously.

On page 38545, we are making conforming corrections to the fixed-loss amount for site neutral discharges due to corrections in the IPPS rates and factors discussed previously.

On pages 38546 and 38547, we are making conforming corrections to the figures used in the example of computing the adjusted LTCH PPS Federal prospective payment for FY 2018.

On page 38548, we have made conforming corrections to the following:

- National adjusted 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).
- LTCH PPS standard Federal payment rate in Table 1E as a result of the correction to area wage level budget neutrality factor (as discussed previously).

Also, on page 38548, in Table 1E, we are correcting a technical error in our terminology by replacing ''Standard Federal Rate'' with 'Standard Federal Payment Rate''.

D. Summary of Errors in the Appendices

On pages 38552 through 38560 and 38572 through 38574 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 2018 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 sections II.A. and II.C. of this correcting document).

In particular, we made changes to the following tables.

- On pages 38552 through 38554, the table titled ''Table I.—Impact Analysis of Changes to the IPPS for Operating Costs for FY 2018''.
- On pages 38557 through 38558, the table titled ''FY 2018 IPPS Estimated Payments Due To Rural and Imputed Floor With National Budget Neutrality''.
- On pages 38559 and 38560, the table titled ''Table II—Impact Analysis of Changes for FY 2018 Acute Care Hospital Operating Prospective Payment System [Payments per Discharge]''.
- On pages 38572 through 38574, the table titled ''Table III—Comparison of Total Payments Per Case [FY 2017 Payments Compared to FY 2018 Payments]''.

On pages 38561 through 38564, we are correcting the discussion of the ''Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2018'' for purposes of the Regulatory Impact Analysis in Appendix A of the FY 2018 IPPS/LTCH PPS final rule in light of the corrections discussed in sections II.D. and II.E. of this correcting document.

On pages 38576 and 38578 through 38579, we made conforming corrections to the area wage level budget neutrality factor and the LTCH PPS standard Federal payment rate as described in section II.C. of this correcting document.

On page 38579, we are making conforming corrections to ''Table IV.—Impact of Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2018.'' We are also correcting technical errors in the terminology used in the title and column headings of Table IV by ensuring the use of ''Standard Federal Payment Rate''.

On page 38585, we made conforming corrections to the estimated increase in capital payments in FY 2018 compared to FY 2017.

E. 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 pages 38547 and 38548 of the FY 2018 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/FY2018-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 2018. The wage data errors related to the six hospitals required the recalculation of the FY 2018 national average hourly wages unadjusted for occupational mix and adjusted for occupational mix which resulted in recalculating the FY 2018 wage indexes. Also, the recalculation of the MS–DRG relative weights, the revisions to Factor 3 of the uncompensated care payment methodology and recalculation of the FY 2018 wage index necessitated the recalculation of the rural and imputed floor budget neutrality factor (as discussed in section II.C. of this correcting document). Therefore, we are correcting the values in the column titled ''FY 2018 Wage Index'' for all hospitals. Additionally, for the six hospitals for which we inadvertently used the incorrect wage data (as discussed in section II.A. of this correcting document), we are correcting the average hourly wages in the columns titled ''Average Hourly Wage FY 2018'' and ''3-Year Average Hourly Wage (2016, 2017, 2018)''.

Table 3.—Wage Index Table by CBSA–FY 2018. The wage data errors related to the six hospitals required the recalculation of the FY 2018 national average hourly wage adjusted for occupational mix which resulted in recalculating the FY 2018 wage indexes. Also, the recalculation of the MS–DRG relative weights, the revisions to Factor 3 of the uncompensated care payment methodology, and recalculation of the FY 2018 wage index necessitated the recalculation of the rural and imputed floor budget neutrality factor (as discussed in section II.C. of this correcting document). Therefore, 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 or Imputed Floor Wage Index'' and ''Eligible for Rural or Imputed Floor Wage Index''. Additionally, for the two CBSAs (24860 and 40340) where the six hospitals for which we inadvertently used the incorrect wage data are located (as discussed in section II.A. of this correcting document), we are correcting the average hourly wages in the

columns titled ''FY 2018 Average Hourly Wage'' and ''3-Year Average Hourly Wage (2016, 2017, 2018)''. As we described previously, we inadvertently used the incorrect wage data for the following hospitals: CCNs 240010, 420033, 420037, 420038, 420078 and 420102.

Table 5.—List of Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay—FY 2018. We are correcting this table to reflect the recalculation of the FY 2018 MS–DRG relative weights and associated statistics as a result of the corrections to the logic for the ICD–10 MS–DRG Grouper Version 35 Software discussed in section II.A. of this correcting document. Specifically, we are correcting the values in the columns titled ''Weights'', ''Geometric mean LOS'', and ''Arithmetic mean LOS''.

Table 6P.—ICD–10–CM and ICD–10–PCS Code Designations, MCE and MS–DRG Changes—FY 2018. As discussed in section II.A of this correcting document, we are correcting the list of the ICD–10–PCS procedure codes in Table 6P.4b to reflect the three ICD–10–PCS procedure codes relating to the percutaneous insertion of intraluminal or monitoring devices that are finalized as non-O.R. procedures for FY 2018.

Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2016 MedPAR Update—March 2017 GROUPER V35.0 MS–DRGs. We are correcting this table to reflect the recalculation of the FY 2018 MS–DRG relative weights and associated statistics as a result of the corrections to the logic for the ICD–10 MS–DRG Grouper Version 35 Software discussed in section II.A. of this correcting document.

Table 10—New Technology Add-On Payment Thresholds for Applications for FY 2019. We are correcting the thresholds in this table as a result of the corrections to the operating standardized amounts discussed in section II.C. of this correcting document.

Table 18.—Final FY 2018 Medicare DSH Uncompensated Care Payment Factor 3. We are correcting this table to reflect revisions to the Factor 3 calculations for purposes of determining uncompensated care payments for the FY 2018 IPPS/LTCH PPS final rule for the following reasons:

- To apply our finalized policy of double weighting the 2013 Factor 3 instead of developing a 2014 Factor 3 using uncompensated care cost data from Worksheet S–10 for several all-inclusive rate providers.
- To reflect mergers where data for the merged hospital were not combined with the data for the surviving hospital for purposes of calculating Factor 3 for the FY 2018 IPPS/LTCH PPS Final Rule.
- To correct the Factor 3 that was computed for a hospital whose FY 2014 cost report in the March 2017 extract of Healthcare Cost Report Information System (HCRIS) inadvertently omitted amended uncompensated care cost data reported on an amended Worksheet S–10 that had been received timely per CR 9648 issued on July, 15, 2016, and that was inadvertently omitted from the hospital's 2014 cost report when it was uploaded into HCRIS.
- To correct the Factor 3 that was computed for a hospital that only had Factor 3 values for two cost reporting periods, but whose Factor 3 was inadvertently calculated by dividing by three cost reporting periods when averaging the Factor 3 values.
- To correct the misapplication of our new hospital policy, where hospitals with a CMS Certification Number (CCN) established after October 1, 2013, but before October 1, 2014, were inadvertently considered subject to that policy when calculating Factor 3. As stated in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38212), only those hospitals with a CCN established after October 1, 2014, are considered new and subject to the new hospital policy when calculating Factor 3 for FY 2018.

We are revising Factor 3 for all hospitals to correct these errors. We are also revising the amount of the total uncompensated care payment calculated for each DSH-eligible hospital. The total uncompensated care payment that a hospital receives is used to calculate the amount of the interim uncompensated care payments the hospital receives per discharge. Per discharge uncompensated care payments are included when determining total payments for purposes of all of the budget neutrality factors and the final outlier threshold. As a result, 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. These corrections will be reflected in Table 18 and the Medicare DSH Supplemental Data File. In section II.D. of this correcting document, we have made corresponding revisions to the discussion of the ''Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2018'' for purposes of the Regulatory Impact Analysis in Appendix A of the FY 2018 IPPS/LTCH PPS final rule to reflect the corrections discussed previously.

We are also correcting the errors in the following LTCH PPS tables that are listed on page 38548 of the FY 2018 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-ServicePayment/LongTermCareHospitalPPS/index.html* under the list item for regulation number CMS–1677–F. The tables that are available on the Internet have been updated to reflect the revisions discussed in this correcting document.

Table 11.—MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2017 through September 30, 2018. We are correcting this table to reflect the recalculation of the FY 2018 MS–LTC–DRG relative weights and associated statistics as a result of the corrections to the logic for the Version 35 Grouper Software discussed in section II.A. of this correcting document.

Table 12A.—LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2017 through September 30, 2018. We are correcting this table to reflect the revisions to the LTCH PPS wage index values discussed in section II.C. of this correcting document.

Table 12B.—LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2017 through September 30, 2018. We are correcting this table to reflect the revisions to the LTCH PPS wage index values discussed in section II.C. of this correcting document.

We also note that we have made conforming changes to the ICD–10 MS–DRG Definitions Manual Version 35 for consistency with the ICD–10 MS–DRG Grouper and Medicare Code Editor (MCE) Version 35 Software. First, the ICD–10–CM diagnosis code P05.18 (Newborn small for gestational age, 2000–2499 grams) was displayed in the ICD–10 MS–DRG Definitions Manual Version 35 as grouping to both MS–DRGs 793 (Full Term Neonate with Major Problems) and 795 (Normal Newborn). The correct MS–DRG assignment for diagnosis code P05.18 is only MS–DRG 795; therefore, corrections were made to the ICD–10 MS–DRG Definitions Manual Version 35 to reflect the correct MS–DRG assignment. Second, the following 9 diagnosis codes were not included in the major problem list in the MS–DRG Definitions Manual: K56.600 (Partial intestinal obstruction, unspecified as to cause); K56.601 (Complete intestinal obstruction, unspecified as to cause);

K56.609 (Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction); K56.690 (Other partial intestinal obstruction); K56.691(Other complete intestinal obstruction); K56.699 (Other intestinal obstruction unspecified as to partial versus complete obstruction); K91.30 (Postprocedural intestinal obstruction, unspecified as to partial versus complete); K91.31 (Postprocedural partial intestinal obstruction); and K91.32 (Postprocedural complete intestinal obstruction). We made corrections to add these 9 diagnosis codes to the major problems list for MS–DRG 793 under Major Diagnostic Category (MDC) 15 (Newborns & Other Neonates with Conditions Originating in Perinatal Period) in the ICD–10 MS–DRG Definitions Manual Version 35.

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, regulations text, addendum, payment rates, tables, and appendices included or referenced in the FY 2018 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 2018 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 2018 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 2018 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.

Correction of Errors

In FR Doc. 2017–16434 of August 14, 2017 (82 FR 37990), we are making the following corrections:

A. Corrections of Errors in the Preamble

1. On page 37990, first column, line 8 (Part headings), the figures ''486, 488, 489, and 495'' are corrected to read ''486, 489, and 495''.

2. On page 38067—

a. Second column, last partial paragraph, line 1, the figure ''28'' is corrected to read ''18''.

b. Third column—

(1) First partial paragraph—

(a) Line 7, the phrase ''28 ICD–10–PCS'' is corrected to read ''28 (18 discrete) ICD–10–PCS''.

(b) Line 15, the phrase ''O.R. procedures. We invite public'' is corrected to read ''O.R. procedures. (We note that Table 6P.4b. associated with the proposed rule listed 28 rather than 18 ICD–10–PCS codes because we inadvertently included 10 duplicate codes. However only 18 discrete ICD–10–PCS codes were listed in that table.) We invite public''.

(2) First full paragraph—

(a) Line 3, the figure ''28'' is corrected to read ''18''.

(b) Line 9, the figure ''28'' is corrected to read ''18''.

3. On page 38068, top half of the page (between the untitled tables) first column—

a. First paragraph, line 5, the figure ''28'' is corrected to read ''18''.

b. Second paragraph, line 4, the figure ''13'' is corrected to read ''3''.

4. On page 38119, third column, first partial paragraph, lines 25 and 26, the phrase ''XW033A3 and XW043A3.'' is corrected to read ''XW033A3 or XW043A3.''

5. On page 38132—

a. Second column, first paragraph, last line, the figure ''$42.1027'' is corrected to read ''$42.0795''.

b. Third column, first partial paragraph, line 4, the figure $42.1027'' is corrected to read ''$42.0795''.

6. On page 38137, third column—

a. First full paragraph, last line, the figure $42.0564'' is corrected to read ''$42.0332''.

b. Last full paragraph, last line, the figure $42.0564'' is corrected to read ''$42.0332''.

7. On page 38144, first column, first partial paragraph, lines 8 through 10, the phrase ''2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244– 2670.'' is corrected to read ''1508 Woodlawn Drive, Suite 100, Baltimore, MD 21207.''.

8. On page 38195—

a. Top of the page, third column, first full paragraph, line 19, the figure ''$15.533'' is corrected to read ''$15.553''.

b. Bottom of the page in the table titled ''FACTORS APPLIED FOR FY 2015 THROUGH FY 2018 TO ESTIMATE MEDICARE DSH EXPENDITURES USING 2014 BASELINE'' last row (FY 2018), last column (Estimated DSH payment), the entry ''15.533'' is corrected to read ''15.553''.

9. On page 38225—

a. First column, last bulleted paragraph, lines 3 through 5, the phrase ''(AMI–Version 8.0, HF–Version 8.0, Pneumonia–Version 8.0, COPD–Version 4.0, and Stroke–Version 4.0: 2016'' is corrected to read ''(AMI–Version 9.0, HF–Version 9.0, Pneumonia–Version 9.0, COPD–Version 5.0, and Stroke–Version 5.0: 2016''.

b. Second column; first bulleted paragraph, lines 2 through 4, the phrase ''(THA and/or TKA–Version 4.0, CABG–Version 2.0: 2016'' is corrected to read ''(THA and/or TKA–Version 5.0, CABG–Version 3.0: 2016)''.

10. On page 38249, second column, last paragraph, lines 23 and 24, the parenthetical phrase ''(for example, the MORT–30–PN measure)'' is corrected to read ''(for example, PN Payment measure)''.

11. On page 38257, third column, footnote paragraph (footnote 69), last line, the date ''Mar 1997'' is corrected to read ''Mar 1977''.

12. On page 38258, first column, third paragraph—

a. Lines 8 and 9, the reference ''(78 FR 50074;'' is corrected to read ''(79 FR 50074;''.

b. Line 9, the reference ''80 FR 49588).'' is corrected to read ''80 FR 49558).''.

13. On page 38259, first column, first partial paragraph, line 14, the date ''June 0'' is corrected to read ''June 30''.

14. On page 38309, third column, first full paragraph, line 29 the figure ''1.28590'' is corrected to read ''1.28593''.

15. On page 38310, first column—

a. First full paragraph, line 29, the figure ''0.9907845'' is corrected to read ''0.9907437''.

b. Second full paragraph—

(1) Line 5, the figure ''1.28590'' is corrected to read ''1.28593''.

(2) Line 6, the figure ''0.9907845'' is corrected to read ''0.9907437''.

16. On page 38426—

a. First column, second full paragraph, line 21, the phrase ''an Application of Percent'' is corrected to read ''Application of Percent''.

b. Third column, third full paragraph, line 10, the phrase ''criteria; however should'' is corrected to read ''criteria. However, the measure should''.

17. On page 38434, in the first column, second paragraph—

a. Line 29, the phrase ''Stage 3 or 4 ulcers.'' is corrected to read ''Stage 3 or 4 pressure ulcers.''.

b. Line 31, the phrase ''Stage 1 and 2 ulcers decreased'' is corrected to read ''Stage 1 and 2 pressure ulcers decreased''.

c. Line 32, the phrase '' of Stage 3 and 4 ulcers'' is corrected to read ''of Stage 3 and 4 pressure ulcers''.

18. On page 38440, third column, last paragraph—

a. Lines 10 and 11, the phrase ''That nearly one third'' is corrected to read ''The fact that nearly one third''.

b. Lines 16 and 17, the phrase ''LTCH, and also indicates'' is corrected to read ''LTCH. It also indicates''.

19. On page 38458, third column, second full paragraph—

a. Lines 21 through 23, the phrase (measure name) ''Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632).'' is corrected to read ''Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support (NQF #2632).''.

b. Lines 31 through 34, the phrase (measure name) ''Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632)'' is corrected to read ''Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support (NQF #2632).''

20. On page 38509, second column, eighth full paragraph (List of subjects 42 CFR 488), the paragraph is corrected by removing the paragraph.

B. Correction of Errors in the Regulations Text

1. On page 38516, in the first column, remove the part heading for part 488 and remove amendatory instructions 34 and 35 in their entirety.

§ 495.4 [Corrected]

2. On page 38516, in the second column, after amendatory instruction 39a, add amendatory instruction a2 to read—

''a2. In the definition of ''Certified electronic health record technology (CEHRT)'':

i. In paragraph (1)(iii), removing the phrase ''for 2018 subsequent years'' and adding in its place the phrase ''for 2019 and subsequent years''; and

ii. In the introductory text of paragraph (2), removing the phrase ''For 2018 and subsequent years,'' and adding in its place the phrase ''For 2019 and subsequent years,''.''

§ 495.24 [Corrected]

3. On page 38517, second column, sixth full paragraph, amendatory instruction 41d is corrected and amendatory instructions 41e and f are correctly added to read as follows:

''d. Revising the paragraph (d) heading.

e. In paragraph (d)(6)(i)(B)(*1*)(*iv*) by removing the phrase ''For an EHR reporting period in 2017 only, an EP'' and adding in its place the phrase ''For an EHR reporting period in 2017 and 2018, an EP''.

f. Revising paragraphs (d)(6)(i)(B)(*2*)(*i*) and (*ii*), (d)(6)(ii)(B)(*1*)(*iv*), and (d)(6)(ii)(B)(*2*)(*i*) and (*ii*).''

C. Correction of Errors in the Addendum

1. On page 38522 —

a. Second column, first full paragraph—

(1) Line 3, the figure ''0.997432'' is corrected to read ''0.997439''.

(2) Line 8, the figure ''0.997432'' is corrected to read ''0.997439''.

b. Third column—

(1) First full paragraph, line 9, the figure ''1.001148'' is corrected to read ''1.000882''.

(2) Last paragraph, line 11 the figure ''0.988008'' is corrected to read ''0.987985''.

2. On page 38523, second column, first partial paragraph, line 2, the figure ''0.993348'' is corrected to read ''0.993324''.

3. On page 38527, lower two-thirds of the page (after the first untitled table), third column—

a. First partial paragraph—

(1) Line 4, the figure ''$26,601'' is corrected to read ''$26,537''.

(2) Line 5, the figure ''85,942,484,975'' is corrected to read ''$90,203,348,168''.

(3) Line 6, the figure ''$4,618,707,285'' is corrected to read ''$4,600,554,656''.

(4) Line 17, the figure ''$26,601'' is corrected to read ''$26,537''.

b. First full paragraph, line 13, the figure ''5.16'' is corrected to read ''5.17''.

c. Following the third full paragraph, the untitled table is corrected to read as follows:

	Operating standardized amounts	Capital federal rate
National	0.948998	0.948259

4. On page 38529, top of the page, the table titled ''CHANGES FROM FY 2017 STANDARDIZED AMOUNTS TO THE FY 2018 STANDARDIZED AMOUNTS'', is corrected to read as follows:

CHANGES FROM FY 2017 STANDARDIZED AMOUNTS TO THE FY 2018 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 2018 Base Rate after removing:				
1. FY 2017 Geographic Reclassification Budget Neutrality (0.988136).	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:
2. FY 2017 Operating Outlier Offset (0.948998).	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.
3. FY 2017 2-Midnight Rule One-Time Prospective Increase (1.006).	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.
4. FY 2017 Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.999997).	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:
	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34. Nonlabor (38%): $2,221.98.
FY 2018 Update Factor	1.0135	0.99325	1.00675	0.9865.
FY 2018 MS–DRG Recalibration Budget Neutrality Factor.	0.997439	0.997439	0.997439	0.997439.
FY 2018 Wage Index Budget Neutrality Factor.	1.000882	1.000882	1.000882	1.000882.
FY 2018 Reclassification Budget Neutrality Factor.	0.987985	0.987985	0.987985	0.987985.
FY 2018 Operating Outlier Factor.	0.948998	0.948998	0.948998	0.98998.
Adjustment for FY 2018 Required under Section 414 of Pub. L. 114–10 (MACRA) and Section 15005 of Pub. L. 114–255.	1.004588	1.004588	1.004588	1.004588.
National Standardized Amount for FY 2018 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7).	Labor: $3,806.04 ..... Nonlabor: $1,766.49	Labor: $3,729.99 ..... Nonlabor: $1,731.20	Labor: $3,780.69 ..... Nonlabor: $1,754.73	Labor: $3,704.65. Nonlabor: $1,719.43.
National Standardized Amount for FY 2018 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,454.97 ..... Nonlabor: $2,117.56	Labor: $3,385.94 ..... Nonlabor: $2,075.25	Labor: $3,431.96 ..... Nonlabor: $2,103.46	Labor: $3,362.93. Nonlabor: $2,061.15.

5. On page 38532, lower two-thirds of the page (after the untitled table)—

a. First column, second full paragraph, line 13, the figure ''0.997432'' is corrected to read ''0.997439''.

b. Third column, second full paragraph, line 6, the figure ''1.61'' is corrected to read ''1.60''.

6. On page 38534—

a. First column—

(1) First full paragraph—

(a) Line 8, the figure ''5.16'' is corrected to read ''5.17''.

(b) Line 12, the figure ''0.9484'' is corrected to read ''0.9483''.

(2) Second full paragraph—

(a) Lines 5 and 6, the phrase ''outlier adjustment of 0.9484 is a 1.04 percent change'' is corrected to read ''outlier adjustment of 0.9483 is a 1.03 percent change''.

(b) Line 10, the figures ''1.0104 (0.9484/0.9386)'' are corrected to read ''1.0103(0.9483/0.9386)''.

(c) Line 12, the figure ''1.04'' is corrected to read ''1.03''.

(3) Fourth full paragraph—

(a) Line 13, the figure ''0.9994'' is corrected to read ''0.9995''.

(b) Line 16, the figure ''0.9844'' is corrected to read ''0.99845''.

b. Second column—

(1). First partial paragraph, line 8, the figure ''0.9837'' is corrected to read ''0.9838''.

(2). Third full paragraph—

(a) Line 1, the figure ''0.9986'' is corrected to read ''0.9987''.

(b) Line 3, the figure ''0.9994'' is corrected to read ''0.9995''.

c. Third column—

(1). First full paragraph—

(a) Line 4, the figure ''1.61'' is corrected to read ''1.60''.

(b) Line 15, the figure ''$453.97'' is corrected to read ''$453.95''.

(c) Second bulleted paragraph, last line, the figure ''0.9986'' is corrected to read ''0.9987''.

(d) Third bulleted paragraph, last line, the figure ''0.9484'' is corrected to read ''0.9483''.

(e) Last paragraph—

(1) Line 15, the figure ''0.14'' is corrected to read ''0.13''.

(2) Line 18, the figure ''1.04'' is corrected to read ''1.03''.

7. On page 38535—

a. Top of page—

(1) Second column, first partial paragraph, last line, the figure ''1.61'' is corrected to read ''1.60''.

(2) The table titled ''COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2017 CAPITAL FEDERAL RATE AND FY 2018 CAPITAL FEDERAL RATE'' is corrected to read as follows:

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2017 CAPITAL FEDERAL RATE AND FY 2018 CAPITAL FEDERAL RATE

	FY 2017	FY 2018	Change	Percent change [3]
Update Factor [1]	1.0090	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor [1]	0.9990	0.9987	0.9987	−0.13
Outlier Adjustment Factor [2]	0.9386	0.9483	1.0103	1.03
Removal of One-Time 2-Midnight Policy Adjustment Factor	1.0060	1/1.006	0.9940	−0.60
Capital Federal Rate	$446.79	$453.95	1.0160	1.60

[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 2017 to FY 2018 resulting from the application of the 0.9987 GAF/DRG budget neutrality adjustment factor for FY 2018 is a net change of 0.9987 (or -0.13 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 2018 outlier adjustment factor is 0.9483/0.9386 or 1.0103 (or 1.03 percent).

[3] Percent change may not sum due to rounding.

b. Middle of page, the table titled ''COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2018 CAPITAL FEDERAL RATE AND FINAL FY 2018 CAPITAL FEDERAL RATE'' is corrected to read as follows:

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2018 CAPITAL FEDERAL RATE AND FINAL FY 2018 CAPITAL FEDERAL RATE

	Proposed FY 2018	Final FY 2018	Change	Percent change
Update Factor [1]	1.0120	1.0130	1.0010	1.10
GAF/DRG Adjustment Factor [1]	0.9992	0.9987	0.9985	−0.05
Outlier Adjustment Factor [2]	0.9434	0.9483	1.0052	0.52
Removal of One-Time 2-Midnight Policy Adjustment Factor	1/1.006	1/1.006	0.0000	0.00
Capital Federal Rate	$451.37	$453.95	1.0057	0.57

c. Lower third of the page, first column, second full paragraph, last line, the figure, ''$26,601'' is corrected to read ''$26,537''.

8. On page 38537—

a. First column last paragraph—

(1) Line 22, the figure ''1.0006434'' is corrected to read ''1.0002704''.

(2) Line 35, the figure ''$41,430.56'' is corrected to read ''$41,415.11''.

(3) Line 36, the figure ''1.0006434'' is corrected to read ''1.0002704''.

b. Second column, first partial paragraph—

(1) Line 5, the figure ''40,610.16'' is corrected to read ''$40,595.02''.

(2) Line 6, the figure ''1.0006434'' is corrected to read ''1.0002704''.

9. On page 38539, second column, fourth full paragraph—

a. Line 6, the figure ''1.0006434'' is corrected to read ''1.0002704''.

b. Line 11, the figure ''1.0006434'' is corrected to read ''1.0002704''.

10. On page 38544—

a. First column—

(1) First partial paragraph—

(a) Line 6, the figure ''27,382'' is corrected to read ''27,381''.

(b) Last line, the figure ''27,382'' is corrected to read ''27,381''.

(2) First full paragraph—

(a) Line 4, the figure ''27,382'' is corrected to read ''27,381''.

(b) Line 27, the figure ''27,240'' is corrected to read ''27,239''.

(3) Second column, first partial paragraph, line 25, the figure ''27,382'' is corrected to read ''27,381''.

10. On page 38545—

a. Second column, second full paragraph—

(1) Line 14, the figure, ''$26,601'' is corrected to read ''$26,537''.

(2) Last line, the figure, ''$26,601'' is corrected to read ''$26,537''.

b. Third column, second full paragraph, line 3, the figure, ''$26,601'' is corrected to read ''$26,537''.

11. On page 38546, third column—

a. Second full paragraph, line 27, the figure ''$41,430.56'' is corrected to read ''$41,415.11''.

b. Last paragraph, line 7, the figure ''1.0547'' is corrected to read ''1.0553''.

12. On page 38547, top of the page—

a. Second column, partial paragraph—

(1) Line 2, the figure ''$41,430.56'' is corrected to read ''$41,415.11''.

(2) Line 3, the figure ''1.0547'' is corrected to read ''1.0553''.

b. Third column, partial paragraph, line 5, the figure ''$41,449.71'' is corrected to read ''$41,450.13''.

c. Untitled table, the table is corrected to read as follows:

LTCH PPS Standard Federal Payment Rate	$41,415.11
Labor-Related Share	× 0.662
Labor-Related Portion of the LTCH PPS Standard Federal Payment Rate	= $27,416.80
Wage Index (CBSA 16974)	× 1.0553

Wage-Adjusted Labor Share of LTCH PPS Standard Federal Payment Rate	= $28,932.95
Nonlabor-Related Portion of the LTCH PPS Standard Federal Payment Rate ($41,415.11 x 0.338)	+ $13,998.31
Adjusted LTCH PPS Standard Federal Payment Amount	= $42,931.26
MS–LTC–DRG 189 Relative Weight	× 0.9655
Total Adjusted LTCH PPS Standard Federal Payment Rate	= $41,450.13

13. On page 38548—

a. Middle of the page,

(1) The table titled ''TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR [(68.3 PERCENT LABOR SHARE/31.7 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2018''] is corrected to read as follows:

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[(68.3 percent labor share/31.7 percent nonlabor share if wage index is greater than 1)—FY 2018]

Hospital submitted quality data and is a meaningful EHR user (update = 1.35 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = −0.675 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 0.675 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = −1.35 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,806.04	$1,766.49	$3,729.99	$1,731.20	$3,780.69	$1,754.73	$3,704.65	$1,719.43

(2) The table titled ''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 2018]'' 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 2018]

Hospital submitted quality data and is a meaningful EHR user (update = 1.35 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = −0.675 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 0.675 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = −1.35 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,454.97	$2,117.56	$3,385.94	$2,075.25	$3,431.96	$2,103.46	$3,362.93	$2,061.15

(3) The table titled ''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 2018]'' 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 2018]

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	$3,454.97	$2,117.56

[1] For FY 2018, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

b. Bottom of the page—

(1) The table titled ''TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE [FY 2018]'' is corrected to read as follows:

TABLE 1D—CAPITAL STANDARD FEDERAL PAYMENT RATE

[FY 2018]

	Rate
National	$453.95

(2) The table titled ''TABLE 1E.—LTCH PPS STANDARD FEDERAL PAYMENT RATE [FY 2018]'' is corrected to read as follows:

TABLE 1E—LTCH PPS STANDARD FEDERAL PAYMENT RATE
[FY 2018]

	Full update (1 percent)	Reduced update * (−1.0 percent)
Standard Federal Payment Rate	$41,415.11	$40,595.02

D. Corrections of Errors in the Appendices

1. On pages 38552 through 38554, the table and table notes for the table titled ''TABLE I.—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2018'' are corrected to read as follows:

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TABLE I.—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2018

	Number of Hospitals [1]	Hospital Rate Update and Adjustments (1) [2]	FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) [3]	FY 2018 Wage Data with Application of Wage Budget Neutrality (3) [4]	FY 2018 MGCRB Reclassifications (4) [5]	Rural and Imputed Floor with Application of National Budget Neutrality (5) [6]	Application of the Frontier Wage Index and Out-Migration Adjustment (6) [7]	Expiration of MDH Status (7) [8]	All FY 2018 Changes (8) [9]
All Hospitals	3,292	1.2	0	0	0	0	0.1	-0.1	1.3
By Geographic Location:									
Urban hospitals	2,492	1.2	0	0	-0.1	0	0.1	0	1.4
Large urban areas	1,340	1.2	0	0	-0.5	-0.1	0	0	1.4
Other urban areas	1,152	1.2	0	0	0.3	0.2	0.2	-0.1	1.4
Rural hospitals	800	0.9	0.1	0	1.4	-0.2	0.2	-0.9	0.2
Bed Size (Urban):									
0-99 beds	648	1.1	0.4	0.1	-0.6	0.1	0.2	-0.7	0.8
100-199 beds	763	1.2	0.2	0.1	0	0.3	0.2	-0.1	1.5
200-299 beds	441	1.2	0.1	0	0.1	0.1	0.1	0	1.5
300-499 beds	426	1.2	0	0.0	-0.1	0	0.1	0	1.4
500 or more beds	214	1.2	-0.2	-0.1	-0.2	-0.1	0.1	0	1.4
Bed Size (Rural):									
0-49 beds	318	0.9	0.3	0	0.4	-0.2	0.3	-1.6	-0.5
50-99 beds	282	0.9	0.2	0	0.6	-0.1	0.4	-2.2	-1.4
100-149 beds	117	0.8	0.1	-0.1	1.1	-0.2	0.1	-0.1	0.8
150-199 beds	44	0.9	0.1	0	2.2	-0.2	0.1	0	1.3
200 or more beds	39	0.9	0	0.2	2.9	-0.2	0	0	1.6
Urban by Region:									
New England	114	1.2	0	-0.5	1.2	1.4	0.1	-0.2	1.4
Middle Atlantic	315	1.2	0	-0.1	0.6	-0.3	0.1	0	1.1
South Atlantic	404	1.2	0	0.1	-0.4	-0.2	0	-0.1	1.6
East North Central	385	1.2	0.1	0.1	-0.3	-0.4	0	0	1.6
East South Central	147	1.2	0	-0.2	-0.3	-0.3	0	0	1.3
West North Central	160	1.1	-0.1	0.4	-0.8	-0.3	0.7	-0.1	1.6
West South Central	378	1.2	0	0.5	-0.5	-0.3	0	-0.1	1.7
Mountain	162	1.1	0	-0.2	0	0.1	0.3	0	0.6
Pacific	375	1.1	-0.1	-0.4	-0.2	0.9	0.1	0	1.5
Puerto Rico	52	1.2	-0.5	1.4	-1.0	0.2	0.1	0	1.1
Rural by Region:									
New England	20	1.0	0.1	1.1	2.1	-0.3	0.2	-2.2	0.6
Middle Atlantic	53	0.8	0.2	0	0.8	-0.2	0.2	-1.7	-0.9
South Atlantic	125	1.0	0.2	-0.1	1.8	-0.2	0.2	-0.8	-0.1

	Number of Hospitals [1]	Hospital Rate Update and Adjustments (1) [2]	FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) [3]	FY 2018 Wage Data with Application of Wage Budget Neutrality (3) [4]	FY 2018 MGCRB Reclassifications (4) [5]	Rural and Imputed Floor with Application of National Budget Neutrality (5) [6]	Application of the Frontier Wage Index and Out-Migration Adjustment (6) [7]	Expiration of MDH Status (7) [8]	All FY 2018 Changes (8) [9]
East North Central	115	0.9	0.1	-0.3	1.2	-0.1	0.1	-1.7	-0.9
East South Central	154	1.1	0.3	0.1	2.4	-0.3	0.1	-0.3	1.1
West North Central	97	0.6	-0.1	0	0.2	0.0	0.3	-0.3	0.6
West South Central	154	0.9	0.3	0.2	1.5	-0.2	0.2	-0.7	0.6
Mountain	58	0.6	0.2	-0.1	0.2	-0.1	0.3	0	0.9
Pacific	24	0.6	0	0	1.2	-0.1	0	0	0.4
By Payment Classification:									
Urban hospitals	2,373	1.2	0	0	-0.3	0	0.1	0	1.4
Large urban areas	1,354	1.2	0	0	-0.5	-0.1	0	0	1.4
Other urban areas	1,019	1.2	0	0	-0.1	0.2	0.2	0	1.4
Rural areas	919	1.0	0.1	0.1	1.6	-0.1	0.2	-0.7	0.8
Teaching Status:									
Nonteaching	2,204	1.1	0.1	0	0.2	0.2	0.1	-0.3	1.2
Fewer than 100 residents	839	1.2	0.1	0	-0.1	-0.1	0.2	0	1.4
100 or more residents	249	1.2	-0.2	-0.1	-0.1	-0.1	0	0	1.4
Urban DSH:									
Non-DSH	551	1.2	0	0	-0.2	-0.1	0.2	-0.3	1.0
100 or more beds	1,543	1.2	0	0	-0.3	0	0.1	0	1.4
Less than 100 beds	370	1.1	0.3	0	-0.2	0.1	0.2	-0.1	1.6
Rural DSH:									
SCH	257	0.6	0	0	-0.1	0	0	0	0.5
RRC	293	1.0	0	0.1	2.0	-0.1	0.2	-0.3	1.6
100 or more beds	34	1.2	0.2	0	1.7	-0.2	0.1	-0.1	0.4
Less than 100 beds	244	1.1	0.5	0	0.5	-0.3	0.7	-4.8	-3.9
Urban teaching and DSH:									
Both teaching and DSH	863	1.2	-0.1	-0.1	-0.3	-0.1	0.1	0	1.4
Teaching and no DSH	92	1.2	0	-0.1	-0.2	-0.2	0.1	0	1.0
No teaching and DSH	1,050	1.2	0.2	0	-0.2	0.3	0.1	0	1.5
No teaching and no DSH	368	1.2	0.1	0.1	-0.4	-0.1	0.2	0	1.5
Special Hospital Types:									
RRC	263	1.2	0.1	0.1	2.5	-0.1	0.3	-0.4	1.8
SCH	316	0.7	-0.2	-0.2	-0.1	0	0	0	0.4

	Number of Hospitals [1]	Hospital Rate Update and Adjustments (1) [2]	FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) [3]	FY 2018 Wage Data with Application of Wage Budget Neutrality (3) [4]	FY 2018 MGCRB Reclassifications (4) [5]	Rural and Imputed Floor with Application of National Budget Neutrality (5) [6]	Application of the Frontier Wage Index and Out-Migration Adjustment (6) [7]	Expiration of MDH Status (7) [8]	All FY 2018 Changes (8) [9]
SCH and RRC	131	0.7	-0.1	0.1	0.3	0	0	0	0.9
Type of Ownership:									
Voluntary	1,914	1.2	0	0	0	0	0.1	-0.1	1.3
Proprietary	863	1.2	0.2	0.2	0	0	0.1	-0.1	1.6
Government	513	1.1	0	-0.1	-0.2	0.1	0.1	-0.1	1.3
Medicare Utilization as a Percent of Inpatient Days:									
0-25	554	1.2	0	0	-0.3	0.1	0.1	0	1.4
25-50	2,149	1.2	0	0	0	0.0	0.1	-0.1	1.4
50-65	485	1.1	0.1	0.1	0.6	0.2	0.2	-0.6	0.8
Over 65	103	1.0	0.6	0.4	-0.9	-0.2	0.3	-4.0	-1.9
FY 2018 Reclassifications by the Medicare Geographic Classification Review Board:									
All Reclassified Hospitals	858	1.1	0.1	0.1	2.2	-0.1	0	-0.2	1.5
Non-Reclassified Hospitals	2,434	1.2	0	0	-0.9	0	0.2	-0.1	1.3
Urban Hospitals Reclassified	590	1.2	0.1	0.1	2.2	-0.1	0	-0.1	1.6
Urban Nonreclassified Hospitals	1,858	1.2	0	0.0	-0.9	0	0.1	0	1.4
Rural Hospitals Reclassified	268	0.9	0.1	0	2.3	-0.2	0	-0.5	0.7
Rural Nonreclassified Hospitals	485	0.9	0.2	0	-0.3	-0.1	0.4	-1.4	-0.5
All Section 401 Reclassified Hospitals:	166	1.1	0	0.1	1.9	0	0.3	-0.5	1.4
Other Reclassified Hospitals (Section 1886(d)(8)(B))	47	1.1	0.4	0.3	3.3	-0.3	0	-1.2	0.5

[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 2016, and hospital cost report data are from reporting periods beginning in FY 2014 and FY 2015.

[2] This column displays the payment impact of the hospital rate update and other adjustments, including the 1.35 percent adjustment to the national standardized amount and the hospital-specific rate (the estimated 2.7 percent market basket update reduced by 0.6 percentage point for the multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the 0.4588 percent adjustment to the national standardized amount required under section 15005 of the 21st Century Cures Act and a factor of (1/1.006) to remove the 1.006 temporary one-time adjustment made in FY 2017 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 35 GROUPER, the changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2016 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 0.997439 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 2014 and 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 .1.000882.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2018 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2018. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.987985.

[6] This column displays the effects of the rural floor and imputed floor. 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 0.993324.

[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 Pub. L. 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 displays the impact of the expiration of MDH status for FY 2018, a non-budget neutral payment provision.

[9] This column shows the estimated change in payments from FY 2017 to FY 2018.

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2. On page 38555,

a. Second column, second full paragraph—

(1) Line 6, the figure ''0.997432'' is corrected to read ''0.997439''.

(2) Line 14, the figure ''0.2'' is corrected to read ''0.1''.

b. Third column, first full paragraph, line 26, the figure ''1.001148'' is corrected to read ''1.000882''.

3. On page 38556, lower half of the page—

a. First column, third full paragraph, line 6, the figure ''0.988008'' is corrected to read ''0.987985''.

b. Third column—

(1) First full paragraph, line 8, the figure ''0.993348'' is corrected to read ''0.993324''.

(2) Last paragraph, line 5, the figure ''0.993348'' is corrected to read ''0.993324''.

4. On page 38557, top of the page, first column, first partial paragraph, line 20, the figure ''$44 million'' is corrected to read ''$43 million''.

5. On pages 38557 and 38558, the table titled ''FY 2018 IPPS ESTIMATED PAYMENTS DUE TO RURAL AND IMPUTED FLOOR WITH NATIONAL BUDGET NEUTRALITY'' is corrected to read as follows:

FY 2018 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 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	84	3	−0.3	−5
Alaska	6	4	1.4	3
Arizona	57	38	0.4	7
Arkansas	44	1	−0.3	−4
California	299	177	1.2	134
Colorado	47	4	0.4	5
Connecticut	30	7	0.1	2
Delaware	6	6	1.8	8
Washington, DC	7	0	−0.4	−2
Florida	171	17	−0.2	−16
Georgia	103	0	−0.3	−9
Hawaii	12	0	−0.3	−1
Idaho	14	0	−0.2	−1
Illinois	127	3	−0.4	−17
Indiana	85	0	−0.3	−8
Iowa	34	0	−0.3	−3
Kansas	53	0	−0.3	−3
Kentucky	66	0	−0.3	−5
Louisiana	94	2	−0.3	−5
Maine	17	0	−0.4	−2
Massachusetts	57	36	1.3	43
Michigan	94	0	−0.3	−14
Minnesota	49	0	−0.3	−6
Mississippi	60	0	−0.3	−4
Missouri	74	0	−0.2	−6
Montana	13	4	0	0
Nebraska	24	0	−0.3	−2
Nevada	23	0	−0.4	−3
New Hampshire	13	9	3.7	20
New Jersey	64	17	−0.1	−4
New Mexico	25	0	−0.2	−1
New York	154	11	−0.3	−23
North Carolina	84	0	−0.3	−10
North Dakota	6	0	−0.2	−1
Ohio	128	6	−0.3	−12
Oklahoma	84	4	−0.2	−3
Oregon	34	5	−0.3	−3
Pennsylvania	150	3	−0.4	−17
Puerto Rico	52	10	0.2	0
Rhode Island	11	10	5.0	19
South Carolina	56	0	−0.3	−5
South Dakota	17	0	−0.2	−1
Tennessee	91	3	−0.3	−8
Texas	310	4	−0.3	−22
Utah	31	1	−0.3	−2
Vermont	6	0	−0.2	0
Virginia	73	1	−0.3	−7
Washington	48	3	−0.2	−5
West Virginia	29	3	−0.1	−1

FY 2018 IPPS ESTIMATED PAYMENTS DUE TO RURAL AND IMPUTED FLOOR WITH NATIONAL BUDGET NEUTRALITY—Continued

State	Number of hospitals (1)	Number of hospitals that will receive the rural 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)
Wisconsin	66	8	−0.2	−3
Wyoming	10	0	−0.1	0

6. On pages 38559 and 38560, the table titled ''TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2018 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER DISCHARGE)'' is corrected to read as follows:

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2018 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per discharge]

	Number of hospitals (1)	Estimated average FY 2017 payment per discharge (2)	Estimated average FY 2018 payment per discharge (3)	FY 2018 changes (4)
All Hospitals	3,292	$11,867	$12,024	1.3
By Geographic Location:				
Urban hospitals	2,492	12,207	12,379	1.4
Large urban areas	1,340	12,881	13,061	1.4
Other urban areas	1,152	11,477	11,642	1.4
Rural hospitals	800	8,911	8,930	0.2
Bed Size (Urban):				
0–99 beds	648	9,730	9,813	0.8
100–199 beds	763	10,248	10,404	1.5
200–299 beds	441	11,079	11,245	1.5
300–499 beds	426	12,366	12,538	1.4
500 or more beds	214	15,011	15,224	1.4
Bed Size (Rural):				
0–49 beds	318	7,523	7,486	−0.5
50–99 beds	282	8,487	8,372	−1.4
100–149 beds	117	8,896	8,966	0.8
150–199 beds	44	9,292	9,410	1.3
200 or more beds	39	10,514	10,679	1.6
Urban by Region:				
New England	114	13,125	13,303	1.4
Middle Atlantic	315	13,819	13,967	1.1
South Atlantic	404	10,783	10,952	1.6
East North Central	385	11,537	11,727	1.6
East South Central	147	10,245	10,375	1.3
West North Central	160	11,915	12,107	1.6
West South Central	378	10,948	11,134	1.7
Mountain	162	12,824	12,898	0.6
Pacific	375	15,634	15,867	1.5
Puerto Rico	52	8,851	8,947	1.1
Rural by Region:				
New England	20	12,091	12,166	0.6
Middle Atlantic	53	8,891	8,812	−0.9
South Atlantic	125	8,274	8,269	−0.1
East North Central	115	9,224	9,144	−0.9
East South Central	154	7,900	7,987	1.1
West North Central	97	9,736	9,794	0.6
West South Central	154	7,539	7,587	0.6
Mountain	58	10,620	10,718	0.9
Pacific	24	12,466	12,517	0.4
By Payment Classification:				
Urban hospitals	2,373	12,148	12,320	1.4

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2018 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per discharge]

	Number of hospitals	Estimated average FY 2017 payment per discharge	Estimated average FY 2018 payment per discharge	FY 2018 changes
	(1)	(2)	(3)	(4)
Large urban areas	1,354	12,867	13,047	1.4
Other urban areas	1,019	11,200	11,362	1.4
Rural areas	919	10,568	10,656	0.8
Teaching Status:				
Nonteaching	2,204	9,850	9,967	1.2
Fewer than 100 residents	839	11,372	11,535	1.4
100 or more residents	249	17,228	17,461	1.4
Urban DSH:				
Non-DSH	551	10,357	10,456	1.0
100 or more beds	1,543	12,512	12,689	1.4
Less than 100 beds	370	8,960	9,102	1.6
Rural DSH:				
SCH	257	9,526	9,578	0.5
RRC	293	11,384	11,568	1.6
100 or more beds	34	10,297	10,339	0.4
Less than 100 beds	244	7,035	6,764	−3.9
Urban teaching and DSH:				
Both teaching and DSH	863	13,579	13,766	1.4
Teaching and no DSH	92	11,410	11,522	1.0
No teaching and DSH	1,050	10,217	10,374	1.5
No teaching and no DSH	368	9,854	10,000	1.5
Special Hospital Types:				
RRC	263	11,165	11,360	1.8
SCH	316	10,774	10,820	0.4
SCH and RRC	131	11,265	11,362	0.9
Type of Ownership:				
Voluntary	1,914	12,058	12,212	1.3
Proprietary	863	10,392	10,554	1.6
Government	513	12,810	12,980	1.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	554	14,910	15,115	1.4
25–50	2,149	11,728	11,890	1.4
50–65	485	9,617	9,695	0.8
Over 65	103	7,591	7,444	−1.9
FY 2018 Reclassifications by the Medicare Geographic Classification Review Board:				
All Reclassified Hospitals	858	11,661	11,830	1.5
Non-Reclassified Hospitals	2,434	11,956	12,108	1.3
Urban Hospitals Reclassified	590	12,202	12,396	1.6
Urban Nonreclassified Hospitals	1,858	12,210	12,381	1.4
Rural Hospitals Reclassified Full Year	268	9,339	9,399	0.7
Rural Nonreclassified Hospitals Full Year	485	8,422	8,379	−0.5
All Section 401 Reclassified Hospitals:	166	12,504	12,677	1.4
Other Reclassified Hospitals (Section 1886(d)(8)(B))	47	8,122	8,165	0.5

7. On pages 38561 through 38564 in the section titled ''Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2018'' (which begins with the phrase ''As discussed in section V.G of the preamble'' and ends with the phrase ''hospitals are projected to receive large increases'') the section is corrected to read as follows:

''5. Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2018.

As discussed in section V.G. of the preamble of this final rule, under section 3133 of the Affordable Care Act, hospitals that are eligible to receive Medicare DSH payments will receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments under section 1886(d)(5)(F) of the Act. The remainder, equal to an estimate of 75 percent of what formerly would have been paid as Medicare DSH payments (Factor 1), reduced to reflect changes in the percentage of uninsured individuals and additional statutory adjustments (Factor 2), is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. Each hospital eligible for Medicare DSH payments will receive an additional payment based on its estimated share of the total amount of uncompensated care for all hospitals eligible for Medicare DSH payments. The uncompensated care payment methodology has redistributive effects based on the proportion of a hospital's uncompensated care relative to the uncompensated care for all hospitals eligible for Medicare DSH payments (Factor 3).

For FY 2018, we are establishing a Factor 2 of 58.01 percent determined using the uninsured estimates produced by CMS' Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA). Although we are continuing to use low-income insured patient days as a proxy for uncompensated care, for the first time, we are using these data in combination with data on uncompensated care costs from Worksheet S–10 in the calculation of Factor 3. The uncompensated care payment methodology has redistributive effects based on the proportion of a hospital's uncompensated care relative to the total uncompensated care for all hospitals eligible for Medicare DSH payments. The change to Medicare DSH payments under section 3133 of the Affordable Care Act is not budget neutral.

In this final rule, we are establishing the amount to be distributed as uncompensated care payments to DSH eligible hospitals, which for FY 2018 is $6,766,695,163.56. This figure represents 75 percent of the amount that otherwise would have been paid for Medicare DSH payment adjustments adjusted by a Factor 2 of 58.01 percent. For FY 2017, the amount available to be distributed for uncompensated care was $5,977,483,146.86, or 75 percent of the amount that otherwise would have been paid for Medicare DSH payment adjustments adjusted by a Factor 2 of 55.36 percent. To calculate Factor 3 for FY 2018, we used an average of data computed using Medicaid days from hospitals' 2012 and 2013 cost reports from the March 2017 update of the HCRIS database, uncompensated care costs from hospitals' 2014 cost reports from the same extract of HCRIS, Medicaid days from 2012 cost report data submitted to CMS by IHS hospitals, and SSI days from the FY 2014 and FY 2015 SSI ratios. For each eligible hospital, we calculated an individual Factor 3 for cost reporting years FYs 2012, 2013, and 2014. We then added the individual amounts and divided the sum by the number of cost reporting periods with data to calculate an average Factor 3 for FY 2018. For purposes of this final rule, as we proposed, we used the most recent data from the March 2017 update of the HCRIS database for the Medicaid days component of the Factor 3 calculation as well as for the Worksheet S–10 uncompensated care cost component.

The FY 2018 policy of using data from hospitals' FY 2012, FY 2013, and FY 2014 cost reporting years to determine Factor 3 is based on our FY 2017 final policy (81 FR 56943 through 56973), which is in contrast to the methodology used in FY 2016, when we used Medicaid days from the more recent of a hospital's full year 2012 or 2011 cost report from the March 2015 update of the HCRIS database, Medicaid days from 2012 cost report data submitted to CMS by IHS hospitals, and SSI days from the FY 2013 SSI ratios to calculate Factor 3. In addition, as explained in section V.G.4.c. of the preamble of this final rule, we are making several additional modifications to the Factor 3 methodology: (1) To annualize Medicaid data and uncompensated care data if a hospital's cost report does not equal 12 months of data; (2) to apply a scaling factor to the uncompensated care payment amount calculated for each DSH eligible hospital so that total uncompensated care payments are consistent with the estimated amount available to make uncompensated care payments for FY 2018; (3) to apply statistical trims to the CCRs on Worksheet S–10 that are considered anomalies to ensure reasonable CCRs are used to convert charges to costs for purposes of determining uncompensated care costs; (4) to calculate Factor 3 for Puerto Rico hospitals, all-inclusive rate providers, and Indian Health Service and Tribal hospitals by substituting data regarding low-income insured days for FY 2013 for the Worksheet S–10 data on uncompensated care costs from FY 2014 cost reports; and (5) to determine the ratio of uncompensated care costs relative to total operating costs on the hospital's 2014 cost report (as of March 2017), and in cases where the ratio of uncompensated care costs relative to total operating costs exceeds 50 percent, to determine the ratio of uncompensated care costs to total operating costs from the hospital's 2015 cost report (as of March 2017) and apply that ratio to the hospital's total operating costs from its 2014 cost report to determine uncompensated care costs for FY 2014.

We also are continuing the policies that were finalized in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50020 through 50022) to address several specific issues concerning the process and data to be employed in determining Factor 3 in the case of hospital mergers for FY 2018 and subsequent years, as well as continuing the policies finalized in the FY 2017 IPPS/LTCH PPS final rule concerning the methodology for calculating each hospital's relative share of uncompensated care, such as combining data from multiple cost reports beginning in the same fiscal year and calculating Factor 3 based on an average of the three individual Factor 3s for FYs 2012, 2013, and 2014, determined by adding the Factor 3 values for these years, and dividing by the number of cost reporting periods with data.

To estimate the impact of the combined effect of changes in Factors 1 and 2, as well as the changes to the data used in determining Factor 3, on the calculation of Medicare DSH payments, including both empirically justified Medicare DSH payments and uncompensated care payments, we compared total DSH payments estimated in the FY 2017 IPPS/LTCH PPS final rule to total DSH payments estimated in this FY 2018 IPPS/LTCH PPS final rule. For FY 2017, for each hospital, we calculated the sum of: (1) 25 percent of the estimated amount of what would have been paid as Medicare DSH in FY 2017 in the absence of section 3133 of the Affordable Care Act; and (2) 75 percent of the estimated amount of what would have been paid as Medicare DSH payments in the absence of section 3133 of the Affordable Care Act, adjusted by a Factor 2 of 55.36 percent and multiplied by a Factor 3 calculated as described in the FY 2017 IPPS/LTCH PPS final rule. For FY 2018, we calculated the sum of: (1) 25 percent of the estimated amount of what would be paid as Medicare DSH payments in FY 2018 absent section 3133 of the Affordable Care Act; and (2) 75 percent of the estimated amount of what would be paid as Medicare DSH payments absent section 3133 of the Affordable Care Act, adjusted by a Factor 2 of 58.01 percent and multiplied by a Factor 3 calculated using the methodology described previously.

Our analysis included 2,438 hospitals that are projected to be eligible for DSH in FY 2018. It did not include hospitals that had terminated their participation in the Medicare program as of July 1, 2017, Maryland hospitals, and SCHs that are expected to be paid based on their hospital specific rates. In addition, data from merged or acquired hospitals were combined under the surviving hospital's CCN, and the non-surviving CCN was excluded from the analysis. The estimated impact of the changes to Factors 1, 2, and 3 across all hospitals projected to be eligible for DSH payments in FY 2018, by hospital characteristic, is presented in the following table.

MODELED DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR ESTIMATED FY 2018 DSHS BY HOSPITAL TYPE: MODEL DSH $ (IN MILLIONS) FROM FY 2017 TO FY 2018

	Number of estimated DSHs (FY 2018) (1)	FY 2017 final rule estimated DSH $ (in millions) (2)	FY 2018 final rule estimated DSH $ (in millions) (3)	Dollar difference: FY 2017–FY 2018 (in millions) (4)	Percent change ** (5)
Total	2,438	$9,553	$10,630	$1,077	11.3
By Geographic Location:					
Urban Hospitals	1,938	9,113	10,110	996	10.9
Large Urban Areas	1,043	5,717	6,377	660	11.5
Other Urban Areas	895	3,396	3,733	336	9.9
Rural Hospitals	500	439	520	80	18.3
Bed Size (Urban):					
0 to 99 Beds	342	185	241	57	30.7
100 to 249 Beds	843	2,154	2,386	233	10.8
250+ Beds	753	6,775	7,482	707	10.4
Bed Size (Rural):					
0 to 99 Beds	371	190	238	48	25.2
100 to 249 Beds	115	193	221	28	14.6
250+ Beds	14	56	60	5	8.2
Urban by Region:					
New England	91	387	415	29	7.4
Middle Atlantic	241	1,570	1,643	73	4.7
South Atlantic	316	1,724	2,037	314	18.2
East North Central	322	1,252	1,372	120	9.6
East South Central	131	566	618	53	9.3
West North Central	103	439	488	48	11.0
West South Central	257	1,165	1,448	283	24.3
Mountain	121	448	497	49	11.0
Pacific	316	1,448	1,463	15	1.0
Puerto Rico	40	116	129	13	10.9
Rural by Region:					
New England	12	16	21	5	32.0
Middle Atlantic	25	33	32	−1	−3.9
South Atlantic	86	92	115	23	25.2
East North Central	68	44	58	13	29.9
East South Central	136	141	150	9	6.2
West North Central	30	19	23	4	22.1
West South Central	111	72	95	23	32.1
Mountain	27	15	20	5	32.2
Pacific	5	7	6	−1	−11.4
By Payment Classification:					
Urban Hospitals	1,928	9,106	10,101	994	10.9
Large Urban Areas	1,043	5,717	6,377	660	11.5
Other Urban Areas	885	3,389	3,724	334	9.9
Rural Hospitals	510	447	529	82	18.5
Teaching Status:					
Nonteaching	1,526	2,955	3,276	321	10.9
Fewer than 100 residents	669	3,213	3,501	288	9.0
100 or more residents	243	3,384	3,853	468	13.8
Type of Ownership:					
Voluntary	1,434	5,971	6,533	563	9.4
Proprietary	552	1,650	1,662	12	0.7
Government	452	1,932	2,434	502	30.0
Medicare Utilization Percent:					
Missing or Unknown	15	1	15	14	2147.4
0 to 25	425	2,972	3,365	393	13.2
25 to 50	1,642	6,218	6,829	611	9.8
50 to 65	310	352	408	57	16.1
Greater than 65	46	11	13	2	17.4

Source: Dobson | DaVanzo analysis of 2012–2014 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 $9,553 million in FY 2017 and $10,630 million in FY 2018.

** Percentage change is determined as the difference between Medicare DSH payments modeled for the FY 2018 IPPS/LTCH PPS final rule (column 3) and Medicare DSH payments modeled for the FY 2017 IPPS/LTCH PPS final rule (column 2) divided by Medicare DSH payments modeled for the FY 2017 final rule (column 2) times 100 percent.

Changes in projected FY 2018 DSH payments from DSH payments in FY 2017 are primarily driven by (1) changes to Factor 1, which increased from $10.797 billion to $11.665 billion; (2) changes to Factor 2, which increased

from 55.36 percent to 58.01 percent; (3) changes to the data used to determine Factor 3; and (4) changes to the number of DSH-eligible hospitals within a given hospital type. The impact analysis found that, across all projected DSH eligible hospitals, FY 2018 DSH payments are estimated at approximately $10.630 billion, or an increase of approximately 11.3 percent from FY 2017 DSH payments (approximately $9.553 billion). While these changes result in a net increase in the amount available to be distributed in uncompensated care payments, DSH payments to select hospital types are expected to decrease. This redistribution of DSH payments is caused by changes in the data used to determine Factor 3 and changes in the number of DSH-eligible hospitals within a given hospital type.

As seen in the above table, percent changes in DSH payments of less than 11.3 percent indicate that hospitals within the specified category are projected to experience a smaller increase in DSH payments, on average, compared to the universe of projected FY 2018 DSH hospitals. Conversely, percent changes in DSH payments that are greater than 11.3 percent indicate a hospital type is projected to have a larger increase than the overall percent change on average, a larger increase than the overall percent change. The variation in the distribution of DSH payments by hospital characteristic is largely dependent on the change in a given hospital's number of Medicaid days and SSI days for purposes of the low-income insured days proxy between FY 2017 and FY 2018, as well as on its uncompensated care costs as reported on its FY 2014 Worksheet S–10.

Many rural hospitals, grouped by geographic location, payment classification, and bed size, are projected to experience a larger increase in DSH payments than their urban counterparts. Overall, rural hospitals are projected to receive an 18.3 percent increase in DSH payments, and urban hospitals are projected to receive a 10.9 percent increase. However, only smaller and medium-sized rural hospitals are projected to receive increases in DSH payments that are, on average, higher than the 11.3 percent change across all hospitals that are projected to be eligible for DSH in FY 2018. Rural hospitals that have 0–99 beds are projected to experience a 25.2 percent payment increase, those with 100–249 beds are projected to receive a 14.6 percent increase, and larger rural hospitals with 250+ beds are projected to experience an 8.2 percent payment increase. This trend is somewhat consistent with urban hospitals, in which the smallest urban hospitals (0– 99 beds) are projected to receive an increase in DSH payments of 30.7 percent. Medium sized hospitals (100–250 beds) and larger hospitals (250+ beds) are projected to receive increases of 10.8 and 10.4 percent in DSH payments, respectively, which are relatively consistent with the overall average.

By region, projected DSH payment increases for urban hospitals are smaller than the overall percent change in the New England, Middle Atlantic, East North Central, East South Central, and Pacific regions. Hospitals in the South Atlantic and West South Central regions are projected to receive increases in DSH payments that are, on average, larger than the 11.3 percent change across all hospitals projected to be eligible for DSH in FY 2018. Increases in the West North Central, Mountain, and Puerto Rico regions are generally consistent with the overall average percent increase of 11.3 percent. Regionally, rural hospitals are projected to receive a wider range of increases. Rural hospitals in the Middle Atlantic and Pacific regions are expected to receive a decrease in DSH payments, while those in the East South Central region are projected to receive an increase in DSH payments smaller than the 11.3 overall percent change. Increases are projected to be substantially larger than the overall average in many regions, including New England, South Atlantic, East North Central, West North Central, West South Central, and Mountain.

Nonteaching hospitals and teaching hospitals with fewer than 100 residents are projected to receive smaller increases than the overall percent change, at 10.9 and 9.0 percent respectively. Conversely, teaching hospitals with 100 or more residents are projected to receive, on average, larger increases than the overall percent change of 11.3 percent, with a projected increase of 13.8 percent. Voluntary hospitals are expected to receive a 9.4 percent increase, which is somewhat smaller than the overall percent change, while proprietary hospitals are expected to receive almost no change in DSH payments. Government hospitals are projected to receive a larger than average 30.0 percent increase. Hospitals with 25 to 50 percent Medicare utilization are projected to receive increases in DSH payments slightly below the overall average at 9.8 percent, while all other hospitals are projected to receive larger increases.''

8. On page 38572 top of the page—

a. First column, fourth bulleted paragraph—

(1) Line 4, the figure ''0.9986'' is corrected to read ''0.9987''

(2) Line 5, the figure ''0.9484'' is corrected to read ''0.9483''

b Second column, first full paragraph—

(1) Line 8, the figure ''0.9484'' is corrected to read ''0.9483''

(2) Line 9, the figure ''1.04'' is corrected to read ''1.03''.

c. Third column—

(1) First partial paragraph—

(a) Line 1, the figure ''2.9'' is corrected to read ''3.0''

(b) Line 4, the figure 2.0'' is corrected to read ''1.9''.

(2) First full paragraph –

(a) Line 4, the figure ''3.7'' is corrected to read ''3.8''.

(b) Line 9, the figure ''5.2'' is corrected to read ''5.3''.

(c) Line 12, the figure ''1.9'' is corrected to read ''2.0''.

(3) Second full paragraph—

(a) Line 7, the figure ''2.3'' is corrected to read ''2.2''.

(b) Lines 10 and 11, the phrase ''3.2 percent.'' is corrected to read ''3.2 percent and 3.3 percent, respectively.''.

(4) Last paragraph—

(a) Line 14, the figure ''1.6'' is corrected to read ''1.7''.

(b) Line 27, the figure ''6.6'' is corrected to read ''6.5''.

9. On pages 38572 through 38574, the table titled ''TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2017 PAYMENTS COMPARED TO FY 2018 PAYMENTS]'' is corrected to read as follows:

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2017 PAYMENTS COMPARED TO FY 2018 PAYMENTS]

	Number of hospitals	Average FY 2017 payments/ case	Average FY 2018 payments/ case	Change
By Geographic Location:				
All hospitals	3,292	920	943	2.5
Large urban areas (populations over 1 million)	1,340	1,007	1,037	3.0
Other urban areas (populations of 1 million of fewer)	1,152	896	913	1.9
Rural areas	800	625	644	3.0
Urban hospitals	2,492	953	977	2.5
0-99 beds	648	768	798	3.9
100-199 beds	763	825	850	3.0
200-299 beds	441	877	897	2.3
300-499 beds	426	965	989	2.4
500 or more beds	214	1,142	1,167	2.2
Rural hospitals	800	625	644	3.0
0-49 beds	318	523	544	3.9
50-99 beds	282	584	599	2.5
100-149 beds	117	625	642	2.7
150-199 beds	44	663	687	3.6
200 or more beds	39	749	771	2.9
By Region:				
Urban by Region	2,492	953	977	2.5
New England	114	1,038	1,056	1.8
Middle Atlantic	315	1,054	1,074	1.9
South Atlantic	404	849	869	2.4
East North Central	385	918	941	2.5
East South Central	147	800	815	1.8
West North Central	160	933	958	2.8
West South Central	378	863	896	3.8
Mountain	162	1,005	1,013	0.8
Pacific	375	1,209	1,250	3.4
Puerto Rico	52	437	451	3.2
Rural by Region	800	625	644	3.0
New England	20	860	905	5.3
Middle Atlantic	53	603	616	2.2
South Atlantic	125	584	596	2.0
East North Central	115	645	661	2.5
East South Central	154	574	591	3.0
West North Central	97	667	690	3.4
West South Central	154	555	574	3.4
Mountain	58	695	716	3.1
Pacific	24	805	836	3.8
By Payment Classification:				
All hospitals	3,292	920	943	2.5
Large urban areas (populations over 1 million)	1,354	1,005	1,036	3.0
Other urban areas (populations of 1 million of fewer)	1,019	883	907	2.8
Rural areas	919	768	771	0.4
Teaching Status:				
Non-teaching	2,204	779	802	2.9
Fewer than 100 Residents	839	890	910	2.3
100 or more Residents	249	1,283	1,314	2.4
Urban DSH:				
100 or more beds	1,543	975	1,003	2.8
Less than 100 beds	370	697	727	4.3
Rural DSH:				
Sole Community (SCH/EACH)	257	622	632	1.7
Referral Center (RRC/EACH)	293	833	834	0.1
Other Rural:				
100 or more beds	34	820	791	-3.5

	Number of hospitals	Average FY 2017 payments/ case	Average FY 2018 payments/ case	Change
Less than 100 beds	244	511	522	2.3
Urban teaching and DSH:				
Both teaching and DSH	863	1,043	1,072	2.8
Teaching and no DSH	92	921	938	1.9
No teaching and DSH	1,050	823	848	3.1
No teaching and no DSH	368	832	863	3.8
Rural Hospital Types:				
Non special status hospitals	2,580	946	973	2.8
RRC/EACH	263	861	862	0.2
SCH/EACH	316	716	734	2.5
SCH, RRC and EACH	131	763	782	2.5
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2018 Reclassifications:				
All Urban Reclassified	590	948	964	1.7
All Urban Non-Reclassified	1,858	956	984	2.9
All Rural Reclassified	268	660	679	2.8
All Rural Non-Reclassified	485	580	596	2.8
All Section 401 Reclassified Hospitals	166	937	922	-1.6
Other Reclassified Hospitals (Section 1886(d)(8)(B))	41	604	643	6.5
Type of Ownership:				
Voluntary	1,914	938	959	2.2
Proprietary	863	823	850	3.3
Government	513	952	983	3.2
Medicare Utilization as a Percent of Inpatient Days:				
0-25	554	1,072	1,100	2.6
25-50	2,149	921	944	2.5
50-65	485	754	774	2.7
Over 65	103	589	657	11.5

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10. On page 38576—

a. First column, last paragraph, line 4, the figure ''$41,430.56'' is corrected to read ''$41,415.11''.

b. Second column—

(1) First partial paragraph—

(a) Line 1, the figure ''1.0006434'' is corrected to read ''1.0002704''.

(b) Line 12, the figure ''$40,610.16'' is corrected to read ''$40,595.02''.

(2) Second full paragraph, line 14, the figure ''1.0006434'' is corrected to read ''1.0002704''.

11. On page 38578, second column, second full paragraph—

a. Line 21, the figure ''$41,430.56'' is corrected to read ''$41,415.11''.

b. Line 22, the figure ''$40,610.16'' is corrected to read ''$40,595.02''.

12. On page 38579—

a. Top of the page, the table title and the table titled ''TABLE IV: IMPACT OF PAYMENT RATE AND POLICY CHANGES TO LTCH PPS PAYMENTS FOR STANDARD PAYMENT RATE CASES FOR FY 2018 [Estimated FY 2017 payments compared to estimated FY 2018 payments]'' are corrected to read as follows:

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TABLE IV: IMPACT OF PAYMENT RATE AND POLICY CHANGES TO LTCH PPS PAYMENTS FOR STANDARD FEDERAL PAYMENT RATE CASES FOR FY 2018
[Estimated FY 2017 payments compared to estimated FY 2018 payments]

LTCH Classification (1)	No. of LTCHs (2)	Number of LTCH PPS Standard Federal Payment Rate Cases (3)	Average FY 2017 LTCH PPS Payment Per Standard Federal Payment Rate (4)	Average FY 2018 LTCH PPS Payment Per Standard Federal Payment Rate[1] (5)	Percent Change Due to Change to the Annual Update to the Standard Federal Payment Rate[2] (6)	Percent Change Due to Changes to Area Wage Adjustment with Wage Budget Neutrality[3] (7)	Proposed Percent Change Due to Change to the Short-Stay Outlier Payment Methodology Change[4] (8)	Percent Change Due to All Standard Federal Payment Rate Changes[5] (9)
ALL PROVIDERS	415	73,915	$46,637	$47,109	0.9	0.0	0.0	1.0
BY LOCATION:								
RURAL	21	2,223	$38,004	$37,969	0.9	-0.3	-0.3	-0.1
URBAN	394	71,692	$46,905	$47,392	0.9	0.0	0.0	1.0
LARGE	199	41,253	$49,568	$50,141	0.9	0.1	0.1	1.2
OTHER	195	30,439	$43,294	$43,665	0.9	-0.1	-0.2	0.9
BY PARTICIPATION DATE:								
BEFORE OCT. 1983	11	1,832	$43,730	$44,550	0.9	-0.6	0.7	1.9
OCT. 1983 - SEPT. 1993	42	9,202	$52,289	$52,672	0.8	-0.1	-0.2	0.7
OCT. 1993 - SEPT. 2002	167	27,657	$46,363	$46,847	0.9	0.1	0.1	1.0
AFTER OCTOBER 2002	195	35,224	$45,527	$45,993	0.9	0.0	-0.1	1.0

LTCH Classification (1)	No. of LTCHs (2)	Number of LTCH PPS Standard Federal Payment Rate Cases (3)	Average FY 2017 LTCH PPS Payment Per Standard Federal Payment Rate (4)	Average FY 2018 LTCH PPS Payment Per Standard Federal Payment Rate[1] (5)	Percent Change Due to Change to the Annual Update to the Standard Federal Payment Rate[2] (6)	Percent Change Due to Changes to Area Wage Adjustment with Wage Budget Neutrality[3] (7)	Proposed Percent Change Due to Change to the Short-Stay Outlier Payment Methodology Change[4] (8)	Percent Change Due to All Standard Federal Payment Rate Changes[5] (9)
BY OWNERSHIP TYPE:								
VOLUNTARY	72	9,636	$48,980	$49,287	0.9	-0.1	-0.3	0.6
PROPRIETARY	329	62,783	$46,105	$46,619	0.9	0.0	0.1	1.1
GOVERNMENT	14	1,496	$53,851	$53,609	0.9	-0.2	-1.1	-0.5
BY REGION:								
NEW ENGLAND	12	2,757	$43,309	$44,407	0.9	-0.3	0.7	2.5
MIDDLE ATLANTIC	25	5,896	$51,862	$52,195	0.9	-0.1	0.2	0.6
SOUTH ATLANTIC	66	13,333	$46,700	$47,213	0.9	-0.1	0.2	1.1
EAST NORTH CENTRAL	68	11,540	$46,371	$46,731	0.9	0.0	-0.1	0.8
EAST SOUTH CENTRAL	34	5,276	$43,787	$44,297	0.9	0.0	0.5	1.2
WEST NORTH CENTRAL	28	4,402	$45,291	$45,233	0.9	0.1	-1.3	-0.1
WEST SOUTH CENTRAL	126	18,529	$41,578	$41,921	0.9	0.01	-0.4	0.8
MOUNTAIN	31	4,279	$48,360	$48,774	0.9	-0.2	-0.1	0.9
PACIFIC	25	7,903	$57,760	$58,810	0.8	0.0	0.5	1.8
BY BED SIZE:								
BEDS: 0-24	26	1,770	$46,206	$46,345	0.9	0.5	-0.7	0.3
BEDS: 25-49	195	26,171	$43,608	$43,971	0.9	-0.1	0.0	0.8
BEDS: 50-74	117	20,276	$48,220	$48,529	0.9	-0.1	-0.2	0.6
BEDS: 75-124	45	12,708	$49,890	$50,560	0.9	0.2	0.1	1.3
BEDS: 125-199	23	8,079	$47,633	$48,228	0.9	0.0	0.0	1.2
BEDS: 200+	9	4,911	$46,341	$47,463	0.8	0.0	0.8	2.4

[1] Estimated FY 2018 LTCH PPS payments for LTCH PPS standard Federal payment rate criteria based on the payment rate and factor changes applicable to such cases presented in the preamble of and the Addendum to this final rule.
[2] Percent change in estimated payments per discharge for LTCH PPS standard Federal payment rate cases from FY 2017 to FY 2018 for the annual update to the LTCH PPS standard Federal payment rate.
[3] Percent change in estimated payments per discharge for LTCH PPS standard Federal payment rate cases from FY 2017 to FY 2018 for changes to the area wage level adjustment under § 412.525(c) (as discussed in section V.B. of the Addendum to this final rule).
[4] Percent change in estimated payments per discharge for LTCH PPS standard Federal payment rate cases from FY 2017 to FY 2018 for change to the SSO payment methodology.
[5] Percent change in estimated payments per discharge for LTCH PPS standard Federal payment rate cases from FY 2017 (shown in Column 4) to FY 2018 (shown in Column 5), including all of the changes to the rates and factors applicable to such cases presented in the preamble and the Addendum to this final rule. We note that this column, which shows the percent change in estimated payments per discharge for all changes, does not equal the sum of the percent changes in estimated payments per discharge for the annual update to the LTCH PPS standard Federal payment rate (Column 6) and the changes to the area wage level adjustment with budget neutrality (Column 7) due to the effect of estimated changes in both estimated payments to SSO cases (prior to accounting for the change to the SSO payment methodology) and aggregate HCO payments for LTCH PPS standard Federal payment rate cases (as discussed in this impact analysis), as well as other interactive effects that cannot be isolated.

13. On page 38585, middle of the page, first column, first paragraph—

b. Lower fourth of the page, third column, partial paragraph, line 5, the figure "1.0006434" is corrected to read "1.0002704".

a. Lines 34, the figure ''2.7'' is corrected to read ''2.5''.

b. Line 38, the figure ''$226'' is corrected to read ''$227''.

Dated: September 29, 2017.

Ann C. Agnew,

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

[FR Doc. 2017–21325 Filed 9–29–17; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 411, 413, 424, and 488

[CMS–1679–CN]

RIN 0938–AS96

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Correction of the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020; Correction

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

ACTION: Final rule; correction.

SUMMARY: This document corrects technical errors in the final rule that appeared in the August 4, 2017 **Federal Register**, which will update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2018.

DATES: This correction is effective October 1, 2017.

FOR FURTHER INFORMATION CONTACT: John Kane, (410) 786–0557.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2017–16256 (82 FR 36530), the final rule entitled ''Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Correction of the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020'', there were a number of technical errors that are identified and corrected in section IV., Correction of Errors. The provisions in this correcting document are effective as if they had been included in the document that appeared in the August 4, 2017, **Federal Register** (hereinafter referred to as the FY 2018 SNF PPS final rule). Accordingly, the corrections are effective October 1, 2017.

II. Summary of Errors

A. Summary of Errors in the Preamble

As discussed in the FY 2018 SNF PPS final rule (82 FR 36539), in developing the wage index to be applied to skilled nursing facilities (SNFs) under the SNF prospective payment system (PPS), we use the updated, pre-reclassified hospital inpatient prospective payment system (IPPS) wage data, exclusive of the occupational mix adjustment. For FY 2018, the updated, unadjusted, pre-reclassified IPPS wage data used under the SNF PPS are for hospital cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014 (FY 2014 cost report data), as discussed in the FY 2018 IPPS final rule (82 FR 38130). In calculating the wage index under the FY 2018 IPPS final rule, we made inadvertent errors related to the wage data collected from the Medicare cost reports of six hospitals which are located in CBSAs 24860 and 40340. Specifically, we used incorrect wage data for these six hospitals to calculate the final FY 2018 IPPS wage indexes, the geographic adjustment factor (GAF) (which is computed from the wage index), as well as certain other IPPS factors and adjustments.

These errors are identified, discussed and corrected in the 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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Services and Tribal Facilities and Organizations; Cost Reporting and Provider Requirements; Agreement Termination Notices; Correction (CMS–1677–CN) that appears elsewhere in this issue of the **Federal Register**.

As discussed above, we use the updated, pre-reclassified, unadjusted IPPS wage data in developing the wage index used under the SNF PPS. Due to the technical errors described above, the published FY 2018 SNF PPS wage indexes were incorrect. Thus, the use of the corrected wage data for the six hospitals required the recalculation of the final FY 2018 SNF PPS wage indexes. Additionally, as discussed on page 36543 of the FY 2018 SNF PPS final rule, section 1888(e)(4)(G)(ii) of the Act requires that we apply the wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage index adjustment had not been made. To achieve this, we apply a budget neutrality factor to the unadjusted SNF PPS federal per diem base rates. Due to the recalculation and subsequent revision of the final FY 2018 SNF PPS wage indexes, it was necessary to recalculate the FY 2018 SNF PPS wage index budget neutrality factor as well. Revising the wage index budget neutrality factor causes a change in the unadjusted SNF PPS federal per diem rates (provided in Tables 2 and 3 of the FY 2018 SNF PPS final rule (82 FR 36535)), which then causes changes in the case-mix adjusted SNF PPS rates (provided in Tables 4 and 5 in the FY 2018 SNF PPS final rule (82 FR 36537 through 36538), as well as the labor adjusted SNF PPS rates (provided in Tables 6 and 7 of the FY 2018 SNF PPS final rule (82 FR 36541 through 36543). Finally, due to the recalculated wage indexes, we recalculated the impact analysis provided in Table 26 of the FY 2018 SNF PPS final rule (82 FR 36629). The corrections to these errors are found in section IV. of this document.

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

We are correcting the wage indexes in Tables A and B setting forth the wage indexes for urban (Table A) and non-urban (Table B) areas based on CBSA labor market areas, which are available exclusively on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* These tables have been updated to reflect the revisions discussed in this correcting document.

We are republishing the wage indexes in Tables A and B accordingly on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

III. Waiver of Proposed Rulemaking and Delayed 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,