Investments 2014 II C.V., AlpInvest Partners 2014 II B.V., AM 2014 Secondary C.V., AlpInvest Mich B.V., AM 2015 Secondary C.V., AlpInvest Partners US Secondary Investments 2015 II C.V., AlpInvest Partners Secondary Investments 2015 II B.V., AlpInvest Secondaries Fund (Euro) V C.V., AlpInvest SF V. B.V., AlpInvest Secondaries Fund V C.V., AlpInvest Partners US Secondary Investments 2014 I C.V., AlpInvest Partners 2014 I B.V., GGG US Secondary C.V., AlpInvest GGG B.V., GGG US Secondary 2015 C.V., AP H Secondaries C.V., AP H Secondaries B.V., AP Fondo Secondaries C.V., AlpInvest Fondo B.V., AlpInvest GA Secondary C.V., AlpInvest GA B.V., AlpInvest A2 Investment Fund C.V., AlpInvest United B.V., AlpInvest A2 Investment Fund II C.V., Alp Holdings Ltd., Alp Intermediate Holdings 2 L.P., Alp Intermediate Holdings I Ltd., Alp Lower Holdings Ltd., Alp Holdings Cooperatief U.A., and AP B.V., all of Amsterdam, The Netherlands; and AlpInvest Partners US Secondary Investments 2014 I, LLC, AlpInvest US Holdings, LLC, The Carlyle Group L.P., Carlyle Group Management L.L.C., Carlyle Holdings III GP Management L.L.C., Carlyle Holdings III GP L.P., Carlyle Holdings III GP Sub L.L.C., Carlyle Holdings III L.P., TC Group Cayman, L.P., all of New York, New York; HarbourVest Partners, LLC, HarborVest Partners L.P., Dover Street VIII L.P., Dover VIII Associates L.P., Dover VIII Associates LLC, HarbourVest Global Annual Private Equity Fund L.P., HarbourVest Global Associates L.P., HarbourVest Global Associates LLC, HarbourVest 2015 Global Fund L.P., HarbourVest 2015 Global Associates L.P., HarbourVest 2015 Global Associates LLC, HarbourVest Partners X Secondary L.P., HarbourVest X Associates LLC, HarbourVest Partners IX-Credit Opportunities Fund L.P., HarbourVest IX Credit Opportunities Associates L.P., HarbourVest IX-Credit Opportunities Associates LLC, HIPEP VII Secondary L.P., HarbourVest Partners X Venture Fund L.P., HarbourVest Partners X Buyout Fund L.P., HarbourVest Partners X AIF Venture L.P., HarbourVest Partners X AIF Buyout L.P., HIPEP VII Partnership Fund L.P., HIPEP VII (AIF) Partnership Fund L.P., HIPEP VII Asia Pacific Fund L.P., HIPEP VII (AIF) Asia Pacific Fund L.P., HIPEP VII Emerging Markets Fund L.P., HIPEP VII Europe Fund L.P., HarbourVest X Associates LLC and HIPEP VII Associates LLC, all of Boston, Massachusetts; and other affiliates; to acquire shares of Carlile Bancshares, Inc., Fort Worth, Texas, and thereby, indirectly acquire shares of, NorthStar Bank of Texas, Denton, Texas, and NorthStar Bank of Colorado, Denver, Colorado.

B. Federal Reserve Bank of St. Louis (David L. Hubbard, Senior Manager) P.O. Box 442, St. Louis, Missouri 63166–2034. Comments can also be sent electronically to *Comments.applications@stls.frb.org:*

1. *John W. Brannan, Jr., individually and as trustee of the Bank of Prescott Employee Stock Ownership Plan, both of Prescott, Arkansas; and as a member of a family control group consisting of Janet P. McAdams; James E. Franks and Linda B. Franks, as trustees of the James E. Franks and Linda B. Franks revocable trust, all of Hot Springs, Arkansas; John Matthew Brannan; Susan Brannan Welch; Lindsay Frank Weeks; Patricia C. Thompson; and Elizabeth Thompson Horowitz,* to acquire additional shares of Prescott Bancshares, Inc., Prescott, Arkansas, and thereby indirectly acquire shares of Bank of Prescott, Prescott, Arkansas.

Board of Governors of the Federal Reserve System, July 27, 2016.

Michele T. Fennell,

Assistant Secretary of the Board.

[FR Doc. 2016–18099 Filed 7–29–16; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1650–N]

RIN 0938–AS76

Medicare Program; FY 2017 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

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

ACTION: Notice.

SUMMARY: This notice updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs) (which include freestanding IPFs and psychiatric units of an acute care hospital or critical access hospital). These changes are applicable to IPF discharges occurring during the fiscal year (FY) beginning October 1, 2016 through September 30, 2017 (FY 2017).

DATES: *Effective:* The updated IPF prospective payment rates are effective for discharges occurring on or after October 1, 2016 through September 30, 2017.

FOR FURTHER INFORMATION CONTACT: Katherine Lucas (410) 786–7723 or Jana Lindquist (410) 786–9374 for general information.

Theresa Bean (410) 786–2287 or James Hardesty (410) 786–2629 for information regarding the regulatory impact analysis.

SUPPLEMENTARY INFORMATION:

Availability of Certain Tables Exclusively Through the Internet on the CMS Web Site

In the past, tables setting forth the Wage Index for Urban Areas Based on Core-Based Statistical Area (CBSA) Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas were published in the **Federal Register** as an Addendum to the annual IPF Prospective Payment System (PPS) rulemaking (that is, the IPF PPS proposed and final rules or notice). However, since FY 2015, these wage index tables are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the Internet, on the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/IPFPPS/WageIndex.html*.

To assist readers in referencing sections contained in this document, we are providing the following table of contents.

Table of Contents

Acronyms

Because of the many terms to which we refer by acronym in this notice, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

ADC Average Daily Census
BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BLS Bureau of Labor Statistics
CAH Critical Access Hospital
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CPI Consumer Price Index
CPI–U Consumer Price Index for all Urban Consumers
CY Calendar Year
DRGs Diagnosis-Related Groups
ECT Electroconvulsive Therapy
ESRD End State Renal Disease
FR Federal Register
FTE Full-time equivalent
FY Federal Fiscal Year (October 1 through September 30)
GDP Gross Domestic Product
GME Graduate Medical Education
HCRIS Healthcare Cost Report Information System
ICD–9–CM International Classification of Diseases, 9th Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, 10th Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, 10th Revision, Procedure Coding System
IGI IHS Global Insight, Inc.
IPF Inpatient Psychiatric Facility
IPFQR Inpatient Psychiatric Facilities Quality Reporting
IPPS Inpatient Prospective Payment System
IRFs Inpatient Rehabilitation Facilities
LOS Length of Stay
LRS Labor-related Share
LTCHs Long-Term Care Hospitals
MAC Medicare Administrative Contractor
MedPAR Medicare Provider Analysis and Review File
MFP Multifactor Productivity
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA Metropolitan Statistical Area
NDAA National Defense Authorization Act
NQF National Quality Forum
OMB Office of Management and Budget
OPPS Outpatient Prospective Payment System
POS Provider of Services
PPS Prospective Payment System
RFA Regulatory Flexibility Act
RPL Rehabilitation, Psychiatric, and Long-Term Care
RY Rate Year (July 1 through June 30)
SBA Small Business Administration
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248)

I. Executive Summary

A. Purpose

This notice updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs) for discharges occurring during the fiscal year (FY) beginning October 1, 2016 through September 30, 2017.

B. Summary of the Major Provisions

In this notice, we are updating the IPF Prospective Payment System (PPS), as specified in 42 CFR 412.428. The updates include the following:

- Effective for the FY 2016 IPF PPS update, we adopted a 2012-based IPF market basket. For FY 2017, we adjusted the 2012-based IPF market basket update (2.8 percent) by a reduction for economy-wide productivity (0.3 percentage point) as required by section 1886(s)(2)(A)(i) of the Social Security Act (the Act). We further reduced the 2012-based IPF market basket update by 0.2 percentage point as required by section 1886(s)(2)(A)(ii) of the Act, resulting in an estimated IPF payment rate update of 2.3 percent for FY 2017.
- The 2012-based IPF market basket resulted in a labor-related share of 75.1 percent for FY 2017.
- We updated the IPF PPS per diem rate from $743.73 to $761.37. Providers that failed to report quality data for FY 2017 payment will receive a FY 2017 per diem rate of $746.48.
- We updated the electroconvulsive therapy (ECT) payment per treatment from $320.19 to $327.78. Providers that failed to report quality data for FY 2017 payment will receive a FY 2017 ECT payment per treatment of $321.38.
- We used the updated labor-related share of 75.1 percent (based on the 2012-based IPF market basket) and CBSA rural and urban wage indices for FY 2017, and established a wage index budget-neutrality adjustment of 1.0007.
- We updated the fixed dollar loss threshold amount from $9,580 to $10,120 in order to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

C. Summary of Impacts

Provision description	Total transfers
FY 2017 IPF PPS payment update.	The overall economic impact of this notice is an estimated $100 million in increased payments to IPFs during FY 2017.

II. Background

A. Overview of the Legislative Requirements for the IPF PPS

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary of the Department of Health and Human Services (the Secretary) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to distinct part psychiatric units of critical access hospitals (CAHs).

Section 3401(f) and section 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to jointly as ''the Affordable Care Act'') added subsection (s) to section 1886 of the Act.

Section 1886(s)(1) of the Act titled ''Reference to Establishment and Implementation of System'', refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the Rate Year (RY) beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY. As noted in our previous IPF PPS final rule (the FY 2016 IPF PPS final rule), for the RY beginning in 2015 (that is, FY 2016), the current estimate of the productivity adjustment is equal to 0.5 percent.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an ''other adjustment'' that reduces any update to an IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. As noted in our FY 2016 IPF PPS final rule, for the RY beginning in 2015 (that is, FY 2016), section 1886(s)(3)(D) of the Act requires the reduction to be 0.2 percentage point.

Sections 1886(s)(4)(A) and 1886(s)(4)(B) of the Act require that for RY 2014 and every subsequent year, IPFs that fail to report required quality data shall have their annual payment rate update reduced by 2.0 percentage points. This may result in an annual update being less than 0.0 for a rate year, and may result in payment rates for the upcoming rate year being less than such payment rates for the preceding rate year. Any reduction for failure to report required quality data shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount for a subsequent rate year. More information about the IPF Quality Reporting Program is available in the April 27, 2016 FY 2017 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Proposed Rule (81 FR 25238 through 25244).

To implement and periodically update these provisions, we have published various proposed and final rules and notices in the **Federal Register**. For more information regarding these documents, see the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/InpatientPsychFacilPPS/*.

B. Overview of the IPF PPS

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF PPS, as required by section 124 of the BBRA and codified at subpart N of part 412 of the Medicare regulations. The November 2004 IPF PPS final rule set forth the per diem federal rates for the implementation year (the 18-month period from January 1, 2005 through June 30, 2006), and provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) of the Medicare program.

The IPF PPS established the federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget-neutrality.

The federal per diem payment under the IPF PPS is comprised of the federal per diem base rate described above and certain patient- and facility-level payment adjustments that were found in the regression analysis to be associated with statistically significant per diem cost differences.

The patient-level adjustments include age, Diagnosis-Related Group (DRG) assignment, comorbidities; additionally, there are variable per diem adjustments to reflect higher per diem costs at the beginning of a patient's IPF stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying Emergency Department (ED).

The IPF PPS provides additional payment policies for: Outlier cases; interrupted stays; and a per treatment adjustment for patients who undergo ECT. During the IPF PPS mandatory 3-year transition period, stop-loss payments were also provided; however, since the transition ended in 2008, these payments are no longer available.

A complete discussion of the regression analysis that established the IPF PPS adjustment factors appears in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

Section 124 of the BBRA did not specify an annual rate update strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final federal per diem base rate to be budget-neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

In RY 2012, we proposed and finalized switching the IPF PPS payment rate update from a rate year that begins on July 1 and ends on June 30 to one that coincides with the federal fiscal year that begins October 1 and ends on September 30. In order to transition from one timeframe to another, the RY 2012 IPF PPS covered a 15-month period from July 1, 2011 through September 30, 2012. Therefore, the update cycle for FY 2016 was October 1, 2015 through September 30, 2016. For further discussion of the 15-month market basket update for RY 2012 and changing the payment rate update period to coincide with a FY period, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and the RY 2012 IPF PPS final rule (76 FR 26432).

C. Annual Requirements for Updating the IPF PPS

In November 2004, we implemented the IPF PPS in a final rule that appeared in the November 15, 2004 **Federal Register** (69 FR 66922). In developing the IPF PPS, to ensure that the IPF PPS is able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In that final rule, we explained the reasons for delaying an update to the adjustment factors, derived from the regression analysis, until we have IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We indicated that we did not intend to update the regression analysis and the patient-level and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (71 FR 27041). We have been performing the necessary analysis to make refinements to the IPF PPS using more current data to set the adjustment factors. We expect we will be ready to propose potential refinements in future rulemaking.

In the May 6, 2011 IPF PPS final rule (76 FR 26432), we changed the payment rate update period to a RY that coincides with a FY update. Therefore, update notices are now published in the **Federal Register** in the summer to be effective on October 1. When proposing changes in IPF payment policy, a proposed rule would be issued in the spring and the final rule in the summer in order to be effective on October 1. For further discussion on changing the IPF PPS payment rate update period to a RY that coincides with a FY, see the IPF PPS final rule published in the **Federal Register** on May 6, 2011 (76 FR 26434 through 26435). For a detailed list of updates to the IPF PPS, see 42 CFR 412.428.

Our most recent IPF PPS annual update occurred in an August 5, 2015, **Federal Register** final rule (80 FR 46652) (hereinafter referred to as the August 2015 IPF PPS final rule), which updated the IPF PPS payment rates for FY 2016. That rule updated the IPF PPS per diem payment rates that were published in the August 2014 IPF PPS final rule (79 FR 45938) in accordance with our established policies.

III. Provisions of the Notice

A. Updated FY 2017 Market Basket for the IPF PPS

1. Background

The input price index that was used to develop the IPF PPS was the ''Excluded Hospital with Capital'' market basket. This market basket was based on 1997 Medicare cost reports for Medicare participating inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), long-term care hospitals (LTCHs), cancer hospitals, and children's hospitals. Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term ''market basket,'' as used in this document, refers to an input price index.

Beginning with the May 2006 IPF PPS final rule (71 FR 27046 through 27054), IPF PPS payments were updated using a 2002-based rehabilitation, psychiatric, and long-term care (RPL) market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding IPFs, and LTCHs. Cancer and children's hospitals were excluded from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act and not through a PPS. Also, the 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of freestanding IRFs, freestanding IPFs, and LTCHs. See the May 2006 IPF PPS final rule (71 FR 27046 through 27054) for a complete discussion of the 2002-based RPL market basket.

In the May 1, 2009 IPF PPS notice (74 FR 20376), we expressed our interest in exploring the possibility of creating a stand-alone IPF market basket that reflects the cost structures of only IPF providers. One available option was to combine the Medicare cost report data from freestanding IPF providers with Medicare cost report data from hospital-based IPF providers. We indicated that an examination of the Medicare cost report data comparing freestanding IPFs and hospital-based IPFs showed differences between cost levels and cost structures. At that time, we were unable to fully understand these differences even after reviewing explanatory variables such as geographic variation, case mix (including DRG, comorbidity, and age), urban or rural status, teaching status, and presence of a qualifying emergency department. As a result, we continued to research ways to reconcile the differences and solicited public comment for additional information that might help us to better understand the reasons for the variations in costs and cost structures, as indicated by the Medicare cost report data (74 FR 20376). We summarized the public comments received and our responses in the April 2010 IPF PPS notice (75 FR 23111 through 23113). Despite receiving comments from the public on this issue, we were still unable to sufficiently reconcile the observed differences in costs and cost structures between hospital-based and freestanding IPFs; and therefore, at that time we did not believe it to be appropriate to incorporate data from hospital-based IPFs with those of freestanding IPFs to create a stand-alone IPF market basket.

Beginning with the RY 2012 IPF PPS final rule (76 FR 26432), IPF PPS payments were updated using a 2008-based RPL market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding IPFs, and LTCHs. The major changes for RY 2012 included: Updating the base year from FY 2002 to FY 2008; using a more specific composite chemical price proxy; breaking the professional fees cost category into two separate categories (Labor-related and Non-labor-related); and adding two additional cost categories (Administrative and Facilities Support Services and Financial Services), which were previously included in the residual All Other Services cost categories. The RY 2012 IPF PPS proposed rule (76 FR 4998) and RY 2012 final rule (76 FR 26432) contain a complete discussion of the development of the 2008-based RPL market basket.

In the FY 2016 IPF PPS proposed rule, we proposed to create a 2012-based IPF market basket, using Medicare cost report data for both freestanding and hospital-based IPFs. After consideration of the public comments, we finalized the creation and adoption of a 2012-based IPF market basket with a modification to the Wages and Salaries and Employee Benefits cost methodologies based on public comments. We believe that the use of the 2012-based IPF market basket to update IPF PPS payments is a technical improvement as it is based on Medicare Cost Report data from both freestanding and hospital-based IPFs. Furthermore, the 2012-based IPF market basket does not include costs from either IRF or LTCH providers, which were included in the 2008-based RPL market basket. We refer readers to the FY 2016 IPF PPS final rule for a detailed discussion of the 2012-based IPF PPS Market Basket and its development (80 FR 46656 through 46679).

2. FY 2017 IPF Market Basket Update

For FY 2017 (beginning October 1, 2016 and ending September 30, 2017), we use an estimate of the 2012-based IPF market basket increase factor to update the IPF PPS base payment rate. Consistent with historical practice, we estimate the market basket update for the IPF PPS based on IHS Global Insight's forecast. IHS Global Insight, Inc. (IGI) is a nationally recognized economic and financial forecasting firm that contracts with the Centers for Medicare & Medicaid Services (CMS) to forecast the components of the market baskets and multifactor productivity (MFP). Based on IGI's second quarter 2016 forecast with historical data through the first quarter of 2016, the 2012-based IPF market basket increase factor for FY 2017 is 2.8 percent.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (a RY that coincides with a FY) and each subsequent RY. For this FY 2017 IPF PPS Notice, based on IGI's second quarter 2016 forecast, the MFP adjustment for FY 2017 (the 10-year moving average of MFP for the period ending FY 2017) is projected to be 0.3 percent. We reduced the IPF market basket estimate by this 0.3 percentage point productivity adjustment, as mandated by the Act. For more information on the productivity adjustment, please see the discussion in the FY 2016 IPF PPS final rule (80 FR 46675).

In addition, for FY 2017 the 2012-based IPF PPS market basket update is further reduced by 0.2 percentage point as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act. This results in an estimated FY 2017 IPF PPS payment rate update of 2.3 percent (2.8 − 0.3 − 0.2 = 2.3).

3. IPF Labor-Related Share

Due to variations in geographic wage levels and other labor-related costs, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index, which would apply to the labor-related portion of the Federal per diem base rate (hereafter referred to as the labor-related share).

The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2012-based IPF market basket, we are continuing to include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair, All Other: Labor-related Services, and a portion (46 percent) of the Capital-Related cost weight from the proposed 2012-based IPF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2012) and FY 2017. Using IGI's second quarter 2016 forecast for the final 2012-based IPF market basket, the IPF labor-related share for FY 2017 is the sum of the FY 2017 relative importance of each labor-related cost category.

Please see the FY 2016 IPF PPS final rule for more information on the labor-related share and its calculation (80 FR 46675 through 46679). For FY 2017, the updated labor-related share based on IGI's second quarter 2016 forecast of the 2012-based IPF PPS market basket is 75.1 percent.

B. Updates to the IPF PPS Rates for FY Beginning October 1, 2016

The IPF PPS is based on a standardized Federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient-level and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA required that we implement the IPF PPS in a budget-neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented. A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

Under the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget-neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

Next, we standardized the IPF PPS Federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. Additional information concerning this standardization can be found in the November 2004 IPF PPS final rule (69 FR 66932) and the RY 2006 IPF PPS final rule (71 FR 27045). We then reduced the standardized Federal per diem base rate to account for the outlier policy, the stop loss provision, and anticipated behavioral changes. A complete discussion of how we calculated each component of the budget-neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the May 2006 IPF PPS final rule (71 FR 27044 through 27046). The final standardized budget-neutral Federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was calculated to be $575.95.

The Federal per diem base rate has been updated in accordance with applicable statutory requirements and § 412.428 through publication of annual notices or proposed and final rules. A detailed discussion on the standardized budget-neutral Federal per diem base rate and the electroconvulsive therapy (ECT) payment per treatment appears in the August 2013 IPF PPS update notice (78 FR 46738 through 46739). These documents are available on the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.*

IPFs must include a valid procedure code for ECT services provided to IPF beneficiaries in order to bill for ECT services, as described in our Medicare claims processing manual, chapter 3, section 190.7.3 (available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.*) There were no changes to the ECT procedure codes used on IPF claims as a result of the update to the ICD–10–PCS code set for FY 2017.

2. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Payment Per Treatment

The current (FY 2016) Federal per diem base rate is $743.73 and the ECT payment per treatment is $320.19. For FY 2017, we applied a payment rate update of 2.3 percent (that is, the 2012-based IPF market basket increase for FY 2017 of 2.8 percent less the productivity adjustment of 0.3 percentage point, and further reduced by the 0.2 percentage point required under section

1886(s)(3)(D) of the Act), and the wage index budget-neutrality factor of 1.0007 (as discussed in section III.D.1.e of this notice) to the FY 2016 Federal per diem base rate of $743.73, yielding a Federal per diem base rate of $761.37 for FY 2017. Similarly, we applied the 2.3 percent payment rate update and the 1.0007 wage index budget-neutrality factor to the FY 2016 ECT payment per treatment, yielding an ECT payment per treatment of $327.78 for FY 2017.

Section 1886(s)(4)(A)(i) of the Act requires that, for RY 2014 and each subsequent RY, the Secretary shall reduce any annual update to a standard Federal rate for discharges occurring during the RY by 2.0 percentage points for any IPF that did not comply with the quality data submission requirements with respect to an applicable year. Therefore, we are applying a 2.0 percentage point reduction to the Federal per diem base rate and the ECT payment per treatment as follows: For IPFs that failed to submit quality reporting data under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) program, we are applying a 0.3 percent payment rate update (that is, 2.3 percent reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget-neutrality factor of 1.0007 to the FY 2016 Federal per diem base rate of $743.73, yielding a Federal per diem base rate of $746.48 for FY 2017. Similarly, for IPFs that failed to submit quality reporting data under the IPFQR program, we are applying the 0.3 percent annual payment rate update and the 1.0007 wage index budget-neutrality factor to the FY 2016 ECT payment per treatment of $320.19, yielding an ECT payment per treatment of $321.38 for FY 2017.

C. Updates to the IPF PPS Patient-Level Adjustment Factors

1. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). We continue to use the existing regression-derived adjustment factors established in 2005 for FY 2017. However, we have used more recent claims data to simulate payments to set the outlier fixed dollar loss threshold amount and to assess the impact of the IPF PPS updates.

2. IPF–PPS Patient-Level Adjustments

The IPF PPS includes payment adjustments for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

a. MS–DRG Assignment

We believe it is important to maintain the same diagnostic coding and DRG classification for IPFs that are used under the Inpatient Prospective Payment System (IPPS) for providing psychiatric care. For this reason, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set (ICD–9–CM) and DRG patient classification system (CMS DRGs) that were utilized at the time under the IPPS. In the May 2008 IPF PPS notice (73 FR 25709), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). In the 2008 IPF PPS notice (73 FR 25716), we provided a crosswalk to reflect changes that were made under the IPF PPS to adopt the new MS–DRGs. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the May 2008 IPF PPS notice (73 FR 25714).

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis. Mapping the DRGs to the MS–DRGs resulted in the current 17 IPF MS–DRGs, instead of the original 15 DRGs, for which the IPF PPS provides an adjustment. For the FY 2017 update, we are not making any changes to the IPF MS–DRG adjustment factors.

In FY 2015 rulemaking (79 FR 45945 through 45947), we proposed and finalized conversions of the ICD–9–CM-based MS–DRGs to ICD–10–CM/PCS-based MS–DRGs, which were implemented on October 1, 2015. Further information on the ICD–10–CM/PCS MS–DRG conversion project can be found on the CMS ICD–10–CM Web site at *https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.*

For FY 2017, we will continue to make a payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS–DRGs listed in Addendum A. Psychiatric principal diagnoses that do not group to one of the 17 designated DRGs will still receive the Federal per diem base rate and all other applicable adjustments, but the payment would not include a DRG adjustment.

The diagnoses for each IPF MS–DRG will be updated as of October 1, 2016, using the final FY 2017 ICD–10–CM/PCS code sets. The FY 2017 IPPS Final Rule with comment period includes tables of the changes to the ICD–10–CM/PCS code sets which underlie the FY 2017 IPF MS–DRGs. Both the FY 2017 IPPS final rule and the tables of changes to the ICD–10–CM/PCS code sets which underlie the FY 2017 MS–DRGs are available on the IPPS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.*

i. Code First

As discussed in the ICD–10–CM Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD–10–CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes (etiology followed by manifestation). In accordance with the ICD–10–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a ''code first'' note, the provider would follow the instructions in the ICD–10–CM text. The submitted claim goes through the CMS processing system, which will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

For more information on ''code first'' policy, please see the November 2004 IPF PPS Final Rule (69 FR 66945). In the FY 2015 IPF PPS final rule, we provided a ''code first'' table for reference that highlights the same or similar manifestation codes where the ''code first'' instructions apply in ICD–10–CM that were present in ICD–9–CM (79 FR 46009). There were no changes to the IPF Code First list as a result of the FY 2017 updates to the ICD–10–CM/PCS code sets.

b. Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. In the May 2011 IPF PPS final rule (76 FR 26451 through 26452), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2012 (76 FR 26451).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Current billing instructions for discharge claims, on or after October 1, 2015, require IPFs to enter the complete ICD–10–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission, or develop subsequently and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM ''code first'' instructions apply. In a ''code first'' situation, the submitted claim goes through the CMS processing system, which will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

As noted previously, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. The 17 comorbidity categories formerly defined using ICD–9–CM codes were converted to ICD–10–CM/PCS in the FY 2015 IPF PPS final rule (79 FR 45947 to 45955). The goal for converting the comorbidity categories is referred to as replication, meaning that the payment adjustment for a given patient encounter is the same after ICD–10–CM implementation as it would be if the same record had been coded in ICD–9–CM and submitted prior to ICD–10–CM/PCS implementation on October 1, 2015. All conversion efforts were made with the intent of achieving this goal. For FY 2017, we will use the comorbidity adjustments in effect in FY 2016, which are found in Addendum A to this notice. We have also updated the ICD–10–CM/PCS codes which are associated with the existing IPF PPS comorbidity categories, based upon the FY 2017 update to the ICD–10–CM/PCS code set. In accordance with the policy established in the FY 2015 IPF PPS Final Rule (79 FR 45949 through 45952), we reviewed all new FY 2017 ICD–10–CM codes to remove site unspecified codes from the new FY 2017 ICD–10–CM/PCS codes in instances where more specific codes are available. Based on our review, we are excluding new FY 2017 ICD–10–CM code D49519 (''Neoplasm of unspecified behavior of unspecified kidney'') in the Oncology Treatment comorbidity category. Please see Addendum B to this notice for a table of changes to the ICD–10–CM/PCS codes which affect FY 2017 IPF PPS comorbidity categories.

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (range of ages) for payment adjustments. In general, we found that the cost per day increases with age. The older age groups are more costly than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant. For FY 2017, we will use the patient age adjustments currently in effect in FY 2016, as shown in Addendum A to this notice.

4. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. We used a regression analysis to estimate the average differences in per diem cost among stays of different lengths. As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section III.D.4 of this notice.

For FY 2017, we will use the variable per diem adjustment factors currently in effect as shown in Addendum A to this notice. A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

D. Updates to the IPF PPS Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

a. Background

As discussed in the May 2006 IPF PPS final rule (71 FR 27061) and in the May 2008 (73 FR 25719) and May 2009 (74 FR 20373) IPF PPS notices, in order to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) and (C).

b. Updated Wage Index for FY 2017

Since the inception of the IPF PPS, we have used the pre-floor, pre-reclassified acute care hospital wage index in developing a wage index to be applied to IPFs because there is not an IPF-specific wage index available. We believe that IPFs compete in the same labor markets as acute care hospitals, so the pre-floor, pre-reclassified hospital wage index should reflect IPF labor costs. As discussed in the May 2006 IPF PPS final rule for FY 2007 (71 FR 27061 through 27067), under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, please see the CY 2013 IPPS/LTCH PPS final rule (77 FR 53365 through 53374). For FY 2017, we will continue to apply the most recent hospital wage index (the FY 2016 pre-floor, pre-reclassified hospital wage index, which is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (data from hospital cost reports for the cost reporting period beginning during FY 2012) without any geographic reclassifications, floors, or other adjustments. We apply the FY 2017 IPF PPS wage index to payments beginning October 1, 2016.

We apply the wage index adjustment to the labor-related portion of the federal rate, which changed from 75.2 percent in FY 2016 to 75.1 percent in FY 2017. This percentage reflects the labor-related share of the 2012-based IPF market basket for FY 2017 (see section III.A.3 of this notice).

c. OMB Bulletins

OMB publishes bulletins regarding Core-Based Statistical Area (CBSA) changes, including changes to CBSA numbers and titles. In the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061 through 27067), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB CBSA geographic designations in RY 2007, we did not provide a separate transition for the CBSA-based wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

In the May 2008 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current IPF PPS wage index and stated that we expect to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721). The OMB bulletins may be accessed online at *https://www.whitehouse.gov/omb/bulletins_default/.*

In accordance with our established methodology, we have historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the hospital wage index used to determine the IPF PPS wage index. For the FY 2015 IPF wage index, we used the FY 2014 pre-floor, pre-reclassified hospital wage index to adjust the IPF PPS payments. On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/omb/bulletins_default/.* Because the FY 2014 pre-floor, pre-reclassified hospital wage index was finalized prior to the issuance of this Bulletin, the FY 2015 IPF PPS wage index, which was based on the FY 2014 pre-floor, pre-reclassified hospital wage index, did not reflect OMB's new area delineations based on the 2010 Census. According to OMB, ''[t]his bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 through 37252) and Census Bureau data.'' These OMB Bulletin changes are reflected in the FY 2015 pre-floor, pre-reclassified hospital wage index, upon which the FY 2016 IPPS PPS wage index was based. We adopted these new OMB CBSA delineations in the FY 2016 IPF PPS wage index; therefore, they are also included in the FY 2017 IPF PPS wage index.

While we believe that the CBSA delineations implemented in the FY 2016 IPF PPS final rule resulted in wage index values that are more representative of the actual costs of labor in a given area, we also recognize that use of the new CBSA delineations resulted in reduced payments to some IPFs and increased payments to other IPFs, due to changes in wage index values. Therefore, in our FY 2016 IPF PPS final rule, we provided for a transition period to mitigate any negative impacts on facilities that experience reduced payments as a result of our adopting the new OMB CBSA delineations. We implemented these CBSA changes using a 1-year transition with a blended wage index for all providers (80 FR 46682 through 46689). The FY 2017 IPF PPS wage index and subsequent IPF PPS wage indices will be based solely on the new OMB CBSA delineations. The final FY 2017 IPF PPS wage index is located on the CMS Web site at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.*

d. Adjustment for Rural Location and Continuing Phase-Out of the Rural Adjustment for IPFs That Lost Their Rural Adjustment Due to CBSA Changes Implemented in FY 2016

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. For FY 2017, we will continue to apply a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C). A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

As noted in section III.D.1.c of this notice, we adopted OMB updates to CBSA delineations in the FY 2016 IPF PPS transitional wage index. Adoption of the updated CBSAs changed the status of 37 IPF providers designated as ''rural'' in FY 2015 to ''urban'' for FY 2016 and subsequent fiscal years. As such, these 37 newly urban providers no longer receive the 17 percent rural adjustment.

In the FY 2016 IPF PPS final rule, we implemented a budget-neutral 3-year phase-out of the rural adjustment for the existing FY 2015 rural IPFs that became urban in FY 2016 and that experienced a loss in payments due to changes from the new CBSA delineations (80 FR 46689 to 46690). This policy allowed rural IPFs that were classified as urban in FY 2016 to receive two-thirds of the IPF PPS rural adjustment for FY 2016. For FY 2017, these IPFs will receive one-third of the IPF PPS rural adjustment. For FY 2018 and subsequent years, these IPFs will not receive any rural adjustment. We are now in the second year of the 3-year rural adjustment phase-out; therefore, these IPFs that were classified as rural in FY 2015, but were changed to urban in FY 2016 as a result of the OMB CBSA changes, will receive one-third of the 17 percent rural adjustment in FY 2017.

e. Budget Neutrality Adjustment

Changes to the wage index are made in a budget-neutral manner so that updates do not increase expenditures. Therefore, for FY 2017, we will continue to apply a budget-neutrality adjustment in accordance with our existing budget-neutrality policy. This policy requires us to update the wage index in such a way that total estimated payments to IPFs for FY 2017 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the IPF PPS rates. We use the following steps to ensure that the rates reflect the update to the wage indexes (based on the FY 2012 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Simulate estimated IPF PPS payments, using the FY 2016 wage index values and labor-related share (as published in the FY 2016 IPF PPS final rule (80 FR 46675 to 46679 and 46681 to 46690)).

Step 2. Simulate estimated IPF PPS payments using the FY 2017 wage index values (available on the CMS Web site) and labor-related share (based on the latest available data as discussed previously).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2017 budget-neutral wage adjustment factor of 1.0007.

Step 4. Apply the FY 2017 budget-neutral wage adjustment factor from step 3 to the Federal per diem base rate for FY 2017, in addition to the market basket described in section III.A2 of this notice.

2. Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the ratio of the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census (ADC).

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under a PPS, and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF's ''teaching variable,'' which is one plus the ratio of the number of FTE residents training in the IPF (subject to limitations described below) to the IPF's ADC.

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a ''base year'' and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (publication date of the IPF PPS final rule). A complete discussion of the temporary adjustment to the FTE cap to reflect residents added due to hospital closure and by residency program appears in the January 27, 2011 IPF PPS proposed rule (76 FR 5018 through 5020) and the May 6, 2011 IPF PPS final rule (76 FR 26453 through 26456).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant. A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the May 2008 IPF PPS notice (73 FR 25721). As with other adjustment factors derived through the regression analysis, we do not plan to rerun the teaching adjustment factors in the regression analysis until we more fully analyze IPF PPS data. Therefore, in this FY 2017 notice, we will continue to retain the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.

3. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare PPSs (for example: The IPPS and LTCH PPS) adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

A COLA for IPFs located in Alaska and Hawaii is made by multiplying the non-labor-related portion of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

The COLA factors are published on the Office of Personnel Management (OPM) Web site (*https://www.opm.gov/oca/cola/rates.asp*).

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

- City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- Rest of the State of Alaska.

As stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the OPM. However, sections 1911 through 1919 of the Nonforeign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) for Fiscal Year 2010 (Pub. L. 111–84, October 28, 2009), transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of NDAA, locality pay is being phased in over a 3-year period beginning in

January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA factors in the January 2011 IPF PPS proposed rule (76 FR 4998), we inadvertently selected the FY 2010 COLA rates, which had been reduced to account for the phase-in of locality pay. We did not intend to propose the reduced COLA rates because that would have understated the adjustment. Since the 2009 COLA rates did not reflect the phase-in of locality pay, we finalized the FY 2009 COLA rates for RY 2010 through RY 2014.

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), we established a methodology for FY 2014 to update the COLA factors for Alaska and Hawaii. Under that methodology, we use a comparison of the growth in the Consumer Price Indices (CPIs) in Anchorage, Alaska and Honolulu, Hawaii relative to the growth in the overall CPI as published by the Bureau of Labor Statistics (BLS) to update the COLA factors for all areas in Alaska and Hawaii, respectively. As discussed in the FY 2013 IPPS/LTCH proposed rule (77 FR 28145), because BLS publishes CPI data for only Anchorage, Alaska and Honolulu, Hawaii, our methodology for updating the COLA factors uses a comparison of the growth in the CPIs for those cities relative to the growth in the overall CPI to update the COLA factors for all areas in Alaska and Hawaii, respectively. We believe that the relative price differences between these cities and the United States (as measured by the CPIs mentioned above) are generally appropriate proxies for the relative price differences between the ''other areas'' of Alaska and Hawaii and the United States.

The CPIs for ''All Items'' that BLS publishes for Anchorage, Alaska, Honolulu, Hawaii, and for the average U.S. city are based on a different mix of commodities and services than is reflected in the non-labor-related share of the IPPS market basket. As such, under the methodology we established to update the COLA factors, we calculated a ''reweighted CPI'' using the CPI for commodities and the CPI for services for each of the geographic areas to mirror the composition of the IPPS market basket non-labor-related share. The current composition of BLS' CPI for ''All Items'' for all of the respective areas is approximately 40 percent commodities and 60 percent services. However, the non-labor-related share of the IPPS market basket is comprised of 60 percent commodities and 40 percent services. Therefore, under the methodology established for FY 2014 in the FY 2013 IPPS/LTCH PPS final rule, we created reweighted indexes for Anchorage, Alaska, Honolulu, Hawaii, and the average U.S. city using the respective CPI commodities index and CPI services index and applying the approximate 60/40 weights from the IPPS market basket. This approach is appropriate because we would continue to make a COLA for hospitals located in Alaska and Hawaii by multiplying the non-labor-related portion of the standardized amount by a COLA factor.

Under the COLA factor update methodology established in the FY 2014 IPPS/LTCH final rule, we adjusted payments made to hospitals located in Alaska and Hawaii by incorporating a 25 percent cap on the CPI-updated COLA factors. We note that OPM's COLA factors were calculated with a statutorily mandated cap of 25 percent, and since at least 1984, we have exercised our discretionary authority to adjust Alaska and Hawaii payments by incorporating this cap. In keeping with this historical policy, we continue to use such a cap because our CPI-updated COLA factors use the 2009 OPM COLA factors as a basis.

In FY 2015 IPF PPS rulemaking, we adopted the same methodology for the COLA factors applied under the IPPS because IPFs are hospitals with a similar mix of commodities and services. We think it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. Therefore, in the FY 2015 IPF PPS final rule, we adopted the cost of living adjustment factors shown in Addendum A for IPFs located in Alaska and Hawaii. Under IPPS COLA policy, the COLA updates are determined every four years, when the IPPS market basket is rebased. Since the IPPS COLA factors were last updated in FY 2014, they are not scheduled to be updated again until FY 2018. As such, we will continue using the existing IPF PPS COLA factors in effect in FY 2016 for FY 2017. The IPF PPS COLA factors for FY 2017 are shown in Addendum A to this notice.

4. Adjustment for IPFs With a Qualifying Emergency Department (ED)

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a freestanding psychiatric hospital with a qualifying ED or a distinct part psychiatric unit of an acute care hospital or a CAH, for preadmission services otherwise payable under the Medicare Outpatient Prospective Payment System (OPPS), furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF (see § 413.40(c)(2)), and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. Those IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described below. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made when a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. We clarified in the November 2004 IPF PPS final rule (69 FR 66960) that an ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital or CAH's psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF. For FY 2017, we will continue to retain the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factor appears in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the May 2006 IPF PPS final rule (71 FR 27070 through 27072).

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and, therefore, reduce the incentives for IPFs to under-serve these patients.

We make outlier payments for discharges in which an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total projected IPF PPS payments.

2. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we are updating the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy, which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases.

Based on an analysis of the latest available data (the March 2016 update of FY 2015 IPF claims) and rate increases, we believe it is necessary to update the fixed dollar loss threshold amount in order to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments. To update the IPF outlier threshold amount for FY 2017, we used FY 2015 claims data and the same methodology that we used to set the initial outlier threshold amount in the May 2006 IPF PPS final rule (71 FR 27072 and 27073), which is also the same methodology that we used to update the outlier threshold amounts for years 2008 through 2016. Based on an analysis of these updated data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 2.1 percent in FY 2016. Therefore, we will update the outlier threshold amount to $10,120 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2017.

3. Update to IPF Cost-to-Charge Ratio Ceilings

Under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount plus the IPF PPS amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the June 2003 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for acute care hospitals because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs in order to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule (69 FR 66961), because we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS. Specifically, we adopted the following procedure in the November 2004 IPF PPS final rule: We calculated 2 national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs using the most recent CCRs entered in the CY 2016 Provider Specific File.

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in FY 2017 is 1.9315 for rural IPFs, and 1.6374 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate, and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. We continue to use these national CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.
- IPFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for which the Medicare Administrative Contractor (MAC) obtains inaccurate or incomplete data with which to calculate a CCR.

We are updating the FY 2017 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS Provider Specific File. Specifically, for FY 2017, to be used in each of the three situations listed above, using the most recent CCRs entered in the CY 2016 Provider Specific File, we estimate a national median CCR of 0.5960 for rural IPFs and a national median CCR of 0.4455 for urban IPFs. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations.

A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

IV. Update on IPF PPS Refinements

For RY 2012, we identified several areas of concern for future refinement, and we invited comments on these issues in our RY 2012 proposed and final rules. For further discussion of these issues and to review the public comments, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and final rule (76 FR 26432).

We have delayed making refinements to the IPF PPS until we have completed a thorough analysis of IPF PPS data on which to base those refinements. Specifically, we will delay updating the adjustment factors derived from the regression analysis until we have IPF

PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We have begun and will continue the necessary analysis to better understand IPF industry practices so that we may refine the IPF PPS in the future, as appropriate.

As we noted in the FY 2016 IPF PPS final rule (80 FR 46693 to 46694), our preliminary analysis of 2012 to 2013 IPF data found that over 20 percent of IPF stays reported no ancillary costs, such as laboratory and drug costs, in their cost reports, or laboratory or drug charges on their claims. Because we expect that most patients requiring hospitalization for active psychiatric treatment will need drugs and laboratory services, we again remind providers that the IPF PPS per diem payment rate includes the cost of all ancillary services, including drugs and laboratory services. We pay only the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF, except for certain professional services, and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10.

We are continuing to analyze data from claims and cost report that do not include ancillary charges or costs, and will be sharing our findings with the Center for Program Integrity and the Office of Financial Management for further investigation, as the results warrant. Our refinement analysis is dependent on recent precise data for costs, including ancillary costs. We will continue to collect these data and analyze them for both timeliness and accuracy with the expectation that these data will be used in a future refinement. Since we are not making refinements for FY 2017, we will continue to use the existing adjustment factors.

V. Waiver of Notice and Comment

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. We can waive this procedure, however, if we find good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice.

We find it is unnecessary to undertake notice and comment rulemaking for this action because the updates in this notice do not reflect any substantive changes in policy, but merely reflect the application of previously established methodologies. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VII. Regulatory Impact Analysis

A. Statement of Need

This notice updates the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2017 (October 1, 2016 through September 30, 2017). We are applying the 2012-based IPF market basket increase of 2.8 percent, less the productivity adjustment of 0.3 percentage point as required by 1886(s)(2)(A)(i) of the Act, and further reduced by 0.2 percentage point as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act, for a total FY 2017 payment rate update of 2.3 percent. In this notice, we are also updating the IPF labor-related share; updating the IPF Wage Index for FY 2017; and continuing with the second year of the rural adjustment phase-out for rural providers which became urban providers in FY 2016 as a result of FY 2016 changes to CBSA delineations.

B. Overall Impact

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for a major rules with economically significant effects ($100 million or more in any 1 year). This notice is designated as economically ''significant'' under section 3(f)(1) of Executive Order 12866.

We estimate that the total impact of these changes for FY 2017 payments compared to FY 2016 payments will be a net increase of approximately $100 million. This reflects a $105 million increase from the update to the payment rates (+$130 million from the unadjusted 2nd quarter 2016 IGI forecast of the 2012-based IPF market basket of 2.8 percent, −$15 million for the productivity adjustment of 0.3 percentage point, and −$10 million for the other adjustment of 0.2 percentage point), as well as a $5 million decrease as a result of the update to the outlier threshold amount. Outlier payments are estimated to decrease from 2.1 percent in FY 2016 to 2.0 percent of total estimated IPF payments in FY 2017.

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IPFs and most other providers and suppliers are small entities, either by nonprofit status or having revenues of $7.5 million to $38.5 million or less in any 1 year, depending on industry classification (for details, refer to the SBA Small Business Size Standards found at *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf*).

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA.

As shown in Table 1, we estimate that the overall revenue impact of this notice on all IPFs is to increase Medicare payments by approximately 2.2 percent. As a result, since the estimated impact of this notice is a net increase in revenue across almost all categories of IPFs, the Secretary has determined that this notice will have a positive revenue impact on a substantial number of small entities. MACs are not considered to be small entities. Individuals and states are not included in the definition of a small entity.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this notice would not have an adverse impact on the rural hospitals based on the data of the 279 rural units and 64 rural hospitals in our database of 1,626 IPFs for which data were available. Therefore, the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is approximately $146 million. This notice will not impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector of $146 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. As stated above, this notice would not have a substantial effect on state and local governments.

C. Anticipated Effects

In this section, we discuss the historical background of the IPF PPS and the impact of this notice on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and May 2006 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem base rate and ECT payment per treatment to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: Outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the May 2008 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

As discussed in section III.D.1 of this notice, we are using the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem base rate and ECT payment per treatment. Therefore, the budgetary impact to the Medicare program of this notice will be due to the market basket update for FY 2017 of 2.8 percent (see section III.A.2 of this notice) less the productivity adjustment of 0.3 percentage point required by section 1886(s)(2)(A)(i) of the Act; further reduced by the ''other adjustment'' of 0.2 percentage point under sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act; and the update to the outlier fixed dollar loss threshold amount.

We estimate that the FY 2017 impact will be a net increase of $100 million in payments to IPF providers. This reflects an estimated $105 million increase from the update to the payment rates and a $5 million decrease due to the update to the outlier threshold amount to set total estimated outlier payments at 2 percent of total estimated payments in FY 2017. This estimate does not include the implementation of the required 2 percentage point reduction of the market basket increase factor for any IPF that fails to meet the IPF quality reporting requirements (as discussed in section III.B.2).

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this notice, we compare estimated payments under the IPF PPS rates and factors for FY 2017 versus those under FY 2016. We determined the percent change of estimated FY 2017 IPF PPS payments compared to FY 2016 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the update to the outlier fixed dollar loss threshold amount; the updated wage index data; the changes to rural adjustment payments resulting from the second year of the rural adjustment phase-out, due to changes in rural or urban status resulting from FY 2016 CBSA changes; the final labor-related share; and the final market basket update for FY 2017, as adjusted by the productivity adjustment according to section 1886(s)(2)(A)(i) of the Act, and the ''other adjustment'' according to sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act.

To illustrate the impacts of the FY 2017 changes in this notice, our analysis begins with a FY 2016 baseline simulation model based on FY 2015 IPF payments inflated to the midpoint of FY 2016 using IHS Global Insight Inc.'s most recent forecast of the market basket update (see section III.A.2. of this notice); the estimated outlier payments in FY 2016; the CBSA delineations for IPFs based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01 (which were implemented in the FY 2016 IPF transitional wage index as described in section III.D.1); the FY 2015 pre-floor, pre-reclassified hospital wage index; the FY 2016 labor-related share; and the FY 2016 percentage amount of the rural adjustment. During the simulation, total outlier payments are maintained at 2 percent of total estimated IPF PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The update to the outlier fixed dollar loss threshold amount;
- the FY 2016 pre-floor, pre-reclassified hospital wage index with the updated CBSA delineations, based on OMB's February 28, 2013 Bulletin No. 13–01, which are applied in full in the FY 2017 IPF PPS wage index;
- the FY 2017 labor-related share;
- the market basket update for FY 2017 of 2.8 percent less the productivity adjustment of 0.3 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act and further reduced by the ''other adjustment'' of 0.2 percentage point in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act, for a payment rate update of 2.3 percent.

Our final comparison illustrates the percent change in payments from FY 2016 (that is, October 1, 2015, to September 30, 2016) to FY 2017 (that is, October 1, 2016, to September 30, 2017) including all the changes in this notice.

TABLE 1—IPF IMPACTS FOR FY 2017

[Percent change in columns 3 through 6]

Facility by type (1)	Number of facilities (2)	Outlier (3)	CBSA wage index & labor share [1] (4)	Payment rate update [2] (5)	Total percent change [3] (6)
All Facilities	1,626	−0.1	0.0	2.3	2.2
Total Urban	1,283	−0.1	0.1	2.3	2.3
Total Rural	343	−0.1	−0.6	2.3	1.6
Urban unit	834	−0.1	0.0	2.3	2.2
Urban hospital	449	0.0	0.2	2.3	2.5
Rural unit	279	−0.1	−0.6	2.3	1.6
Rural hospital	64	0.0	−0.8	2.3	1.4
By Type of Ownership:					
Freestanding IPFs:					
Urban Psychiatric Hospitals:					
Government	123	−0.1	0.0	2.3	2.2
Non-Profit	103	0.0	0.0	2.3	2.3
For-Profit	223	0.0	0.3	2.3	2.6
Rural Psychiatric Hospitals:					
Government	35	0.0	−0.6	2.3	1.7
Non-Profit	11	0.0	0.2	2.3	2.5
For-Profit	18	0.0	−1.2	2.3	1.1
IPF Units:					
Urban:					
Government	122	−0.2	0.0	2.3	2.1
Non-Profit	536	−0.1	0.1	2.3	2.3
For-Profit	176	−0.1	0.0	2.3	2.2
Rural:					
Government	71	−0.1	−0.7	2.3	1.4
Non-Profit	141	−0.1	−0.5	2.3	1.7
For-Profit	67	−0.1	−0.6	2.3	1.6
By Teaching Status:					
Non-teaching	1,438	−0.1	0.0	2.3	2.2
Less than 10% interns and residents to beds	100	−0.1	0.1	2.3	2.3
10% to 30% interns and residents to beds	60	−0.2	0.1	2.3	2.2
More than 30% interns and residents to beds	28	−0.2	0.1	2.3	2.1
By Region:					
New England	109	−0.1	0.5	2.3	2.7
Mid-Atlantic	237	−0.1	0.1	2.3	2.3
South Atlantic	242	−0.1	−0.1	2.3	2.2
East North Central	267	−0.1	0.1	2.3	2.3
East South Central	158	−0.1	−0.5	2.3	1.7
West North Central	135	−0.1	−0.4	2.3	1.8
West South Central	250	−0.1	−0.4	2.3	1.8
Mountain	105	−0.1	−0.2	2.3	2.0
Pacific	123	−0.1	0.8	2.3	3.0
By Bed Size:					
Psychiatric Hospitals;					
Beds: 0–24	83	0.0	−0.6	2.3	1.7
Beds: 25–49	82	0.0	0.2	2.3	2.4
Beds: 50–75	84	0.0	0.0	2.3	2.3
Beds: 76 +	264	0.0	0.2	2.3	2.5
Psychiatric Units:					
Beds: 0–24	653	−0.1	−0.2	2.3	2.0
Beds: 25–49	298	−0.1	0.0	2.3	2.2
Beds: 50–75	105	−0.1	0.1	2.3	2.2
Beds: 76 +	57	−0.1	0.1	2.3	2.3

[1] Includes a FY 2017 IPF wage index, a labor-related share of 0.751, and a rural adjustment. Providers which changed from rural to urban status in FY 2016 will receive ⅓ of the 17 percent rural adjustment in FY 2017.

[2] This column reflects the payment rate update impact of the IPF market basket update for FY 2017 of 2.8 percent, a 0.3 percentage point reduction for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act, and a 0.2 percentage point reduction in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act.

[3] Percent changes in estimated payments from FY 2016 to FY 2017 include all of the changes presented in this notice. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

3. Results

Table 1 displays the results of our analysis. The table groups IPFs into the categories listed below based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from the Healthcare Cost Report Information System:

- Facility Type
- Location
- Teaching Status Adjustment
- Census Region
- Size

The top row of the table shows the overall impact on the 1,626 IPFs included in this analysis. In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.1 percent in FY 2016. Thus, we are adjusting the outlier threshold amount in this notice to set total estimated outlier payments equal to 2 percent of total payments in FY 2017. The estimated change in total IPF payments for FY 2017, therefore, includes an approximate 0.1 percent decrease in payments because the outlier portion of total payments is expected to decrease from approximately 2.1 percent to 2.0 percent.

The overall impact of this outlier adjustment update (as shown in column 3 of Table 1), across all hospital groups, is to decrease total estimated payments to IPFs by 0.1 percent. The largest decrease in payments is estimated to be a 0.2 percent decrease in payments for urban government IPF units and IPFs with 10 percent or greater interns and residents to beds.

In column 4, we present the effects of the budget-neutral update to the IPF wage index and the Labor Related Share (LRS). This represents the effect of using the most recent wage data available and taking into account the updated OMB delineations. That is, the impact represented in this column reflects the update from the FY 2016 IPF transitional wage index to the FY 2017 IPF wage index, which includes the full effect of FY 2016 changes to the OMB delineations, and the LRS update from 75.2 percent in FY 2016 to 75.1 percent in FY 2017. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4, however, there will be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 0.8 percent for IPFs in the Pacific region, and the largest decrease in payments to be 1.2 percent for rural for-profit freestanding IPFs.

In column 5, we present the estimated effects of the update to the IPF PPS payment rates of 2.3 percent, which are based on the 2012-based IPF market basket update of 2.8 percent, less the productivity adjustment of 0.3 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act, and further reduced by 0.2 percentage point in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act.

Finally, column 6 compares our estimates of the total changes reflected in this notice for FY 2017 to the estimates for FY 2016 (without these changes). The average estimated increase for all IPFs is approximately 2.2 percent. This estimated net increase includes the effects of the 2.8 percent market basket update reduced by the productivity adjustment of 0.3 percentage point, as required by section 1886(s)(2)(A)(i) of the Act and further reduced by the ‘‘other adjustment’’ of 0.2 percentage point, as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(D) of the Act. It also includes the overall estimated 0.1 percent decrease in estimated IPF outlier payments as a percent of total payments from the update to the outlier fixed dollar loss threshold amount.

IPF payments are estimated to increase by 2.3 percent in urban areas and 1.6 percent in rural areas. Overall, IPFs are estimated to experience a net increase in payments as a result of the updates in this notice. The largest payment increase is estimated at 3.0 percent for IPFs in the Pacific region.

4. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the FY 2017 IPF PPS, but we continue to expect that paying prospectively for IPF services will enhance the efficiency of the Medicare program.

D. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS using the methodology published in the November 2004 IPF PPS final rule; applying the FY 2017 2012-based IPF PPS market basket update of 2.8 percent, reduced by the statutorily required multifactor productivity adjustment of 0.3 percentage point and the other adjustment of 0.2 percentage point, along with the wage index budget neutrality adjustment to update the payment rates; finalizing a FY 2017 IPF PPS wage index which is fully based upon the OMB CBSA designations which were adopted in the FY 2016 IPF PPS wage index; and continuing with the second year of the 3-year phase-out of the rural adjustment for IPF providers which changed from rural to urban status in FY 2016 as a result of adopting the updated OMB CBSA delineations used in the FY 2016 IPF PPS transitional wage index.

E. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/omb/circulars_a004_a-4*), in Table 2 below, we have prepared an accounting statement showing the classification of the expenditures associated with the updates to the IPF PPS wage index and payment rates in this notice. This table provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this notice and based on the data for 1,626 IPFs in our database.

TABLE 2—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Change in Estimated Transfers from FY 2016 IPF PPS to FY 2017 IPF PPS

Category	Transfers
Annualized Monetized Transfers.	$100 million.
From Whom to Whom?	Federal Government to IPF Medicare Providers.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Dated: July 18, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 19, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

Note: The following addenda will not publish in the Code of Federal Regulations.

Addendum A—IPF PPS FY 2017 Final Rates and Adjustment Factors

PER DIEM RATE

Federal Per Diem Base Rate	$761.37
Labor Share (0.751)	$571.79
Non-Labor Share (0.249)	$189.58

PER DIEM RATE APPLYING THE 2 PERCENTAGE POINT REDUCTION

Federal Per Diem Base Rate	$746.48
Labor Share (0.751)	$560.61
Non-Labor Share (0.249)	$185.87

Fixed Dollar Loss Threshold Amount: $10,120.

Wage Index Budget-Neutrality Factor: 1.0007.

FACILITY ADJUSTMENTS

Rural Adjustment Factor	1.17.
Teaching Adjustment Factor	0.5150.
Wage Index	Pre-reclass Hospital Wage Index (FY 2016).

COST OF LIVING ADJUSTMENTS (COLAS)

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

PATIENT ADJUSTMENTS

ECT—Per Treatment	$327.78
ECT—Per Treatment Applying the 2 Percentage Point Reduction	$321.38

VARIABLE PER DIEM ADJUSTMENTS

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

AGE ADJUSTMENTS

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

DRG ADJUSTMENTS

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

COMORBIDITY ADJUSTMENTS

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

COMORBIDITY ADJUSTMENTS—Continued

Comorbidity	Adjustment factor
Severe Musculoskeletal & Connective Tissue Diseases	1.09
Poisoning	1.11

NATIONAL MEDIAN AND CEILING COST-TO-CHARGE RATIOS (CCRS)

	Rural	Urban
National Median CCRs	0.5960	0.4455
National Ceiling CCRs	1.9315	1.6374

Addendum B—Changes to the FY 2017 ICD–10–CM/PCS Code Sets Which Affect FY the FY 2017 IPF PPS Comorbidity Adjustments

Four IPF PPS Comorbidity Categories Were Affected

(1) Oncology Treatment

Add the following codes to the Oncology Treatment code list:

DX	Long description
C49A0	Gastrointestinal stromal tumor, unspecified site.
C49A1	Gastrointestinal stromal tumor of esophagus.
C49A2	Gastrointestinal stromal tumor of stomach.
C49A3	Gastrointestinal stromal tumor of small intestine.
C49A4	Gastrointestinal stromal tumor of large intestine.
C49A5	Gastrointestinal stromal tumor of rectum.
C49A9	Gastrointestinal stromal tumor of other sites.
D49511	Neoplasm of unspecified behavior of right kidney.
D49512	Neoplasm of unspecified behavior of left kidney.
D4959	Neoplasm unspecified behavior of other genitourinary organ.

Delete the following code from the Oncology Treatment code list:

DX	Long description
D495	Neoplasm of unspecified behavior of other genitourinary organs.

The following codes from the Oncology Treatment code list have long description changes:

DX	Old long description	New long description
C7A094	Malignant carcinoid tumor of the foregut NOS	Malignant carcinoid tumor of the foregut, unspecified.
C7A095	Malignant carcinoid tumor of the midgut NOS	Malignant carcinoid tumor of the midgut, unspecified.
C7A096	Malignant carcinoid tumor of the hindgut NOS	Malignant carcinoid tumor of the hindgut, unspecified.
C8110	Nodular sclerosis classical Hodgkin lymphoma, unspecified site.	Nodular sclerosis Hodgkin lymphoma, unspecified site.
C8111	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of head, face, and neck.	Nodular sclerosis Hodgkin lymphoma, lymph nodes of head, face, and neck.
C8112	Nodular sclerosis classical Hodgkin lymphoma, intrathoracic lymph nodes.	Nodular sclerosis Hodgkin lymphoma, intrathoracic lymph nodes.
C8113	Nodular sclerosis classical Hodgkin lymphoma, intra-abdominal lymph nodes.	Nodular sclerosis Hodgkin lymphoma, intra-abdominal lymph nodes.
C8114	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of axilla and upper limb.	Nodular sclerosis Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C8115	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.	Nodular sclerosis Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.
C8116	Nodular sclerosis classical Hodgkin lymphoma, intrapelvic lymph nodes.	Nodular sclerosis Hodgkin lymphoma, intrapelvic lymph nodes.

DX	Old long description	New long description
C8117	Nodular sclerosis classical Hodgkin lymphoma, spleen	Nodular sclerosis Hodgkin lymphoma, spleen.
C8118	Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of multiple sites.	Nodular sclerosis Hodgkin lymphoma, lymph nodes of multiple sites.
C8119	Nodular sclerosis classical Hodgkin lymphoma, extranodal and solid organ sites.	Nodular sclerosis Hodgkin lymphoma, extranodal and solid organ sites.
C8120	Mixed cellularity classical Hodgkin lymphoma, unspecified site.	Mixed cellularity Hodgkin lymphoma, unspecified site.
C8121	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of head, face, and neck.	Mixed cellularity Hodgkin lymphoma, lymph nodes of head, face, and neck.
C8122	Mixed cellularity classical Hodgkin lymphoma, intrathoracic lymph nodes.	Mixed cellularity Hodgkin lymphoma, intrathoracic lymph nodes.
C8123	Mixed cellularity classical Hodgkin lymphoma, intra-abdominal lymph nodes.	Mixed cellularity Hodgkin lymphoma, intra-abdominal lymph nodes.
C8124	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of axilla and upper limb.	Mixed cellularity Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C8125	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.	Mixed cellularity Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.
C8126	Mixed cellularity classical Hodgkin lymphoma, intrapelvic lymph nodes.	Mixed cellularity Hodgkin lymphoma, intrapelvic lymph nodes.
C8127	Mixed cellularity classical Hodgkin lymphoma, spleen	Mixed cellularity Hodgkin lymphoma, spleen.
C8128	Mixed cellularity classical Hodgkin lymphoma, lymph nodes of multiple sites.	Mixed cellularity Hodgkin lymphoma, lymph nodes of multiple sites.
C8129	Mixed cellularity classical Hodgkin lymphoma, extranodal and solid organ sites.	Mixed cellularity Hodgkin lymphoma, extranodal and solid organ sites.
C8130	Lymphocyte depleted classical Hodgkin lymphoma, unspecified site.	Lymphocyte depleted Hodgkin lymphoma, unspecified site.
C8131	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of head, face, and neck.	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of head, face, and neck.
C8132	Lymphocyte depleted classical Hodgkin lymphoma, intrathoracic lymph nodes.	Lymphocyte depleted Hodgkin lymphoma, intrathoracic lymph nodes.
C8133	Lymphocyte depleted classical Hodgkin lymphoma, intra-abdominal lymph nodes.	Lymphocyte depleted Hodgkin lymphoma, intra-abdominal lymph nodes.
C8134	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of axilla and upper limb.	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C8135	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.
C8136	Lymphocyte depleted classical Hodgkin lymphoma, intrapelvic lymph nodes.	Lymphocyte depleted Hodgkin lymphoma, intrapelvic lymph nodes.
C8137	Lymphocyte depleted classical Hodgkin lymphoma, spleen	Lymphocyte depleted Hodgkin lymphoma, spleen.
C8138	Lymphocyte depleted classical Hodgkin lymphoma, lymph nodes of multiple sites.	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of multiple sites.
C8139	Lymphocyte depleted classical Hodgkin lymphoma, extranodal and solid organ sites.	Lymphocyte depleted Hodgkin lymphoma, extranodal and solid organ sites.
C8140	Lymphocyte-rich classical Hodgkin lymphoma, unspecified site.	Lymphocyte-rich Hodgkin lymphoma, unspecified site.
C8141	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of head, face, and neck.	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of head, face, and neck.
C8142	Lymphocyte-rich classical Hodgkin lymphoma, intrathoracic lymph nodes.	Lymphocyte-rich Hodgkin lymphoma, intrathoracic lymph nodes.
C8143	Lymphocyte-rich classical Hodgkin lymphoma, intra-abdominal lymph nodes.	Lymphocyte-rich Hodgkin lymphoma, intra-abdominal lymph nodes.
C8144	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of axilla and upper limb.	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C8145	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.
C8146	Lymphocyte-rich classical Hodgkin lymphoma, intrapelvic lymph nodes.	Lymphocyte-rich Hodgkin lymphoma, intrapelvic lymph nodes.
C8147	Lymphocyte-rich classical Hodgkin lymphoma, spleen	Lymphocyte-rich Hodgkin lymphoma, spleen.
C8148	Lymphocyte-rich classical Hodgkin lymphoma, lymph nodes of multiple sites.	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of multiple sites.
C8149	Lymphocyte-rich classical Hodgkin lymphoma, extranodal and solid organ sites.	Lymphocyte-rich Hodgkin lymphoma, extranodal and solid organ sites.
C8170	Other classical Hodgkin lymphoma, unspecified site	Other Hodgkin lymphoma, unspecified site.
C8171	Other classical Hodgkin lymphoma, lymph nodes of head, face, and neck.	Other Hodgkin lymphoma, lymph nodes of head, face, and neck.
C8172	Other classical Hodgkin lymphoma, intrathoracic lymph nodes.	Other Hodgkin lymphoma, intrathoracic lymph nodes.
C8173	Other classical Hodgkin lymphoma, intra-abdominal lymph nodes.	Other Hodgkin lymphoma, intra-abdominal lymph nodes.
C8174	Other classical Hodgkin lymphoma, lymph nodes of axilla and upper limb.	Other Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C8175	Other classical Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.	Other Hodgkin lymphoma, lymph nodes of inguinal region and lower limb.

DX	Old long description	New long description
C8176	Other classical Hodgkin lymphoma, intrapelvic lymph nodes.	Other Hodgkin lymphoma, intrapelvic lymph nodes.
C8177	Other classical Hodgkin lymphoma, spleen	Other Hodgkin lymphoma, spleen.
C8178	Other classical Hodgkin lymphoma, lymph nodes of multiple sites.	Other Hodgkin lymphoma, lymph nodes of multiple sites.
C8179	Other classical Hodgkin lymphoma, extranodal and solid organ sites.	Other Hodgkin lymphoma, extranodal and solid organ sites.
D3A094	Benign carcinoid tumor of the foregut NOS	Benign carcinoid tumor of the foregut, unspecified.
D3A095	Benign carcinoid tumor of the midgut NOS	Benign carcinoid tumor of the midgut, unspecified.
D3A096	Benign carcinoid tumor of the hindgut NOS	Benign carcinoid tumor of the hindgut, unspecified.

2) Oncology Treatment Procedure

Add the following code to the Oncology Treatment procedure code list:

DX	Long description
3E0Q005	Introduction of Other Antineoplastic into Cranial Cavity and Brain, Open Approach.

3) Infectious Disease

Add the following code to the Infectious Disease code list:

DX	Long description
A925	Zika virus disease.

4) Artificial Openings Digestive and Urinary

Add the following codes to the Artificial Openings, Digestive and Urinary code list:

DX	Long description
N99523	Herniation of incontinent stoma of urinary tract.
N99524	Stenosis of incontinent stoma of urinary tract.
N99533	Herniation of continent stoma of urinary tract.
N99534	Stenosis of continent stoma of urinary tract.

The following codes from the Artificial Openings Digestive and Urinary code list have long description changes:

DX	Old long description	New long description
N99520	Hemorrhage of other external stoma of urinary tract	Hemorrhage of incontinent external stoma of urinary tract.
N99521	Infection of other external stoma of urinary tract	Infection of incontinent external stoma of urinary tract.
N99522	Malfunction of other external stoma of urinary tract	Malfunction of incontinent external stoma of urinary tract.
N99528	Other complication of other external stoma of urinary tract.	Other complication of incontinent external stoma of urinary tract.
N99530	Hemorrhage of other stoma of urinary tract	Hemorrhage of continent stoma of urinary tract.
N99531	Infection of other stoma of urinary tract	Infection of continent stoma of urinary tract.
N99532	Malfunction of other stoma of urinary tract	Malfunction of continent stoma of urinary tract.
N99538	Other complication of other stoma of urinary tract	Other complication of continent stoma of urinary tract.

Tables showing the complete listing of ICD–10–CM/PCS codes underlying the IPF PPS comorbidity adjustment and the IPF PPS Code First adjustment, and associated with the IPF PPS ECT per treatment payment, are available online at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

[FR Doc. 2016–17982 Filed 7–28–16; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects: