CMS Finalizes 2018 Medicare IPPS, LTCH Rules

The Centers for Medicare & Medicaid Services (CMS) has issued the fiscal year (FY) 2018 Medicare Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCHPPS) final rule, which updates Medicare payment and policies when patients are discharged from those hospitals for the 12-month period beginning October 1, 2017. The IPPS rule will increase overall acute care hospital inpatient PPS rates by 1.2% in FY 2018, after accounting for inflation and other adjustments required by law, while CMS spending on LTCH services will drop by 2.4%, or $110 million, in FY 2018.

Specifically, the IPPS update includes an initial market-basket update of 2.7%, less 0.6% for productivity, 0.75% mandated by the Affordable Care Act (ACA), and 0.6% to remove the one-time, temporary adjustment that it made in FY 2017 to restore the unlawfully instituted two-midnight policy payment cuts from FYs 2014-2016. CMS also includes an increase of 0.4588% to partially restore cuts made as a result of the American Taxpayer Relief Act (ATRA) requirement that the agency recoup what it claims is the effect of documentation and coding changes from FYs 2010-2012. CMS also will increase the amount of uncompensated care payments made to acute care hospitals by $800 million, to approximately $6.8 billion, for FY 2018. The combination of payment rate increases and other policies and payment adjustments, particularly the changes in uncompensated care payments, will result in a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in FY 2018.

The rule will impact the Critical Access Hospital (CAH) 96-hour Certification Requirement, which currently requires that a physician certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. In the new rule, CMS states that it reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. As a result, the agency states that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC) and Recovery Audit Contractors (RACs) to make the requirement a low priority for medical record reviews conducted on or after October 1, 2017. This means that, absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will not conduct medical record reviews to determine compliance with the CAH 96-hour certification requirement.

For LTCHs, CMS has finalized a 12-month extension to a one-year statutory moratorium on the full implementation of the LTCH 25% Rule. The moratorium, effective for FY 2017, will seamlessly extend the relief through FY 2018. For more details, go to the American Hospital Association website (www.aha.org) and see the Special Bulletins on both final rules.

Help for Veterans Available through Crisis Line

The Veterans Administration in Little Rock has made the Arkansas Hospital Association aware that hospitals are calling for help with veterans presenting with self-harm wounds. Please spread the word in your facility that the Veterans Crisis Line (formerly called the National Veterans Suicide
Prevention Hotline) is available 24/7 by calling (800) 273-8255 where those in crisis will be connected with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline or online chat. Additionally, help is available by text message to 838255. Support for deaf and hard of hearing individuals also available. The Veterans Crisis Line has support information online at www.veteranscrisisline.net. There, you will find information about the signs of crisis, suicide and crisis resources for veterans, how to get help for those individuals, and a toolkit to engage your community about these resources.

Since its launch in 2007, the Veterans Crisis Line has answered nearly 2.8 million calls and initiated the dispatch of emergency workers to callers in crisis nearly 74,000 times. The online chat service, added in 2009, has engaged in more than 332,000 calls. And, in November 2011, the crisis line introduced a text-messaging service to provide another way for veterans to connect with confidential, round-the-clock support, by responding to more than 67,000 texts.

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**AHA Distributes Health Care Legislative Summary**

The Arkansas Hospital Association (AHA) last week mailed member hospital CEOs a copy of the initial edition of its *Health Care Legislative Summary*, a compilation of concise but detailed information about Acts passed during the 2017 Legislative Session. The book, developed by AHA, with assistance of outside counsel with the Mitchell Williams law firm, is intended to serve not as legal advice, but as a ready resource to assist member hospitals understand the effect, purpose, implications and impact on hospitals and their patients stemming from some of the most important legislation gaining legislative approval and the Governor’s signature. AHA’s comments are included after some of the summaries to highlight certain operational or policy issues affecting hospitals.

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**Planning Resource for August 21 Solar Eclipse**

The Department of Health and Human Services’ Office of the Assistant Secretary for Preparedness and Response has released a resource ([https://asprtracie.hhs.gov/documents/aspr-tracie-solar-eclipse-resources.pdf](https://asprtracie.hhs.gov/documents/aspr-tracie-solar-eclipse-resources.pdf)) to help emergency healthcare planners and providers prepare for and address response concerns related to the August 21 solar eclipse. “It is expected that millions will travel to locations across the country to view this rare event,” the document notes. “Many of these locations are rural with limited healthcare infrastructure, and since these sites are not (yet) officially sponsored, the typical augmentation of resources that accompanies planned mass gatherings will not take place.” The resource provides links to factsheets, checklists, locally-developed guidance documents and news articles on eye safety, injury treatment and planned mass gatherings.

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**Committee Wants Ideas on Reducing Regulatory Burdens**

The House Ways and Means Health Subcommittee is seeking input through August 25 on how Congress can reduce legislative and regulatory burdens on Medicare providers. The request is the first step in a committee initiative to work with healthcare providers and the administration to deliver regulatory relief. The panel also plans to host roundtables with stakeholders across the country. For more information and the feedback submission form, click on [https://waysandmeans.house.gov/tiberti-announces-new-initiative-reduce-medicare-regulations-mandates-improve-seniors-health-care/](https://waysandmeans.house.gov/tiberti-announces-new-initiative-reduce-medicare-regulations-mandates-improve-seniors-health-care/). All ideas are welcome.
Rural Broadband Loan Applications Due September 30

The Rural Utilities Service at USDA has available at least $60 million to fund the second round of applications for the Rural Broadband Access Loan and Loan Guarantee Program, which provides funds for the costs of construction, improvement, or acquisition of facilities and equipment needed to provide broadband service in eligible rural areas. Eligible applicants include nonprofit or for-profit corporations or cooperative organizations as well as state or local governments and American Indian tribal agencies. Rural healthcare providers with improved access to broadband internet may be able to provide telehealth services connecting residents to distant specialty or emergency services. The application window is July 25, 2017 through September 30, 2017. Visit their website at https://www.rd.usda.gov/programs-services/farm-bill-broadband-loans-loan-guarantees.

Quality Payment Program Exceptions

The Quality Payment Program Hardship Exception Application for the 2017 transition year is now available on the Quality Payment Program website. Merit-based Incentive Payment System (MIPS) eligible clinicians and groups may qualify for a reweighting of their Advancing Care Information performance category score to 0% of the final score, and can submit a hardship exception application, for one of the following specified reasons: Insufficient internet connectivity, extreme and uncontrollable circumstances or lack of control over the availability of Certified EHR Technology. Some MIPS eligible clinicians who are considered Special Status will be automatically reweighted (or, exempted in the case of MIPS eligible clinicians participating in a MIPS APM) and do not need to submit a Quality Payment Program Hardship Exception Application. For more information contact the Quality Payment Service Center at (866) 288-8292 or OPP@cms.hhs.gov. Visit the Quality Payment Program website at https://qpp.cms.gov/about/hardship-exception.

Grants for Telehealth Substance Abuse Treatment

Federal Office of Rural Health Policy is accepting applications through August 23 for fiscal year (FY) 2017 Substance Abuse Treatment Telehealth Network Grant Program. The purpose of this program is to demonstrate how telehealth programs and networks can improve access to healthcare services, particularly substance abuse treatment services in rural, frontier and underserved communities. Join the technical assistance call for applicants on Tuesday, August 8 at 1:00 p.m. CT, call-in Number: (888) 324-8132, participant code: 2444307, weblink: https://hrsa.connectsolutions.com/sud-tngp/.

Cyber Vulnerability Found in Siemens Imaging Products

Siemens has identified four vulnerabilities in molecular imaging products running Windows 7 that could allow an attacker to remotely execute arbitrary code, according to an August 4 Department of Homeland Security (DHS) advisory (https://ics-cert.us-cert.gov/advisories/ICSMA-17-215-02). Siemens is preparing updates for the affected products, and DHS recommends that organizations evaluate the impact of these vulnerabilities based on their operational environment and specific clinical usage. The Federal Bureau of Investigation alerted the private sector August 3 to certain cyber-attacks that exploit internet-connected printers and how to prevent them. For additional information on that alert, visit www.aha.org/cybersecurity.
**Home Health PPS Proposed Rule**

The Centers for Medicare & Medicaid Services’ July 25 proposed rule for the home health prospective payment system (HH/PPS) for calendar year (CY) 2018, which also proposes major HH/PPS refinements for CY 2019, would decrease net HH payments during 2018 by 0.4%, or $80 million, relative to CY 2017. This includes a 1.0% update to current rates, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015; a 0.5% reduction due to the sunset of the rural payment add-on; and the third and final 0.97% cut for estimated case mix growth from CYs 2012 through 2014 that the agency states was unrelated to increases in patient acuity. In addition, CMS proposes a major modification to the PPS effective January 1, 2019. Specifically, it would implement a new case-mix methodology, called the home health groupings model (HHGM), and reduce the unit of payment from a 60-day to a 30-day episode of care. The proposed HHGM would rely on clinical characteristics and other patient information, rather than the current therapy service-use thresholds, to set payments. It includes changes in the episode timing categories, the addition of an admission source category, the creation of six clinical groups used to categorize patients based on their primary reason for HH care, revised functional levels and patient assessment items, the addition of a comorbidity adjustment, and a proposed change to low utilization payment adjustments.

The rule presents two fiscal impact estimates that reflect possible payment policy scenarios that CMS may pursue in upcoming rulemaking, which would reduce total payments by either 4.3% or 2.2% ($950 or $480 million, respectively). Under these scenarios, hospital-based agencies fare better, with either a 0.0% or +2.2% change, due to their distinct case-mix profile. CMS also proposes a few changes to the HH Value-Based Purchasing program by raising the minimum number of cases required and removing one measure from the program.

For the HH Quality Reporting Program, CMS proposes to adopt two new measures while removing 247 data elements from 35 OASIS items. As with the other post-acute proposed rules, CMS also proposes the addition of standardized patient assessment data to the program, and the agency proposes to introduce an extraordinary circumstances exemption process for HH agencies beginning in CY 2019.

The proposed rule can be viewed at [https://www.federalregister.gov/public-inspection](https://www.federalregister.gov/public-inspection). American Hospital Association members can find a Special Bulletin with more information at [www.aha.org](http://www.aha.org). CMS will accept comments on the proposed rule through September 25.

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**The AHA Calendar**

**August 2018**

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<td>Mindfulness in Clinical Practice – Webinar T4062</td>
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<td>11</td>
<td>ASDVS Summer Conference, CHI St. Vincent Hot Springs Mercy Room, Little Rock</td>
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<tr>
<td>15</td>
<td>Unlocking the Door to the MACRA Quality Payment Program – Webinar IA0815</td>
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<tr>
<td>16</td>
<td>ICD-10-CM Webinar Series: Part IX: Orthopedic – Musculoskeletal and Fractures</td>
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<tr>
<td>16-18</td>
<td>HFMA Summer Quarterly Meeting, The Hotel Hot Springs and Spa at the Convention Center</td>
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<tr>
<td>16-18</td>
<td>15th Annual Mid-South CAH Conference, Renaissance Nashville, TN</td>
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<td>Quality Management Programs: Meaningful Use Stage 3 Deep Dive – Webinar NE082217</td>
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<td>ABCs of MACRA and Potential Impact On Hospital Quality Initiatives – Webinar T4065</td>
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Information on all AHA educational programs and activities is available at [http://www.arkhospitals.org/events](http://www.arkhospitals.org/events).