Dateline: September 2, 2011

PA YTD FY 2011-2012 Revenue Collections Less than Budgeted

On September 1 the PA Department of Revenue reported that the Commonwealth of Pennsylvania collected $1.8 billion in general fund revenue in August, which was $63.1 million, or 3.4 percent, less than anticipated for the month. As a result, fiscal year-to-date General Fund collections total $3.5 billion, which is $63.1 million, or 1.8 percent, below estimate. Sales tax receipts totaled $734.9 million for August, $15.7 million below estimate. Year-to-date sales tax collections total $1.5 billion, which is $15.7 million, or 1.1 percent, less than anticipated. Personal income tax (PIT) revenue in August was $749.9 million, $55.2 million below estimate. This brings year-to-date PIT collections to $1.4 billion, which is $55.1 million, or 3.8 percent, below estimate. Inheritance tax revenue for the month was $69.5 million, $5.1 million below estimate, bringing the year-to-date total to $135.8 million, which is $5.1 million, or 3.6 percent, below estimate. The Department of Revenue also reported that realty transfer tax revenue was $28 million for August, $4.5 million below estimate, bringing the fiscal-year total to $55.7 million, which is $4.5 million, or 7.5 percent, less than anticipated. In contrast to these shortfalls, August corporation tax revenue of $59.9 million was $3.7 million above estimate. Year-to-date corporation tax collections total $137.9 million, which is $3.4 million, or 2.6 percent, above estimate. Other General Fund tax revenue, including cigarette, malt beverage, liquor and table games taxes, was also above estimates. Other General Fund tax revenue totaled $129.9 million for the month; $2.1 million above estimate and bringing the year-to-date total to $243.2 million, which is $2.2 million, or 0.9 percent, above estimate. Non-tax revenue totaled $33.8 million for the month, $11.6 million above estimate, which brings the year-to-date total to $60.9 million, which is $11.6 million, or 23.7 percent, above estimate. In addition to the General Fund collections, the Motor License Fund received $237.6 million for the month, $19.3 million above estimate. Fiscal year-to-date collections for the fund – which include the commonly known gas and diesel taxes, as well as other license, fine and fee revenues – total $428.7 million, which is $19.2 million, or 4.7 percent, above estimate. For more information, visit www.revenue.state.pa.us.

Special Discount on Hotel Rates for PARF 2011 Annual Conference Ends September 7

The PARF Room-Discount for the PARF 2011 Annual Conference to be held at the Nittany Lion from September 20-23 has been extended to Wednesday, September 7, 2011. Those attending the PARF Conference can still obtain hotel accommodations at the Nittany Lion at special discounted hotel rates until Wednesday, September 7, 2011. Hotel reservations should be made directly with the Nittany Lion Inn by visiting www.pshs.psu.edu/nittanylioninn or by calling 1-800-233-7505. Please identify yourself as a participant of the 2011 PARF Annual Conference (#MARD10C) to receive special rates. In registering for the PARF 2011 Annual Conference, the PARF registration form should be completed and forwarded to PARF as directed. FMI: See www.parf.org and www.parfeducation.org for more information and forms to be completed. Please contact PARF at parfmail@parf.org.
Knittel Selected to Lead PA Independent Fiscal Office

Matthew Knittel has been selected to serve as the first director of Pennsylvania’s new Independent Fiscal Office (IFO). The new state IFO will provide revenue and expenditure projections for the state legislature. The office will undertake special studies and will report its findings and recommendations to the legislature and the public. The IFO was appropriated $1.9 million in the FY 2011-12 state budget. The IFO as created by Act 120 of 2010 has several specific responsibilities, including: (a) Preparing annual revenue estimates; (b) providing an annual assessment, by November 15 of each year, of the state's fiscal condition; (c) developing performance measures for executive-level programs and departments; (d) providing an analysis of all tax and revenue proposals made by the Governor or the Office of the Budget; (e) studying and analyzing the existing sales and use tax law and making recommendations for change; and, (f) establishing a website for the agency. Pursuant to the provisions of Act 120, Knittel was appointed to a six-year term. FMI: See www.pasenategop.com and http://www.pasenategop.com/news/2011/0811/pileggi-083011.htm

DPW Advises Providers on Healthcare Transactions Upgrade

The PA Department of Public Welfare (DPW) has issued a memorandum to providers concerning the January 1, 2012 deadline for upgrading to the X12 v5010. DPW says that as the January 31 deadline is approaching providers may have questions whether or not they need to certify their 837 healthcare transaction method. The DPW memorandum aims to assist providers by describing the many ways for providers to submit healthcare claims to DPW and by listing the media used by PROMISe™ to accept healthcare transactions. In its memorandum DPW also indicates whether or not certification is required. Various situations are addressed, including: (A) Submission of claims through a clearinghouse: If claims are submitted to PROMISe™ through a clearinghouse, individual provider certification is not required. The clearinghouse is required to certify with PROMISe™. When the clearinghouse is certified, the provider is automatically certified. It is important that you contact your clearinghouse to remind them of the department’s requirement for certification. (B) Submission of claims using third party software: If you currently submit batch 837 transactions to PROMISe™ and have a submitter ID, you are required to certify under the X12 v5010 format. Software vendors are required to certify their software under the X12 v5010 format. (C) Submission of claims using the Provider Electronic Solutions (PES): On January 1, 2012, PES users will be required to have the X12 v5010 version. The new version of PES, version 3.58 will be available in December 2011. DPW says that providers who use Provider Electronic Solutions (PES) do not need to certify. Information about upgrading to version 3.58 can be found in DPW Provider Quick Tip #106 at http://www.dpw.pa.us/ucmprd/groups/webcontent/documents/communication/p_011492.pdf. (D) Submission of claims using the PROMISe™ Internet Portal: The PROMISe™ Internet Portal will be upgraded on January 1, 2012. DPW says that providers who use the PROMISe™ Internet Portal will not need to certify. (E) Submission of paper claims to PROMISe™: Providers who use paper claims do not need to certify. More information is available on the DPW 5010/D.0 website http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/softwareandservicevendors/hipaa5010d.0upgradeinformation/index.htm.
MA-Waiver Providers Required to Screen Employees and Contractors

The PA Department of Public Welfare (DPW) has confirmed that its Medical Assistance (MA) Bulletin 99-11-05, released on August 15, 2011 outlining the requirement that all Medical Assistance (MA) providers screen their employees and certain contractors for exclusion from participation in federal and/or state health care programs, applies to all providers of Medical Assistance (MA), including providers of MA waiver services. The DPW MA bulletin requires MA Providers to screen their employees and certain contractors against three (3) specific Exclusion Lists on a monthly basis. All staff (employees and contractors) delivering MA services must be screened monthly to ensure that they have not been excluded from MA participation. DPW has confirmed that this requirement applies to waiver services. DPW explained that the federal requirement went into effect about 18 months ago and therefore this bulletin was issued to implement a consistent statewide process for compliance with the federal requirement. The federal requirement and this corresponding medical assistance policy bulletin is applicable to Medical Assistance services which includes waiver service providers and staff who provide services to waiver participants. Providers who participate in the Medical Assistance (MA) Program must screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care program. Providers are advised to conduct self audits to determine compliance with this requirement and to report any discovered exclusion of an employee or contractor, either an individual or entity, to the Department of Public Welfare (DPW) Bureau of Program Integrity (BPI). The bulletin applies to all providers enrolled in the MA Program’s Fee-for-Service (FFS) and the managed care delivery systems. FMI: See www.dpw.state.pa.us.

PHLP Urges Families to Complete Survey on Co-Payments for MA Services

As part of the Pennsylvania state budget for 2011-2012 the PA Department of Public Welfare (DPW) will begin charging co-payments for Medical Assistance services for children with disabilities whose family income is more than 200% of the federal poverty guidelines (or about $45,000 a year for a family of four). At this point, DPW is still deciding how to implement the co-pays. Various advocacy groups and state associations have indicated that they are concerned about the financial impact of co-pays on families with children with disabilities, especially those families who already have high out-of-pocket expenses. The Pennsylvania Health Law Project (PHLP) is encouraging families to complete a short online survey that would give DPW some information about both the out-of-pocket costs for those families affected by the copayments and the impact on other programs that might be affected by co-payments. Families who have a child or children who qualify for Medical Assistance due to a disability and are not on SSI are asked to complete the survey at http://www.surveymonkey.com/s/S7JLQ88. Families are advised to complete a separate survey for each child on Medical Assistance due to a disability. The survey does not collect any information that can be used to identify individual families. PHLP says that summaries of the information will be shared with DPW. FMI: If you have any questions regarding the survey, please contact Ann Bacharach, Special Projects Director, PHLP, at 215-625-3596, x101 or abacharach@phlp.org.
DPW Increases Time-Period for Review of Readmissions to Acute Care Hospitals

In the Saturday, September 3, 2011 edition of the Pennsylvania Bulletin the PA Department of Public Welfare (DPW) announced revisions to the Medical Assistance (MA) payment policy for inpatient acute care general hospital readmissions. The changes are consistent with the statutory amendments to the Public Welfare Code enacted on June 30, 2011 (P. L. 89, No. 22) (Act 22) which increase the time period for review of readmissions from fourteen (14) days to thirty (30) days from the date of discharge. DPW will review inpatient hospital admissions occurring within 30 days of the date of discharge of a prior admission as previously detailed. The fiscal year 2011-2012 fiscal impact as a result of this change to the MA Program payment policy for readmissions is a savings of $0.826 million ($0.371 million in State General Funds and $0.455 million in federal funds upon approval by the Centers for Medicare and Medicaid Services). Interested persons are invited to submit written comments regarding this notice to the PA Department of Public Welfare, Office of Medical Assistance Programs, c/o Regulations Coordinator, Room 515, Health and Welfare Building, Harrisburg, PA 17120. Comments received within 30 days will be reviewed and considered for any subsequent revision to this notice. See www.pabulletin.com.

ODP Announces Provider Monitoring Follow-Up Conference Calls

On August 31 the PA DPW Office of Developmental Programs (ODP) distributed ODP Announcement Number 114 on provider monitoring follow-up conference calls scheduled for the provider monitoring process webcasts. ODP Announcement 114 encourages providers and AEs to register for the follow-up conference calls related to the provider monitoring webcasts. ODP is requesting that participants/registrants who will be participating in the follow-up conference calls submit questions and/or issues to the provider monitoring mailbox (ru-odpprovidermonito@pa.gov) in advance of the scheduled calls. FMI: More information is provided in the announcement. See also www.odpconsulting.net

CMS Reports on Pennsylvania ODP Consolidated and PFDS Waiver Services Available

On August 30 the PA Department of Public Welfare (DPW) Office of Developmental Programs (ODP) released ODP Announcement Number 113-11 on Quality Strategy and the ODP Home and Community Based Services (HCBS) Waivers. The purpose of ODP Announcement 113-11 is to provide an update on Center for Medicare and Medicaid Services (CMS) Reports and the Quality Strategy for ODP Home and Community Based (HCBS) Waivers. ODP says that on June 30, 2011, DPW received final reports from the Centers for Medicare & Medicaid Services (CMS) on the CMS review of the Consolidated and Person/Family Directed Support (P/FDS) Home and Community Based Services (HCBS) Waivers. The reports are in accord with the CMS protocol to conduct a review and issue a report to the state prior to the expiration of each HCBS Waiver. ODP says that CMS continues to strengthen oversight of the waivers and has recently clarified and emphasized some important expectations for states. ODP encourages stakeholders to read the reports in their entirety. The report on the ODP Consolidated Waiver is at: http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_011594.pdf
The report on the Person and Family Directed Services Waiver is available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_011593.pdf
White House Releases Final Versions of Regulatory Reform

On August 23 the White House released the Obama administration’s final regulatory reform plans, saying that plans will save businesses $10 billion over five years. The Office of Information and Regulatory Affairs (OIRA) says that federal agencies were announcing plans which include initiatives to reduce costs, simplify the system, and eliminate redundancy and inconsistency. The final plans were released after more than two dozen preliminary plans were made available in May, opened for public comment and then revised. Some examples include: U.S. Department of Health and Human Services proposal ending unnecessary regulatory and reporting requirements currently imposed on hospitals and other health care providers with projected savings of $4 billion over the next five years; U.S. Department of Labor rules simplifying and improving hazard warnings for workers with estimated savings of $2.5 billion over the next five years; U.S. Department of Transportation rules expected to save $340 million or more by cutting out unnecessary regulation of the railroad industry; and Internal Revenue Service cuts in reporting requirements. See http://www.whitehouse.gov/21stcenturygov/actions/21st-century-regulatory-system. For the U.S. Department of Health and Human Services (HHS) proposals see http://www.slideshare.net/whitehouse/healthand-humanservicesregulatoryreformplanaugust2011.

Workforce Development Systems Advised on Ticket to Work

The U.S. Department of Labor, Employment and Training Administration has issued a notice (TEN 6-11) highlighting ways public workforce development systems can increase their participation in the Social Security Administration’s Ticket to Work (TTW) program. TTW is intended to provide people who receive Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) with greater choices in obtaining employment services, vocational rehabilitation services, or other support services. The new notice provides information on TTW for state workforce agencies, local workforce investment boards, and One-Stop Career Centers. FMI: See http://wdr.doleta.gov/directives/attach/TEN/TEN6-11-ACC.pdf

CBO Expects Delay in New Healthcare Program

On August 24 the Congressional Budget Office (CBO) reported that the administration will likely fall a year behind schedule in implementing the Community Living Assistance Services and Supports (CLASS) Act. The healthcare law states that the CLASS Act is slated to begin collecting premiums next year, although CBO reported that based on the pace of implementation actions thus far, it does not expect the program to start collecting funds until 2013. The CLASS program collects premiums for several years before it begins paying out benefits. U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius has repeatedly noted that HHS will not fully implement the program unless it is financially solvent. HHS is expected to issue a proposed rule in October 2011 that could make significant changes to the program to ensure its solvency for the next seventy-five (75) years. However, legislation in both chambers (HR 1173 and S 720) has been introduced to repeal the program. FMI: See www.cbo.gov and http://www.cbo.gov/ftpdocs/123xx/doc12316/08-24-BudgetEconUpdate.pdf.
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CCD Asks CMS to Provide Strong Oversight of Medicaid Rate-Setting

On August 25 the Consortium for Citizens with Disabilities (CCD) wrote to the Centers for Medicare & Medicaid Services (CMS) expressing its concerns regarding pending cuts to Medicaid providers of services to individuals with disabilities both nationwide and in California. The CCD said that that states that have proposed to reduce (or have already reduced) Medicaid provider rates must take steps to ensure that quality of care and access to services are (and will be) preserved. CCD commented specifically on the actions of the state of California which has submitted a State Plan Amendment (SPA) to CMS that includes a 10% reduction in rates to Medi-Cal providers. In June, California submitted a request to CMS seeking approval to cut Medicaid spending by $1.5 billion through a combination of reimbursement rate reductions, mandatory copayments, and physician visit limitations. CCD says that with rate cuts this deep it is concerned that some service providers could go out of business and people with disabilities would lose access to critical services. CCD asked CMS to provide strong oversight of Medicaid rate-setting and that the cumulative impact of multiple reductions in all states must be analyzed to fully assess the impact on quality and access to services. CCD says that CMS should be scrutinizing those states where cuts endanger ability of people to live successfully in the community. CCD called attention to the situation in which providers would be required to close their doors and said that those types of closures could force beneficiaries into state-run facilities and, in turn, even further aggravate economic hardship for the state. CCD said that CMS should ensure that states set and maintain their Medicaid rate structures at levels to assure that there is sufficient provider participation so that Medicaid enrollees can access necessary services. CCD strongly urged CMS to consider the lack of provider access and the barriers that such a problem would pose to beneficiaries. CCD asked that CMS consider holding harmless providers in those catchment areas without excess capacity. Meanwhile, the California Medical Association has filed a Freedom of Information Act (FOIA) request with CMS to determine whether state officials considered the effect of proposed Medicaid cuts on health care access. Association officials are requesting that CMS provide documents demonstrating whether California has considered the impact of the cuts on access FMI: See http://thehill.com/images/stories/blogs/healthwatch/disabilitiescalif.pdf.

HHS-OIG Calls on Maryland to Clarify Definition of Residential Rehab Services

On September 2 the US Department of Health and Human Services Office of the Inspector General (HHS OIG) issues its Review of Medicaid Residential Rehabilitation Services for Children in Maryland (A-03-08-00209). HHS OIG says that it could not determine whether residential rehabilitative services claimed by Maryland complied with federal and state requirements. HHS OIG says that the state plan is unclear about the precise definition of a residential rehabilitative service and the requirements for documentation of claims for residential rehabilitative services. HHS OIG says that it therefore was unable to determine whether the documentation that the State submitted as support for the 2,652 claims in the HHS OIG 100-sampled beneficiary-months was sufficient to demonstrate that a service had been provided. For a copy of the report see http://go.usa.gov/0Yi.
AARP Hosts Forum on Delivery of Long-Term Services and Supports on September 8

On September 8 the AARP, The Commonwealth Fund and The SCAN Foundation are hosting a lunch and discussion of a new AARP report being released entitled Raising Expectations: A State Scorecard on Long-Term Services and Supports (LTSS) for Older Adults, People with Physical Disabilities and Family Caregivers. The discussion will be held on September 8, 2011 from 11:30 am to 2:30 pm in Room SH-902 at the Hart Senate Office Building, Constitution Avenue and First Street NE, Washington DC 20510. Developed by AARP’s Public Policy Institute with support from The Commonwealth Fund and The SCAN Foundation, the State LTSS Scorecard presents the first broad evaluation of how well states provide assistance to millions of adults who need help with daily activities. The Scorecard ranks states by performance, identifies specific areas where each state can improve and highlights state policies that result in better performance. Speakers who will discuss scorecard findings and address policy options include: Jennifer Burnett, Director, CMS Division of Community Systems Transformation; Bruce Chernof, M.D., President and CEO, The SCAN Foundation; Henry Claypool, Director, HHS Office on Disability; Robert Hornyak, Acting Director, Center for Policy, Planning and Evaluation, Administration on Aging; Bonnie Kantor-Burman, Director, Ohio Department of Aging; Kathleen A. Kelly, Executive Director, Family Caregiver Alliance; Mary Jane Koren, M.D., VP, The Commonwealth Fund; Dawn Lambert, Connecticut Money Follows the Person Program Director; Susan Reinhard, AARP SVP for Public Policy; Martha Roherty, Executive Director, NASUAD; Herb Sanderson, Associate State Director, AARP Arkansas. Lunch is available at 11:30. Forum starts at 12 noon. For more information, contact Andrew Bianco, 202-434-3839 or abianco@aarp.org. Register now. Space is limited. Watch a live Webcast at: www.longtermscorecard.org. FMI: Contact Andrew Bianco at 202-434-3839 or abianco@aarp.org.

NEC Webinar on Peer-Run Respite on September 28

The National Empowerment Center’s Peer-Run Respite Webinar Series is offering its first webinar on Wednesday, September 28 from 1:00 - 2:30 pm Eastern Time. “So You Want to Start a Peer-Run Respite? Options and Important Considerations” is the first webinar in a peer-run respite series sponsored by the National Empowerment Center’s Technical Assistance Center. Peer-run respite offers an alternative to traditional mental health hospitalization, are operated by peers, and are cost-effective. The purpose of the first webinar in this series will be to address specific issues around starting up, maintaining, and sustaining quality peer-run respite. Panelists will provide practical tips and suggestions on advocacy, funding, core values and principles, and staffing issues, among others. Space is limited. Register by clicking on https://www3.gotomeeting.com/register/728369694. Registration will close on Tuesday, September 27. FMI: See www.samhsa.gov. Contact the Technical Assistance Center of the National Empowerment Center at 599 Canal Street, Lawrence, MA 01840. Telephone: 1-800-POWER2U. Email: info4@power2u.org. Web: www.power2u.org.