Governor Corbett Freezes Spending, Cuts State Budget

On January 4 PA Governor Tom Corbett directed his Budget Office to freeze nearly $160 million in state spending and asked government entities not under his jurisdiction to reduce their spending by nearly $66 million. For a list of funds placed into budgetary reserve, please see the Current and Proposed Commonwealth Budgets section of the PA Office of the Budget website at www.budget.state.pa.us. The Governor’s Office of the Budget applied five levels of budgetary freeze to all state appropriations: Zero (0%), 1%, 3%, 5%, or 10%. Most agencies were asked to reduce their 2011-12 spending by 3%. Some individual appropriations will see spending reductions of up to 10%. Medicaid entitlement appropriations were spared from being cut. PA Department of Public Welfare spending will be reduced by 0.5% ($54,959,000). Medical Assistance Programs appropriations for Outpatient, Inpatient, Capitation, Long Term Care, Home and Community-Based Services, Medical Assistance Transportation will not be cut. However, funding for Medical Assistance - Critical Access Hospitals, Trauma Centers, and Hospital Based Burn Centers will be cut by 10%. Developmental Programs budgets for ICF-MR and the Intellectual Disabilities (ID) Community Waiver program are maintained at current amounts. However, funding for the ID Community Base Program is cut by 5% ($8,326,000). Early Intervention is cut by 1% ($1,129,000) and Autism Intervention and Services by 10% ($1,355,000). Mental Health Services (funding for state hospitals and community mental health programs) will be cut by 1% – or $7,172,000. Behavioral Health Services will be cut by 5% ($2,395,000). Homeless Assistance will be cut 5% ($1,028,000). The Human Services Development Fund will be cut 5% ($748,000). Home and Community Based Services, Services to Persons with Disabilities, Attendant Care, and Medical Assistance - Workers with Disabilities are not to be reduced. The PA Department of Labor and Industry spending will be reduced by 1.5% ($1,088,000). The Transfer to Vocational Rehabilitation Fund currently at $40,473,000 will not be cut. However, 3 special programs for people with disabilities will be cut - each by 5%: Supported Employment will be reduced by $21,000, Centers for Independent Living by $101,000, and Assistive Technology by $34,000. New Choices/New Options and Industry Partnerships will be cut by 10% ($50,000 and $161,000, respectively). For the Governor’s statement, see http://www.budget.state.pa.us/portal/server.pt/community/office_of_the_budget___home/4408.

Call in PA Senate for Hearings on DPW Spending Cuts

On December 23 PA Senator Shirley Kitchen said she will call for public hearings to investigate the Pennsylvania Department of Welfare (DPW) process for cutting costs and eliminating fraud and waste. Senator Kitchen serves as the Minority Chair of the Senate Public Health and Welfare Committee. Senator Kitchen cited reports on December 15 that 150,000 people – including 43,000 children – have been cut from Medical Assistance since August and that around 90,000 people were cut off in November. Medical Assistance provides health care services for 2 million eligible Pennsylvanians. The FY2011-12 state budget approved in 2011 mandated that DPW make more than $470 million in cuts. See http://www.delcotimes.com/articles/2011/12/09/opinion/doc4ee180e0ad7d5591424769.txt
Statewide Average Weekly Wage Increases by 3.5%, PA WC 2012 Medical Payments Rise

In the January 7, 2012 edition of the Pennsylvania Bulletin, the Pennsylvania Department of Labor & Industry (L&I) announced that for purposes of calculating the update to payments for medical treatment rendered on and after January 1, 2012, the percentage increase in the statewide average weekly wage is 3.5 percent. Rates for medical services provided under workers compensation are adjusted by the factor. Rates for indemnity benefits are also set in accord with the percentage increase in the statewide average weekly wage. BWC posted notice to its website that as a result of the increase the statewide average weekly wage for injuries occurring on and after January 1, 2012, shall be $888.00 per week. Under the Workers’ Compensation Act, injured workers are entitled to indemnity (wage-loss) benefits equal to two-thirds of their weekly wage for a work-related injury. However, there are both minimum and maximum adjustments provided in the Act, and the benefit rate is set using the annual maximum in place at the time of injury. The maximum is based on the statewide average weekly wage. Weekly rates from 2007 to 2012 are at http://www.portal.state.pa.us/portal/server.pt/community/workers'_compensation/10386. FMI: For a copy of the Pennsylvania Bulletin, see www.pabulletin.com

SB 1352 to Amend Speech-Language-Hearing Practice Act

On December 13, a bill (Senate Bill 1352) was introduced in the PA Senate to add specific provisions concerning speech pathologist and audiologists to the current law on speech-language and hearing. The proposed legislation (SB 1352) amending the 1984 Speech-Language and Hearing Licensure Act further provides for policy, definitions, a practice board, requirements for licensure, application and fees, examinations, requirements of a medical examination, renewal fees and records, enforcement of certification to board, for impaired professionals, for penalties, for injunction against lawful practice and for appropriation. FMI: See www.legis.state.pa.us.

CARF Training in Pennsylvania on Accreditation of Brain Injury HCBS Programs

On Monday and Tuesday, January 23 and 24 PARF is hosting a special two-day training on CARF Accreditation of Brain Injury Residential Rehabilitation & Home and Community Based Services. Christine M. MacDonell, CARF International, will present the two day training which will address the needs of brain injury service providers to prepare for accreditation of services and programs. In the event the January 23rd & 24th training is not offered due to inclement weather and is rescheduled, the two day session will be held on Monday, January 30th & Tuesday, January 31st, 2012. The two-day session provides a solid foundation for organizations seeking CARF accreditation for brain injury rehabilitation services. Participants will gain valuable insight into the accreditation process and help in preparing for a survey and how to avoid the pitfalls some organizations may experience on their survey. Session topics include: How to successfully prepare for CARF accreditation; how to complete the Intent for Survey and join to Customer Connect; standards that will be applied during Brain Injury Residential Rehabilitation and Brain Injury Home and Community services surveys; the survey process itself; outcome measurement and management; and, working with their resource specialist at CARF. If more information is needed, please contact PARF at parfmail@parf.org.
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Dateline: January 6, 2012

DPW Issues RFA for Vendor Fiscal/Employer Agent Financial Management Services

On January 5 the PA Department of Public Welfare (DPW) issued a Request for Application (RFA) for Vendor Fiscal/Employer Agent Financial Management Services. DPW Secretary Gary Alexander said the change will improve efficiency and lower the cost of state programs by reducing the number of organizations that can provide financial management services to Medicaid recipients who receive home-based and community-based services. DPW says that Pennsylvania now has 37 organizations that help 22,000 state residents manage money. Under the RFA, the Commonwealth will accept applications for up to three (3) entities that will provide Financial Management Services (FMS) throughout the Commonwealth or on a regional basis for eligible participants who receive participant directed services in the Office of Long-Term Living (OLTL) and the Office of Developmental Programs (ODP). The RFA includes services under the Aging, Attendant Care, Independence, COMMCARE, OBRA, Consolidated and Person/Family Directed Support waivers, along with the Act 150 program. The selected vendor(s) will start accepting new consumers September 1, 2012. The selected vendor(s) will provide services for all existing participants effective January 1, 2013. The RFA is posted on the Department of General Services website: http://www.emarketplace.state.pa.us/search.aspx. The attachment is available in alternate format upon request at 1-800-932-0939. FMI: See www.dpw.state.pa.us

ODP Schedules Pennsylvania’s Outcomes Training Sessions

On January 6 the PA DPW Office of Developmental Programs (ODP) issued ODP Announcement 001-12 inviting those who develop, review and/or approve Individual Support Plans (ISP) to attend four (4) newly rescheduled “Pennsylvania’s Outcomes Training” sessions. Registration is on a first come, first served basis. Sessions will be offered on January 24 at Spectrum Community Services, 1655 Valley Center Parkway, Suite 150, Bethlehem, PA 18017 and PaTTAN Pittsburgh, 3190 William Pitt Way, Pittsburgh, PA 15238. Sessions will also be offered on January 26 at PaTTAN Harrisburg, 6340 Flank Drive, Harrisburg, PA 17112 and at Riverview IU 6, 270 Mayfield Road, Clarion, PA 16214 Individuals may register for one session only. All sessions are scheduled from 9:00 a.m. to 4:00 p.m. Registration begins at 8:30 a.m. Walk-in registration will not be accepted. For registration, see www.odpconsulting.net

ODP Communication Number: Announcement 001-12 on Pennsylvania’s Outcomes Training.

DPW Transitions to ANSI X12 v5010 Software

On January 1 PA Department of Public Welfare issued a notice that it has transitioned to upgrade to the ANSI X12 version 5010 (v5010) software. All covered entities (health plans, health care clearinghouses, certain health care providers, and waiver providers) conducting electronic claim transactions must be certified by March 31, 2012 using the new transaction standards. To be in compliance with v5010 software, a valid ICD-9 diagnosis code is required on all electronic claims submissions. The absence of a valid ICD-9 diagnosis code on an electronic claim transaction will result in a claim denial. Please contact the v5010 certification helpdesk at pahippa5010@hp.com for transaction certification and v5010 transaction formatting issues. DPW says that it is imperative that providers notify DPW of changes that would affect their provider file, especially e-mail addresses. Other changes would include physical addresses and telephone numbers. Please notify the BPS Provider Call Center at 1-800-932-0939 and callers would be directed to the appropriate staff. FMI: See www.dpw.state.pa.us.
President Signs Payroll Tax Cut Act, Includes Physician Update Fix and Therapy Caps

On Friday, December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). The new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. It also extends the exceptions process for outpatient therapy caps. While the negative update for the 2012 Medicare Physician Fee Schedule is now scheduled to take effect on March 1, 2012, the Obama administration has said that it remains strongly opposed to letting the cut take effect. President Obama and Congressional leaders have indicated that they are committed to a permanent solution to eliminating the Sustainable Growth Rate’s cut. The new law also extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012. All patients begin a new cap year on January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,880. For occupational therapy services, the limit is $1,880. Deductible and coinsurance amounts applied to therapy services will count toward the amount accrued before a cap is reached and also will apply for services above the cap where the KX modifier is used. FMI: For updates on legislation see www.house.gov and www.senate.gov. For updates on Medicare payment changes see www.whitehouse.gov and www.hhs.gov.

Congress Urged to Maintain IRF Payments

PARF members are calling on Congress to insure that Medicare inpatient rehabilitation facility (IRF) payments are not used to offset the cost of legislation extending payroll tax cuts and unemployment benefits and fixing the Medicare physician payment formula. In addition, PARF is continuing to advocate for an extension of the therapy caps exceptions process. The calls to members of Congress are in response to action by House and Senate leaders to act on an extension of payroll tax cut and unemployment benefits and to fix the Medicare physician payment formula. On December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA), extending the payroll tax cut and unemployment benefits and providing for a Medicare physician payment fix and therapy caps exceptions process through February 29. As part of the agreement leading to passage of the legislation, House Speaker John Boehner (R-OH) and Senate Majority Leader Harry Reid (D-NV) agreed to set up a conference committee to draft legislation to extend the payroll tax cut and unemployment benefits for one (1) year and to provide for a two (2) year Medicare physician payment fix. House and Senate conferees have been named. Members of Congress are in their States/Districts until Congress reconvenes late this month. The House convenes on Tuesday, January 17; the Senate convenes on Monday, January 24.

RSA Commissioner Lynnae Rutledge Resigns

On January 4 Rehabilitation Services Administration (RSA) Commissioner Lynnae Rutledge announced her resignation, effective January 13, 2012. Commissioner Rutledge said that she was returning home to the Pacific Northwest to spend more time with her family. Alexa Posny, Assistant Secretary for the Office of Special Education and Rehabilitative Services, has asked Ed Anthony, Deputy Commissioner of RSA to serve as interim Commissioner. FMI: Contact PARF at parfmail@parf.org.
**PARF NEWS**  
Dateline: January 6, 2012

**DOL Webinar on Updates to Section 503 of the Rehab Act**

On January 11 from 2:00 p.m. to 3:30 p.m. U.S. Department of Labor is offering a Webinar on the Section 503 NPRM Notice of Proposed Rulemaking. On December 9 the U.S. Department of Labor announced a proposal to strengthen the affirmative action requirements of federal contractors to improve employment for individuals with disabilities. See [http://www.dol.gov/odep/](http://www.dol.gov/odep/)

**DOL ETA & ODEP Release Notice on Transportation Services**


**Kessler Foundation Funds Employment Programs for People with Disabilities**

The Kessler Foundation Signature Employment Grants Program is funding cutting-edge, non-traditional solutions that increase employment outcomes for individuals with disabilities. The solutions that are funded may include new pilot initiatives, demonstration projects, or other social ventures that lead to the generation of new ideas to solve unemployment. Preference will be given to interventions that overcome specific employment barriers related to long-term dependence on public assistance, advance competitive employment, or launch a social enterprise project. A priority is placed on serving individuals with mobility disabilities, traumatic brain injury, spinal cord injury, multiple sclerosis, stroke, cerebral palsy, spina bifida, epilepsy or other related impairments. Grants of $100,000 to $250,000 per year for up to two years are available to nonprofit organizations, educational institutions, and government agencies throughout the U.S. The deadline for concept submissions is February 3, 2012. FMI: See the Foundation’s website for program details at [http://kesslerfoundation.org/grantprograms/signatureemploymentgrants.php](http://kesslerfoundation.org/grantprograms/signatureemploymentgrants.php)

**HHS Issues New Standards on Electronic Funds Transfers in Healthcare**

On January 5 the U.S. Department of Health and Human Services (HHS) issued new standards for electronic funds transfers in health care, required by the Affordable Care Act. The standards build upon regulations published earlier this year that set industry-wide standards for how health providers use electronic systems to quickly and easily determine a patient’s eligibility for health coverage and check on the status of a health claim. The rule—the Adoption of Standards for Health Care Electronic Funds Transfers and Remittance Advice — adopts streamlined standards for the format and data content of the transmission a health plan sends to its bank when it wants to pay a claim to a provider electronically (through an electronic funds transfer) and to issue a Remittance Advice notice. The regulation is effective January 1, 2012. All health plans covered under HIPAA must comply by January 1, 2014. To view the Interim Final Regulation with comment period, go to: [http://www.regulations.gov](http://www.regulations.gov). FM: See the June 2011 HIPAA Administrative regulation – Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status – at [http://www.hhs.gov/news/press/2011pres/06/20110630a.html](http://www.hhs.gov/news/press/2011pres/06/20110630a.html).
Comment on HHS Proposed Essential Health Benefits Bulletin due on January 31

On December 16, 2011 the U.S. Department of Health and Human Services (HHS) issued a bulletin to provide information and solicit comments on the regulatory approach that HHS plans to propose to define the essential benefits of health. The Affordable Care Act ensures that health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges, offer a comprehensive package of items and services, known as "essential health benefits." Essential health benefits must include items and services within at least the following ten (10) categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the HHS approach, states would have flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." Public input on this proposal is encouraged. Comments are due by January 31, 2012. Comments should be sent to EssentialHealthBenefits@cms.hhs.gov. FMI: See http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf for the Essential Health Benefits Fact Sheet.

HHS-OIG Claims Hospital Incident Reporting Systems Do Not Capture Most Patient Harm

On January 4 the US Department of Health and Human Services (HHS) Office of Inspector General (OIG) posted its report entitled Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. See (OEI-06-09-00091) http://go.usa.gov/RtX. In its report HHS OIG said that hospital incident reporting systems captured only an estimated 14 percent of the patient harm events experienced by Medicare beneficiaries. HHS OIG said that hospitals investigated those reported events that they considered most likely to lead to quality and safety improvements and made few policy or practice changes as a result of reported events. Hospital administrators classified the remaining events (86 percent) as either events that staff did not perceive as reportable (61 percent) or as events that staff commonly report but did not report in this case (25 percent). In conducting its study HHS OIG requested and reviewed incident reports from hospitals regarding patient harm events. HHS OIG reported that all of the hospitals it reviewed had incident reporting systems designed to capture events and hospital administrators who were interviewed indicated that they rely heavily on the systems to identify problems. HHS OIG recommended that that AHRQ and CMS collaborate to create and promote a list of potentially reportable events for hospitals to use. HHS OIG further recommended that CMS provide guidance to accreditors regarding their assessments of hospital efforts to track and analyze events. CMS should also suggest that surveyors evaluate the information collected by hospitals using AHRQ's Common Formats. Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event tracking. AHRQ and CMS concurred with the recommendations. CMS also stated that it is developing draft guidance for surveyors regarding assessment of patient safety improvement efforts within hospitals. FMI: See http://go.usa.gov/RtX.
CMS Delays PMD and RAC Demonstrations

The Centers for Medicare & Medicaid Services (CMS) has posted a notice to its website that it is delaying the implementation of its demonstration programs for Prepayment Review and Prior Authorization of Power Mobility Devices (PMDs) and the Recovery Audit Prepayment Review. The delay is in response to comments it has received on those programs. CMS did not announce a new date but said that it will provide at least 30 days notice before the demonstrations begin.

CMS says that the Part A to Part B rebilling demonstration remains on schedule and will begin on January 1, 2012. Under the Recovery Audit Prepayment Review demonstration CMS had planned to allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs would conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews would focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. CMS said that the demonstration would help lower the error rate by preventing improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur. The three demonstration programs were announced on November 15, 2011. FMI: See https://www.cms.gov/CERT/02_Demonstrations.asp.

Enforcement for Non-Compliant HIPAA Entities

On December 14 the Medicare Fee-For-Service (FFS) program issued an announcement regarding its plan for the 90 Day Discretionary Enforcement Period for non-compliant HIPAA covered entities. Centers for Medicare & Medicaid Services (CMS) has published six frequently asked questions (FAQs) items related to this plan. These new FAQs are at: http://www.cms.gov/Versions5010andD0/Downloads/QandA_for_90_day_announcement.pdf. For more information on ASC X12 Version 5010, NCPDP D.0, and NCPDP 3.0; please visit www.CMS.gov/Versions5010andD0.

CMS Posts ACO Standards and SSP

The Centers for Medicare & Medicaid Services (CMS) has added new information concerning quality measures for accountable care organizations and applications to its Medicare Shared Savings Program to its website at www.cms.gov/sharedsavingsprogram. A new webpage on the program’s Quality Measures and Performance Standards has been established at http://www.cms.gov/sharedsavingsprogram/37e_Quality_Measures_Standards.asp with the most recent information on Medicare Accountable Care Organization (ACO) quality measures. The 2012 ACO Narrative Quality Measures Specifications Manual provides guidance about the 33 required quality measures that are part of the quality performance standard. In addition, two (2) crosswalks have been added to the Shared Savings Program Application webpage at http://www.cms.gov/sharedsavingsprogram/37_Application.asp. Organizations who submitted an application under the Pioneer ACO Model or have been participating in the PGP Transition Demonstration and who wish to submit a Shared Savings Program application should view www.cms.gov/sharedsavingsprogram and scroll down for links to the two application crosswalks.
CMS Selects Innovation Advisors

On January 5 the Centers for Medicare and Medicaid Services (CMS) announced that it has selected 73 individuals from 27 States and the District of Columbia for its Innovation Advisors program. For the list see [http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4240](http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4240). The initiative, launched by the CMS Innovation Center in October 2011, will help health professionals deepen skills that will drive improvements to patient care and reduce costs. After an initial orientation phase, Innovation Advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States. Funding for this initiative was made possible by the Affordable Care Act. The 73 individuals were selected from 920 applications through a competitive process, and include clinicians, allied health professionals, health administrators and others. Each Innovation Advisor’s home organization will receive a stipend of up to $20,000. The stipend will support an individual’s activities while serving as an Innovation Advisor. More information about the Innovation Advisors Program, including a fact sheet and list of participants and their home organization, can be found at: [http://innovations.cms.gov/initiatives/innovation-advisors/index.html](http://innovations.cms.gov/initiatives/innovation-advisors/index.html).

CMS Announces Independence-at-Home Demonstration Program

On December 20 the Centers for Medicare & Medicaid Services (CMS) announced its new Independence at Home Demonstration Program that is intended to expand the scope of in-home services Medicare beneficiaries can receive. The Independence at Home Demonstration will provide chronically ill patients with a complete range of primary care services. Participation in the demonstration is voluntary for Medicare beneficiaries. Medical practices led by physicians or nurse practitioners will provide primary care home visits to beneficiaries with multiple chronic conditions and functional limitations. The Demonstration will reward healthcare providers with an incentive payment and use quality measures to ensure high quality care. Applications and Letters of Intent, if applicable, are due on February 6, 2012. Questions on this demonstration may be submitted to CMS at: [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov). Additional information about this demonstration, including how to apply, can be found at [https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4230](https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4230).

CMS Posts Version 5010 Benefits and Resources

The Centers for Medicare and Medicaid Services (CMS) has announced that the Version 5010 compliance deadline remains January 1, 2012. CMS says that upgrading from Version 4010/4010A standards to Version 5010 is a critical step that is necessary for the ICD-10 transition and must be implemented before ICD-10 implementation is possible. Noting that Version 5010 offers great improvement over Version 4010/4010A, CMS says that Version 5010 greatly improves standardization of administrative data and supports both ICD-9 and ICD-10 codes sets; supports electronic submission of claims, provides greater specificity of clinical data and patient information; and, has a more logical structure, which will assist in faster code selection and improved ease of use. FMI: See the Version 5010 and Latest News pages on the CMS ICD-10 website at [https://www.cms.gov/ICD10/11a_Version_5010.asp](https://www.cms.gov/ICD10/11a_Version_5010.asp). See also [https://www.cms.gov/ICD10/02b_Latest_News.asp](https://www.cms.gov/ICD10/02b_Latest_News.asp).
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CMS Issues Rule on Standards for the Health Care Electronic Funds Transfers

On January 5 the Centers for Medicare & Medicaid Services (CMS) announced an interim final rule with comment period (IFC) (CMS-0024-IFC) under which the Department of Health and Human Services (HHS) adopts standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice transaction (RA) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 1104 of the Patient Protection and Affordable Care Act of 2010 requires CMS to issue a series of regulations over the next five (5) years that are designed to streamline health care administrative transactions, encourage greater use of standards by providers, and make existing standards work more efficiently. CMS published the first regulation on July 8, 2011 that puts in place operating rules for two electronic health care transactions that make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer. This regulation is the second in the series and establishes Electronic Funds Transfers (EFT) standards. The effective date of this regulation is January 1, 2012. Under the Affordable Care Act, HIPAA-covered entities must be in compliance with the standards (in other words, use the health care EFT standards) on January 1, 2014. The rule (CMS-0024-IFC) is may be viewed at www.ofr.gov/inspection.aspx. A news release on the rule may be viewed at http://www.hhs.gov/news.

CMS Home Health, Hospice & DME/Quality Open Door Forum on January 11

On January 11 the Centers for Medicare and Medicaid Services (CMS) will host the next Home Health, Hospice & DME/Quality Open Door Forum from 2:00 p.m. to 3:00 p.m. ET. The agenda is as follows: Home Health Grouper; Competitive Bidding Announcement and Update; Hospice Quality Reporting Announcement; Home Health Oasis Update; Home Health CAHPS Update; Home Health Billing Update. This Forum is an audio only streaming web forum. To register for the forum, visit: http://www.cms.gov/apps/events/event.asp?id=654. See the announcement at http://www.cms.gov/OpenDoorForums/17_ODF_HHHDME.asp#TopOfPage. See also www.cms.gov.

CMS Hospital & Hospital Quality Open Door Forum on January 12

On January 12 the Centers for Medicare and Medicaid Services (CMS) will host a Hospital & Hospital Quality Open Door Forum from 2:00pm-3:00pmET. The agenda includes: Hospital Compare; Claims Reprocessing; Status of 2 month extenders; Wage Index Time table Update; Injection and Infusion Update; HVBP Dry Run; and, Engaging Consumer Caregivers in HAI Prevention: The WAVE Campaign. To register for the forum, see http://www.cms.gov/apps/events/event.asp?id=655. Please see the full announcement at http://www.cms.gov/OpenDoorForums/18_ODF_Hospitals.asp#TopOfPage. See also www.cms.gov.