**PA Disability Groups File Lawsuit against Governor Corbett and DPW**

On March 13 the Disability Rights Network (DRN) of Pennsylvania and other disability advocacy groups filed a lawsuit in PA Commonwealth Court charging Governor Tom Corbett, the Governor’s Budget Office, and the Department of Public Welfare (DPW). The lawsuit (or petition) charges the parties with a failure to request appropriations to assure that people with mental illness and intellectual disabilities are provided the services that they need. The petition focuses on Governor Corbett’s proposal to reduce funding for services to people with mental illness and intellectual disabilities. The budget proposal would eliminate designated funding for mental health and intellectual disability services in seven state grant programs. Governor Corbett proposes to fund a Human Service Development Fund (HSDF) block grant at a level that is $139 million less than all the funds previously designated and used for the seven areas of human services that were previously funded. There is no commitment to use that funding for the programs and services funded under the current base funding. The March 13, 2012 DRN Petition for an Injunction and a DRN press release dated March 14, 2012 are available at [www.drnpa.org](http://www.drnpa.org).

If more information is needed, please contact PARF at parfmail@parf.org.

**PA House Human Services Holds Hearing on Food Stamp Asset Test**

On March 15 the PA House Human Services Committee held a public hearing on Department of Public Welfare plans to reinstate an asset test for those who apply for food stamp assistance, known as the Supplemental Nutrition Assistance Program (SNAP). The plan is scheduled to take effect on May 1. Under the assets test households with eligible assets of more than $5,500, and $9,000 for those with an elderly or disabled member would not be eligible for federal food stamps. Currently there is an income limit but not an assets test. DPW estimates about 4,000 food-stamp households — mostly those with elderly or disabled people — have assets that exceed the limits. Those offering testimony included representatives from Community Legal Services, PA Food Merchants Association, Pennsylvania Convenience Store Council, Just Harvest, Coalition Against Hunger, United Way of Southeastern Pennsylvania, Service Employees International Union, Food Research and Action Center, Lutheran Children and Family Service/Liberty Lutheran, Allison Hill Community Ministries, Temple Beth El, PA Association of Area Agencies on Aging and Pennsylvania Hunger Action Center. Testimony included comment on the effect of the imposition of an assets test upon elderly individuals and people with disabilities, the administrative burden and increased costs in applying the assets test to the 450,000 households subject to the new requirement, the loss of $12.5 million in federal funds, and the impact on 1,000 stores and grocers. FMI: For details of the hearings see [http://www.philly.com/philly/news/politics/state/20120315_ap_plannedfoodstampassettestgetsfirsthearing.html](http://www.philly.com/philly/news/politics/state/20120315_ap_plannedfoodstampassettestgetsfirsthearing.html) and [http://www.pennlive.com/newsflash/index.ssf/story/planned-food-stamp-asset-test-gets-first-hearing/41f924f5b7784df0bc552db7564f46ce](http://www.pennlive.com/newsflash/index.ssf/story/planned-food-stamp-asset-test-gets-first-hearing/41f924f5b7784df0bc552db7564f46ce).
Governor Corbett Signs Voter ID Bill

On March 14 Governor Tom Corbett signed into law House Bill 934, also known as the Photo Voter ID bill, which will require Pennsylvanians to produce photo identification when they vote. The law goes into effect immediately, but the photo ID will not be required for the primary election next month. However, voters will be reminded at that time that a photo ID will be required for November’s general election. Any voter who does not have an acceptable form of photo ID can obtain an ID, free of charge, at any PennDOT driver license center. Some examples of a photo ID include a Pennsylvania driver’s license or non-driver license photo ID, a military ID, valid U.S. passport, county or municipal employee ID, college ID or personal care home ID. All photo IDs must be current and include an expiration date. Individuals applying to register to vote must be: A citizen of the United States for at least one month before an election; a resident of Pennsylvania and the election district in which the individual desires to register and vote for at least 30 days before the election; and, at least 18 years of age on or before the election. Election laws fall under the jurisdiction of the Department of State. For more information on the voter ID law or voter registration, call the Department of State’s toll-free hotline at 1-877-VOTESPA (1-877-868-3772) or visit www.VotesPA.com. Proponents claim that a uniform voter identification requirement assures all voters will be treated equally and fairly and will prevent some voters from being singled out for identification while other voters are allowed to vote without identifying themselves. Opponents say the law be unreasonably costly (an estimated $5 and $11 million in the first year and another $2.25 million per year every year) and unnecessary because it already carries harsh fines and imprisonment of up to five years under federal law. FMI: See www.legis.state.pa.us.

DPW Reduces DSH Payments

In the March 17 edition of the Pennsylvania Bulletin, the PA Department of Public Welfare (DPW) announced that it intends to decrease the allocation of funding for Fiscal Year (FY) 2011-2012 for disproportionate share hospital (DSH) payments to qualifying hospitals based on the designation as a Critical Access Hospital (CAH) or as a qualifying rural hospital. In the notice on an Additional Class of Disproportionate Share Payments for Critical Access Hospitals and Qualifying Rural Hospitals, DPW says that the reduction reflects the reduction in the amount allocated for Medical Assistance (MA) inpatient services in the current state budget. DPW says that there is no change in the current qualifying criteria or methodology for determining eligibility for these payments. The FY 2011-2012 fiscal impact is $7.162 million ($3.218 million in State general funds and $3.944 million in Federal funds). Interested persons are invited to submit written comments regarding this notice to the 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 of the notice. Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users). FMI: See www.pabulletin.com.
PA House Approves Changes to Unemployment Compensation Law

On March 13 the PA House of Representatives unanimously approved legislation that would add certain penalties for unemployment compensation fraud. House Bill 1852 increases the penalty period for individuals who commit unemployment compensation fraud from two weeks to 10 weeks, removes the current four-year limit on the imposition of these penalty weeks, adds a 15 percent penalty to the total owed to the fund for a fraudulent claim, creates a 52-week penalty for individuals who commit willful fraud to collect benefits while in prison, and raises the penalty of employers who fail to report from 10 percent to 15 percent and the penalty for accepting employee contributions from a minimum of $100 to a minimum of $500, with a maximum of $1,500 and six months in prison. House Bill 1852 has been referred to the PA Senate Committee on Labor and Industry will now go before the Senate for its consideration.

Changes in PA Licensure of Social Workers & Counselors Signed into Law

On March 14 PA Governor Tom Corbett has signed into law House Bill 816 (P.N. 1853) amending the Social Workers, Marriage and Family Therapist and Professional Counselors Act, to change certain licensing requirements. The bill clarifies the experience requirements for clinical social workers, marriage and family therapists, and professional counselors. House Bill 816 would reduce the number of supervised experience hours required to obtain a license from 3,600 to 3,000 for marriage and family therapists and professional counselors, and would remove the specified number of years. It would also extend a grandfathered provision of the law to allow applicants who graduated prior to June 30, 2009, to receive a license even if they were awarded a master’s degree requiring less than 48 credits. To read the full text of the bill signed by Governor Corbett on March 14, visit the PA General Assembly’s website at www.legis.state.pa.us

DRN and ACLU Challenge Restrictions on Access to PA Capitol Building

The Disability Rights Network of Pennsylvania (DRN) and American Civil Liberties Union-PA (ACLU) have called upon Governor Tom Corbett to retract a policy that excludes people with disabilities from certain areas of the Capitol. Citing recent incidents in which wheelchair users were prohibited by Capitol police from using the elevators in the Capitol Building while other individuals were granted access to public places, the DRN and ACLU asked that the policy that Capitol Police followed and their actions be explained. DRN and ACLU said that while Pennsylvania policy bars public events within the Capitol Complex that interfere with a legislative session or the conduct of public business, there is nothing in that policy that permits Capitol Police to bar access to public spaces in the Capitol to people who are not causing any such disruption or disturbance. DRN and ACLU said that if the Governor and his agents fail to provide assurances that the restrictive policy will be repealed and not applied or enforced, the DRN and ACLU will take necessary action to block the policy. FMI: For a copy of the letter see http://media.pennlive.com/midstate_impact/other/Capitol%20Access%20Letter.pdf. For details, see http://www.pennlive.com/midstate/index.ssf/2012/03/groups_call_for_repeal_of_poli.html. For updates and more information see www.drnpa.org. For comment see http://www.pasenate.com/?p=8065.
HAP Webinar on Determining Medical Necessity in Rehabilitation on April 24

The Hospital and Healthsystem Association of Pennsylvania (HAP), in cooperation with the Georgia Hospital Association, will be offering a webinar, “Determining Medical Necessity: Implications for Inpatient and Outpatient Rehabilitation,” on April 24 at 10 a.m. The program will focus on: philosophical and economic problems over medical necessity; recent history of medical necessity determinations; ethical issues in rehabilitation; conflicts of interest in making medical necessity determinations confronting payers and providers of care; and current methods of resolving conflicts. Questions about the webinar may be directed to Mary Barth, member relations and education, at (717) 561-5270.

OMHSAS Promotes Work of MH Task Force on Outpatient Services

On March 14 the PA Office of Mental Health and Substance Abuse Services (OMHSAS) released a summary report that outlines the actions that a special OMHSAS-led task force has taken to address various outpatient mental health issues. The summary report includes the next steps to be taken to continue efforts in addressing the concerns. The Outpatient Taskforce Summary responds to the June 2010 PCPA white paper entitled The Collapse of Pennsylvania’s Outpatient Clinics. OMHSAS said there needs to be a continued focus on the needs of the outpatient clinics and that it looks forward to continued participation of the mental health stakeholders in the task force. FMI: For a copy of the white paper, contact PARF at parfmail@parf.org. For additional information, contact OMHSAS Director of Western Operations Valerie Vicari.

OMHSAS Issues New Bulletin on Summer Therapeutic Activities Programs

The PA Office of Mental Health and Substance Abuse Services (OMHSAS) has published a new bulletin outlining new requirements for Summer Therapeutic Activities Programs (STAPs), effective March 1, 2012. The bulletin updates the original 1996 bulletin notifying providers that the Summer Therapeutic Activities Program had been added to the Medical Assistance fee schedule and establishing procedures for accessing these services; it also updates the 2005 bulletin modifying the procedures. The new bulletin has several purposes: (a) to clarify programmatic expectations for STAPs and to provide direction to providers for developing and operating STAPs, (b) to reiterate the services that are allowable for payment by the Medical Assistance Program, (c) to update the format for STAP service descriptions, and (c) to clarify the staffing requirements and role of director/supervisor and unit director/supervisor.

IRRC to Act on Licensure of Behavior Specialists

On April 5 the Independent Regulatory Review Commission is scheduled to act on final form regulations issued by the State Board of Board of Medicine (#16A-4929) on Behavior Specialist. The rulemaking implements licensure of behavior specialists as required by the Act 62 amendments to the insurance law. FMI: For documents and background information see http://www.irrc.state.pa.us/regulation_details.aspx?IRRCNo=2820. For a copy of the agenda with meeting time and location see http://www.irrc.state.pa.us/view_doc.aspx?file=Document-26362&mod=Thu%2c+2+15+Mar+2012+15%3a04%3a28+GMT&IRRCNo=00001.
MedPAC Releases 2012 Report to Congress

On March 15 the Medicare Payment Advisory Commission (MedPAC) released its *March 2012 Report to the Congress: Medicare Payment Policy*. The report includes the Commission’s analyses of payment adequacy in fee-for-service (FFS) Medicare, Medicare Advantage and Part D and the MedPAC assessment of the sustainable growth rate (SGR) system for physician payment. MedPAC recommends that Congress eliminate the update to the Medicare payment rates for IRFs, skilled nursing facilities (SNFs) and long term care hospitals (LTCHs) in FY 2013. MedPAC says that its analyses show that IRFs should be able to absorb cost increases and continue to provide care to clinically appropriate Medicare cases with no update to payments in 2013. The report also re-publishes its October 2011 letter to Congress outlining options for replacing the Sustainable Growth Rate (SGR) formula. That letter included potential Medicare offset options for repealing the SGR system, including reinstatement of the 75% Rule and application of the hospital readmission policy to IRFs. The MedPAC reports also recommends repealing the sustainable growth rate (SGR), revising and rebasing the skilled nursing facility payment system, encouraging innovation in Medicare Advantage plans, and modifying the co-payments for low income subsidy (LIS) enrollees to encourage the use of generics. The full report is available online at [http://medpac.gov/documents/Mar12_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf).

CBO Updates Estimates of Affordable Care Act, Sees No Change in Effects

On March 16 the Congressional Budget Office (CBO) issued a notice saying that in two reports – one that CBO released in the past week on the Affordable Care Act (ACA) and one that CBO conducted with the Joint Committee on Taxation (JCT) – that there had been no change to its estimates of the impact of the Affordable Care Act since the CBO assessment conducted in 2010. CBO said that the projections for each given year have changed little, on net, since March 2010. CBO also noted that the CBO and JCT projections of the net cost to the federal government of all the provisions of the ACA that were made last February (its most recent one for all the provisions of the ACA) extended the original ones by two years, but again changed little, on net, from the original projections for each given year. FMI: See [http://www.cbo.gov/directors-blog](http://www.cbo.gov/directors-blog).


CMS Expands Community-based Care Transitions Program

On March 14 Centers for Medicare & Medicaid Services (CMS) announced twenty-three (23) additional participants in the Community-based Care Transitions Program (CCTP). These participants will join seven (7) other community-based organizations already working with local hospitals and other healthcare and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care setting. CCTP is designed specifically to provide support for high-risk Medicare beneficiaries following a hospital discharge. FMI: See [http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313](http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313). See also [http://www.HealthCare.gov/PartnerShipForPatients](http://www.HealthCare.gov/PartnerShipForPatients). For the CMS press release see [http://www.CMS.gov/apps/media/press/release.asp?Counter=4302](http://www.CMS.gov/apps/media/press/release.asp?Counter=4302).
DOL Seeks Comments on Homecare Rule

Comments on the proposed home care rule are still being delivered to the U.S. Department of Labor (DOL), which has extended its comment period through March 21. More than 8,000 comments had been published to date on the DOL comment submission web page. On December 27, 2011 DOL published a Notice of Proposed Rulemaking (NPRM) to revise the companionship and live-in worker regulations to more clearly define the tasks that may be performed by an exempt companion and to limit the companionship exemption to companions employed only by the family or household using the services. Third party employers, such as in-home care staffing agencies, could not claim the exemption, even if the employee is jointly employed by the third party and the family or household. On February 24, 2012, DOL published a notice to extend the comment period to March 12, 2012, and on March 13, DOL extended the comment period until March 21, 2012. Comments received between December 27, 2011, the date of publication of the NPRM, and March 21, 2012 will be included in the rulemaking record. Meanwhile, the US House Committee on Education & the Workforce hearing on the proposed home care rule is set for March 20. The hearing will be held by the Workforce Protections subcommittee and will explore how the regulation would affect access to care. Interested parties are invited to submit written comments on the proposed rule on or before March 21, 2012 at www.regulations.gov.

National Work Incentives Seminar Event Webinar on Ticket to Work on March 28

On Wednesday, March 28, 2012 at 3:00 p.m. EST a National Work Incentives Seminar Event (WISE) Webinar on Ticket to Work will be held to discuss Preventing and Managing Overpayments. The webinar is for Social Security Disability beneficiaries. Social Security disability beneficiaries who want to make more money through a good job that leads to a good career and a better, self-sufficient future are encouraged to participate. The March28 national WISE webinar will present information about special Social Security programs and rules. In addition to learning about the Ticket to Work program, information from Social Security representatives will be provided on overpayments what to do when an overpayment notice is received and how to avoid overpayments. Speakers will also give information on using Social Security’s Supplemental Security Income Telephone Wage Reporting System. Register online or call 1-866-968-7842 or 1-866-833-2967 (TTY/TDD). For questions about the webinar, please call 1-866-968-7842 or 1-866-833-2967 (TTY/TDD). See https://www.chooseworkttw.net/wise/jsp/wise.jsp

SAMHSA Webinar on Managed Care Organizations

A webinar hosted by the US Substance Abuse and Mental Health Services Administration (SAMHSA) entitled Helping Providers Understand Managed Care Organization Networks, Qualifications, and Participation will be held on Tuesday, March 27, from 1:30 to 2:30 pm EST.. The major forms or structures of MCO networks and the role of behavioral health providers, the qualifications and general application process for participation in a MCO network, conditions and requirements of participation in a MCO network and the challenges and opportunities for behavioral health providers are reviewed. To register, see http://event.on24.com/r.htm?e=412103&s=1&k=DDCAA36549DFE7D07EF7B866880C8A0A.
HHS Announces Policies on Establishing State Health Insurance Exchanges

On March 12 the US Department of Health and Human Services (HHS) published rules on policies to assist states in building Affordable Insurance Exchanges. The policies are to help states in establishing by 2014 their state health insurance exchanges in which consumers and small businesses will choose private health insurance plans. The policies offer guidance about the options on how to structure exchanges in two key areas: (a) Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange, and certifying health plans for participation in the Exchange; (b) Establishing a streamlined, web-based system for consumers to apply for and enroll in qualified health plans and insurance affordability programs. HHS says that the final rule builds on the flexibility and resources provided by HHS already to build state-based Exchanges. FMI: To learn more about this final rule, visit: http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html. See also http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html. For more information on Exchanges, including fact sheets, visit http://www.healthcare.gov/exchanges.

HHS Issues Final Regulations on Eligibility Changes to Medicaid under ACA

On March 16, the U.S. Department of Health and Human Services (HHS) released a 268 page final regulation implementing provisions of the Patient Protection and Affordable Care Act expanding access to health insurance coverage through Medicaid and Children’s Health Insurance (CHIP) programs for individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level, currently $14,856 for an individual and $30,656 for a family of four. People with disabilities receiving long term services and supports (LTSS) now or applying for Medicaid in the future with incomes below 138% of the federal poverty line will continue to have the option of receiving long term services and supports (LTSS) under an eligibility category based on disability. In the final regulation, HHS acknowledges that individuals with disabilities will be considered for eligibility in optional groups so that they can gain access to long term services and supports even if they are also eligible for the new mandatory category for low-income childless adults. The final rule places greater reliance on data-based verification as opposed to documentation required from individuals; streamlines eligibility categories into four primary groups covering children, pregnant women, parents and the new adult group; simplifies income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals; and promotes better coordination across Medicaid, CHIP and the Exchanges. These changes will become effective in 2014 when Affordable Insurance Exchanges begin operation. The federal government will pay 100 percent of the cost of the Medicaid expansion for the first three years and at least 90 percent after that. The policies announced on March 16 were first proposed in August 2011. FMI: See http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html.
**PARF NEWS**  
**Dateline: March 16, 2012**

**HHS OIG Investigates Documentation of Coverage Requirements for Medicare**

On March 12 the US Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released its study *Documentation of Coverage Requirements for Medicare Home Health Claims (OEI-01-08-00390)* and reported on the high error rate in submission of claims for home health services and significant overpayment and underpayment of claims. HHS OIG said that it conducted its study because of the accelerated growth in home health agencies. The number of home health agencies (HHA) grew from 7,052 in the year 2002 to 9,801 in the year 2008 - a total of 39 percent. More importantly, Medicare spending on home health had increased 84 percent from $8.5 billion in 2000 to $15.7 billion in 2007. That rise in home health spending caused greater concern over the potential for improper payments due to fraud and abuse. In its review of the medical records of home health care HHS OIG has found that the home health agencies submitted 22 percent of claims in error because services were not medically necessary or claims were coded inaccurately. HHS has estimated that the errors resulted in $432 million in improper Medicare payments. HHS OIG found also that home health agencies up-coded (i.e., billed at a level higher than warranted) about 10 percent ($278 million) of claims and down-coded (i.e., billed at a level lower than warranted) about 10 percent ($184 million) of claims. HHS concluded that further investigations beyond the medical record are needed to determine whether Medicare beneficiaries are eligible, services are furnished, and Medicare requirements for payment are met. For a copy of the HHS OIG report OEI-01-08-00390 see [http://go.usa.gov/Ppk](http://go.usa.gov/Ppk) and [http://oig.hhs.gov](http://oig.hhs.gov).

**CMS Posts Draft LTCH CARE Data Set Version 1.00.1 Specifications**


**CMS Proposes Coverage for Electrical Nerve Stimulation for Chronic Low Back Pain**

On March 13 the Centers for Medicare and Medicaid Services (CMS) posted a proposed decision memo on Electrical Nerve Stimulation for Chronic Low Back Pain. The decision memo is at: [https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=256](https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=256). In its draft posted decision memo CMS proposes coverage for Transcutaneous Electrical Nerve Stimulation (TENS) for chronic low back pain when certain conditions are met. CMS is requesting public comments to this proposed decision pursuant to section 1862(l) of the Social Security Act (the Act). CMS says that the public comment period closes on April 12, 2012. After consideration of the public comments and any additional evidence, CMS will issue a final determination responding to the public comments. FMI: See [www.cms.gov](http://www.cms.gov).
CMS Expands Community-based Care Transitions Program

On March 14 Centers for Medicare & Medicaid Services (CMS) announced twenty-three (23) additional participants in the Community-based Care Transitions Program (CCTP). These participants will join seven (7) other community-based organizations already working with local hospitals and other healthcare and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care setting. CCTP is designed specifically to provide support for high-risk Medicare beneficiaries following a hospital discharge. These 23 sites will work with CMS and local hospitals to provide support for patients as they move from hospitals to new settings, including skilled nursing facilities and home. CCTP is part of the Partnership for Patients, a public-private partnership aiming to cut preventable errors in hospitals by 40 percent and reduce preventable hospital readmissions by 20 percent over a three-year period. As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high-risk for readmission to the hospital. The 23 sites will join the seven organizations announced in November 2011, bringing the total number of sites to 30. This is the second round of CCTP participants announced since the program was launched in April 2011. FMI: See http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313. See also http://www.HealthCare.gov/PartnershipForPatients. For the CMS press release see http://www.CMS.gov/apps/media/press/release.asp?Counter=4302.

CMS Delays Enforcement of Change to Version 5010 Standards

On March 15 Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS) announced that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0. The deadline for the change to 5010 standards was January 1. CMS said that steady progress in the conversion is being made and that the Medicare Fee-for-Service program was successfully processing 70% of Medicare Part A claims and more than 90% of Part B claims in the 5010 format. CMS said that it is aware that there are still a number of outstanding issues and challenges impeding full implementation and that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS says that it is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. OESS says that the Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions. The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. FMI: See www.cms.gov. CMS said that issues related to implementation problems with the states may be sent to Medicaid5010@cms.hhs.gov.
CMS Aims to Reduce Use of Antipsychotic Medications in Nursing Homes

On March 29 at 1:00 p.m. the Centers for Medicare & Medicaid Services (CMS) will be offering a one-hour premiere presentation via video stream broadcast to launch its Initiative to Improve Behavioral Health and Reduce Use of Antipsychotic Medications in Nursing Home Residents. The CMS national action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors. Patrick Conway (MD, MSc, Chief Medical Officer for CMS and Director of the Office of Clinical Standards and Quality), Shari Ling (MD, CMS, Deputy Chief Medical Officer serving in the Office of Clinical Standards and Quality), and Alice Bonner (PhD, RN, Director for the Division of Nursing Homes in the Office for Clinical Standards and Quality) will be providing an overview of this national initiative and resources for technical assistance, discussion of behavioral health opportunities, and plans for upcoming training sessions. Handouts for the broadcast are available at http://surveyortraining.CMS.hhs.gov. Registration and viewing instructions can be found at http://surveyortraining.CMS.hhs.gov. The program will continue to be available for viewing for up to one year.

CMS Launches Initiative on Avoidable Hospitalizations among Nursing Facility Residents

On March 15 Centers for Medicare & Medicaid Services (CMS) announced its Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, a new effort designed to improve care for people living in nursing facilities who are enrolled in Medicare and Medicaid. The initiative aims to reduce costly and avoidable hospitalizations among nursing facility residents by funding organizations that would partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents. CMS has committed up to $128 million to support various evidence-based interventions. The initiative will be run collaboratively by the CMS Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation. Through this initiative, CMS will partner with independent organizations to improve care for long-stay nursing facility residents. These organizations will collaborate with nursing facilities and states to provide coordinated, person-centered care with the goal of reducing avoidable hospital stays. Eligible organizations can include physician practices, care management organizations, and other public and not-for-profit entities. CMS issued a Request for Applications on March 15. Organizations interested in participating in this initiative must submit an application by June 14, 2012. More information about this initiative, including the Request for Applications, is available at http://Innovation.CMS.gov/initiatives/rahnfr, or by searching for CFDA 93.621 at www.Grants.gov. The full text of the CMS press release issued on March 15 can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4303. A media factsheet can be found at http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4304

CMS Forum on Medicare Prior Authorization for Power Mobility Devices Demonstration

On March 13 Centers for Medicare and Medicaid Services (CMS) posted a notice that its open door forum on Medicare's Prior Authorization for Power Mobility Devices Demonstration would be held on Wednesday, March 21, 2012 from 3:00 p.m. to 4:30 p.m. ET. The call will be a conference call only. To participate, dial: (866) 501-5502 & Conference ID: 61952238. FMI: See http://www.cms.gov/OpenDoorForums/18_ODF_Hospitals.asp.