Dateline: November 2, 2012

PA YTD Revenues for FY 2012-2013 Higher Than Expected

Pennsylvania’s revenue picture is better than was anticipated by the FY2012-2013 state budget. For the second consecutive month revenue collections have exceeded estimates. On November 1 the PA Department of Revenue reported that Pennsylvania collected $2 billion in General Fund revenue in October, which was $71.5 million, or 3.6 percent, more than anticipated. Fiscal year-to-date General Fund collections total $8.1 billion, which is $82.2 million, or 1 percent, above estimate. Personal income tax and corporation tax collections as well as realty transfer tax revenues were all higher than expected. Personal income tax (PIT) revenue in October was $867.6 million, $14.5 million above estimate. This brings year-to-date PIT collections to $3.3 billion, which is $38.9 million, or 1.2 percent, above estimate. October corporation tax revenue of $164.5 million was $49.8 million above estimate. Year-to-date corporation tax collections total $869.7 million, which is $136.2 million, or 18.6 percent, above estimate. Realty transfer tax revenue was $31.8 million for October, or $6.9 million above estimate, bringing the fiscal-year total to $120.4 million, which is $4.8 million, or 4.2 percent, more than anticipated. Sales tax receipts, inheritance tax revenue, and other general tax fund revenue were lower than budgeted. Sales tax receipts totaled $755.3 million for October, $2.9 million below estimate. Year-to-date sales tax collections total $3 billion, which is $73.2 million, or 2.4 percent, less than anticipated. Inheritance tax revenue for the month was $67.2 million, $7.2 million below estimate, bringing the year-to-date total to $257 million, which is $25.2 million, or 8.9 percent, below estimate. FMI: See www.revenue.state.pa.us. See also http://www.revenue.state.pa.us/portal/server.pt/community/revenue_home/10648.

Governor Corbett Signs House and Senate Bills into Law

On October 24 PA Governor Tom Corbett signed several recently approved bills into law. They include: (a) House Bill 140, which establishes the Methadone Death and Incident Review Team to review and examine the circumstances surrounding methadone-related deaths and provides for its powers and duties; (b) House Bill 1548 which regulates child labor and repeals and replaces the former Child Labor Law in its entirety; (c) House Bill 2407 which amends the Older Adults Protective Services Act allowing electronic fingerprinting process for FBI background checks of prospective facility personnel; (d) Senate Bill 444 which amends the Local Option Small Games of Chance Act further providing for definitions, games permitted, major league sports drawings, exceptions, registration, distribution of proceeds and enforcement; (e) Senate Bill 623, amending Title 51 (Military Affairs) providing for contracting with veteran-owned small businesses and service-disabled veteran-owned small businesses, establishing an annual goal of not less than 3 percent contracting participation by veteran-owned small business, and requiring annual reports on actual utilization of veteran-owned small businesses; (f) Senate Bill 1144 which amends the Health Security Act defining "covered dentist services" and prohibiting insurers from setting fees for non-covered dentist services; and (g) Senate Bill 1480 which provides for the capital budget for the fiscal year 2012-2013. To read the bills, visit the General Assembly’s website at www.legis.state.pa.us. For updates from Governor Corbett see www.governor.pa.gov.
PA Expected to Miss Deadline for State-Run Health Insurance Exchange

As states face deadlines for complying with provisions of the Affordable Care Act, Pennsylvania Insurance Commissioner Michael Consedine said on October 17 that the Commonwealth of Pennsylvania would most likely not have a state-run health insurance exchange up and running by January 2014. It is anticipated that that the Commonwealth will not meet the November 16 deadline for submitting a blueprint to the U.S. Department of Health and Human Services. In his comments on October 17 PA Insurance Commissioner Consedine suggested that Pennsylvania might opt for the federally run exchange at first and consider switching to a state-run exchange at a later time. FMI: See the Associated Press report at http://www.eveningsun.com/ci_21792678/pa-health-insurance-exchange-plan-stalls.

No Decision on Medicaid Expansion in PA

Pennsylvania Governor Tom Corbett has not yet announced a decision on the expansion of Medicaid in Pennsylvania. The Affordable Care Act (ACA) of 2010 creates a national Medicaid minimum eligibility level of 133% of the federal poverty level ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion goes into effect on January 1, 2014, but states can choose to expand coverage with Federal support anytime before this date. Currently Florida, Georgia, Louisiana, Mississippi, South Carolina and Texas have rejected the Medicaid expansion. Arkansas, California, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Rhode Island, Vermont and Washington are expanding. The other states remain undecided. Idaho has engaged consulting firms to explore the option of expanding Medicaid coverage. See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html. See related Federal Policy Guidance at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10005.PDF. To review the eligibility provisions in the Affordable Care Act see http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html.

DPW Cross-Checks Federal and State Benefits

On October 24 the PA Department of Public Welfare (DPW) announced that it has identified more than 900 Pennsylvanians who were receiving welfare benefits when they should not have been. DPW said that it was able to identify ineligible individuals by using the federal Public Assistance Reporting Information System, also known as PARIS. PARIS is a federal-state partnership that includes a nationwide exchange of information and data about various welfare and pension programs from every state in the country. By checking records with the U.S. Departments of Veterans Affairs, Defense and Personnel Management, and by using state-to-state information sharing, PARIS helped identify 933 incidences where individuals were not eligible for state welfare benefits or should have been receiving fewer benefits. For more information about the Department of Public Welfare (DPW), visit the department’s website at www.dpw.state.pa.us.
DPW & CLS Agree on Reinstatement of Individuals in PA Medical Assistance Program

On October 23 Community Legal Services (CLS) announced that it had arrived at a legal settlement with the PA Department of Public Welfare (DPW) concerning 130,000 individuals whom were dropped from the state’s Medical Assistance program between August 2011 and January 2012. In accord with the settlement agreement DPW will review and potentially reinstate thousands of those individuals who had been determined to be ineligible for Medical Assistance. DPW also agreed to send letters to 100,000 people inviting them to be enrolled in Medical Assistance by completing a simple two-page form. (See story below.) The settlement also enables individuals who lost their benefits last year and incurred medical bills to see those bills resolved if the state determines the individuals had actually been eligible for Medicaid but had been removed from the program improperly. FMI: See news report of Philadelphia Inquirer at http://www.philly.com/philly/health/20121024_Deal_may_reinstate_Pennsylvania_residents_dropped_from_Medicaid.html.

DPW Process for Expedited Reinstatement into PA Medicaid Program

In accord with the October 23 legal settlement on the determination of eligibility for PA Medical Assistance (see above), starting in late October or early November 2012 the Pennsylvania Department of Public Welfare (DPW) will send a letter on blue paper to approximately 100,000 individuals who were terminated from Medical Assistance in the past year, advising them how they may seek expedited reinstatement of their benefits. Enclosed with this letter will be a simple 2-page form to fill out. Individuals have 30 days to fill out the form and return it to DPW. Along with the form, individuals should also provide (a) pay stubs if anyone in the household works and (b) unpaid medical bills from the time they did not have Medical Assistance or receipts from medical bills paid while they did not have Medical Assistance. The form or supporting documentation should not be returned to a local County Assistance Office because all reinstatement forms will be reviewed in a central location. Instead, the form should be returned in the envelope provided. Decisions on eligibility will be made within 30 days unless more information is needed. County specific legal aid phone numbers were listed on the blue letters. FMI: Contact Justine Elliot at CLS at 215-981-3721. FMI: For the final version of the blue letter and reinstatement form as well as project updates see www.clsphila.org/News.aspx.

Community Legal Services to Assist Applicants for Reinstatement in PA Medical Assistance

In implementing the October 23 legal settlement on the determination of eligibility for PA Medical Assistance (see above), Community Legal Services (CLS) says that it eager to keep track of any problems with the rapid reinstatement process established under the legal settlement on Medicaid eligibility, including: Difficulty reaching the 800 number listed on the blue letter; difficulty receiving reimbursement for paid medical bills or receiving payment for unpaid medical bills; problems with lost paperwork; problems with receiving an eligibility decision within 30 days (unless more information is needed, in which case a decision should be made within 45 days); and appeals not being properly processed or resolved In Philadelphia, inquiries can be made to the CLS helpline dedicated to this initiative. The helpline number is 267-765-6494. FMI: Contact Justine M. Elliot, Staff Attorney (Email: Jelliot@clsphila.org) or Richard P. Weishaupt, Senior Attorney (Email: Rweishaupt@clsphila.org) at Community Legal Services, Inc., 1424 Chestnut Street, Philadelphia, PA 19102. Ph: 215-981-3721. Fax: 267-765-6481.
DPW MAAC Reviews Health Choices Expansion

On October 25 at the regular meeting of the DPW Medical Assistance Advisory Committee (MAAC) the DPW Office of Medical Assistance Programs (OMAP) reported on the status of the expansion of DPW’s managed care program HealthChoices and changes in payment policies. Concerning expansion of HealthChoices, OMAP officials reported that the New West expansion was implemented on October 1 with approximately 124,000 recipients moving into HealthChoices. (Approximately 49,000 to 50,000 people remain in traditional Fee-For-Service program.) Network development is continuing, since there are still concerns with access, particularly in pediatric and obstetrics/gynecological services. Concerning the New East expansion which involves 22 counties and approximately 210,000 people, OMAP officials said that readiness review is underway and open enrollment is scheduled for January 11, 2013 through February 7, 2013. DPW plans extensive outreach efforts, including: meetings with community based organizations, town hall meetings with DPW and health plan staff, trainings for parents with DPW and Pennsylvania Health Law Project staff, local meetings with provider associations, and expanded outreach to hospitals. FMI: Contact parfmail@parf.org.

DPW MAAC Updated on MA Payment Changes

At the October 25 meeting of the DPW Medical Assistance Advisory Committee (MAAC) the DPW Office of Medical Assistance Programs (OMAP) reported on the status of the expansion of DPW’s managed care program HealthChoices and changes in payment policies. (See above story on Health Choices Expansion.) Concerning changes in payment policies OMAP reported that a public notice published in the October 27, 2012 Pennsylvania Bulletin officially announces the delay in implementing co-payments for children services effective October 5, 2012. It was noted that any co-payments charged to date would be refunded. Officials also announced that DPW has decided to implement a primary care practitioner (PCP) fee increase effective January 1, 2013. DPW will pay up to 100% of the Medicare rates for certain primary care specialties (family practice, internal medicine, general practitioner, and pediatric), where at least 60% of the services are primary care services. Physicians must submit copies of their Board Certification to MA Enrollment in order to be eligible for the increase. A public notice is forthcoming. OMAP said that the terms of this policy could change once a final rule is issued by the Centers for Medicare and Medicaid Services (CMS). DPW officials also reported on upcoming changes in PROMISe concerning electronic documents, the national correct coding initiative, and national provider identification (NPI). Concerning electronic documents: beginning in the first quarter of 2013, DPW will discontinue mailing paper copies of Prior Authorizations (including ODP); Program Exceptions (including Behavioral Health); Benefit Limit Exceptions; Place of Service Reviews; Automated Utilization Reviews; and Provider Enrollment Letters (excluding letters related to initial enrollment and termination). The documents will be emailed to a provider mailbox unless a provider opts out because of lack of internet access or financial hardship and submits an attestation form to that effect. Providers must have a PROMISe portal ID and updated email addresses in order to receive documents. Concerning the federally mandated National Correct Coding Initiative (NCCI), it was also reported that Phase 2 of the NCCI will be implemented on or after November 1. FMI: Contact parfmail@parf.org. See also www.dpw.state.pa.us for future postings of the minutes of the DPW MAAC meetings. Also see PARF News story below DPW Publishes Notice of Delay in Implementing MA Co-Payments for Children Services.
DPW Publishes Notice of Delay in Implementing MA Co-Payments for Children Services

In the October 27, 2012 edition of the Pennsylvania Bulletin the PA Department of Public Welfare (DPW) published a public notice announcing its delay in implementation of alternative cost sharing for families of children with disabilities with incomes over 200% of the federal poverty income guidelines. DPW had previously published a public notice in the Pennsylvania Bulletin on September 29, 2012 announcing the implementation of copayments for services provided to children eligible for Medical Assistance (MA) under the MA for Children with Special Needs category with family income above 200% of the Federal Poverty Income Guidelines. The copayments were to be effective for dates of service on and after October 1, 2012, for newly eligible beneficiaries and November 1, 2012, for current beneficiaries. DPW said that based upon feedback from families, stakeholders and other interested parties, DPW has decided to delay the implementation of copayments. Families of children eligible for MA under this category of assistance will not owe a copayment for any services until further notice. DPW says that many stakeholders have acknowledged the need for cost sharing in the MA for Children with Special Needs program and have indicated that a premium would be preferred over copayments. The Department says that it agrees, but has been unable to implement premiums because the Centers for Medicare and Medicaid Services (CMS) has taken the position that implementing premiums violates the Maintenance of Effort provisions of the Affordable Care Act. DPW further says that delaying the implementation of copayments will allow the Department the opportunity to work with stakeholders and to seek approval from CMS to apply premiums or to identify and implement other cost-sharing alternatives. DPW says that once a decision has been reached, families will receive advance notice of their cost-sharing requirements. DPW estimates that this delay is anticipated to result in costs of $9.405 million ($4.300 million in State funds) in the MA Outpatient Program in Fiscal Year 2012-2013 and annualized costs of $12.540 million ($5.813 million in State funds) in Fiscal Year 2013-2014. Interested persons are invited to submit written comments regarding this notice to the Department of Public Welfare, Office of Medical Assistance Programs, c/o Deputy Secretary's Office, Attention: Regulations Coordinator, Room 515, Health and Welfare Building, Harrisburg, PA 17120. Comments received within 30 days will be reviewed and considered in the development of subsequent notice. FMI: See http://www.pabulletin.com/secure/data/vol42/42-43/2112.html

PA House Approves Bill Requiring Income Verification for Weatherization Assistance

On October 18 the PA House of Representatives passed a bill (House Bill 1991) requiring the use of a 19-point electronic system to verify the income of recipients receiving energy assistance through the Low-Income Home Energy Assistance Program (LIHEAP). The bill also imposes the same requirement on Department of Community and Economic Development (DCED) program providing weatherization services. The bill also strengthens fraud reporting measures and expands whistleblower protections for these programs. House Bill 1991 has been sent to the governor for his approval. For information on this bill see www.state.pa.us and www.legis.state.pa.us.
PA Supreme Court Asked to Act on GA Cut, Human Services Block-Grant

On October 31 the Pennsylvania Supreme Court was presented with an appeal of the PA Commonwealth Court’s decision to reject a request for a court injunction to stop Act 80. To speed up the process, a request will be made to the Pennsylvania Supreme Court on November 5 to expedite consideration of the appeal. The petitions to the PA Supreme Court come as a result of the decision by the PA Commonwealth Court that was presented on October 25 that it would not issue a preliminary injunction to stop implementation of Act 80. (See below – PA Commonwealth Court Holds Hearing on Block Grants, Elimination of GA – for an account of the hearing held by Commonwealth Court on the request for a preliminary injunction to stop Act 80.) Act 80 eliminates the state General Assistance cash grants and establishes a block grant program to fund human services administered by Pennsylvania’s counties. In its decision on the request for an injunction the PA Commonwealth Court offered very little comment on the request for the preliminary injunction and dismissed the legal arguments against Act 80. The rejection by the Commonwealth Court, the appeal to the Supreme Court, and the request for an expedited review by the Supreme Court follow the filing of a lawsuit Billie Washington v. Department of Public Welfare. The individual petitioners in this case are Ms. Billie Washington, Opal Gibson, and Tina Smith. Organizational petitioners include the Disability Rights Network, Community Legal Services, and Pennsylvania Community Providers Association. Community Legal Services is seeking more information about the effects of eliminating General Assistance on individuals and organizations. The survey for individuals who lost their General Assistance benefit is at http://pacaresforall.org/?page_id=441. The survey for organizations assisting individuals who lost their General Assistance is at http://pacaresforall.org/?page_id=493. For a posting on the lawsuit by the Disability Rights Network see http://www.drnpa.org/drn-files-lawsuit-to-challenge-constitutionality-of-act-80-of-2012/.

PA Commonwealth Court Holds Hearing on Block Grants, Elimination of GA

On October 23 the PA Commonwealth Court held a hearing in Harrisburg on the lawsuit to enjoin Act 80, the law that eliminates the General Assistance Cash Assistance program. Sister Mary Scullion (Project HOME) and Debbie Plotnick (Mental Health Association of Southeastern PA) testified on the harm caused by the elimination of the PA General Assistance Cash Assistance program. Billie Washington, the named petitioner in the lawsuit, testified about her experience since GA Cash Assistance program was eliminated. George Kimes (Pennsylvania Community Providers Association - PCPA) and Pennsylvania representative Gene DiGirolamo (R–Bucks) testified on the potential harm of the pilot block grant program that was established by Act 80. In opposition to the injunction, the Commonwealth offered testimony by four witnesses: two testifying about the pilot block grant program, one about the nursing facilities assessment program, and a fourth about the Department of Public Welfare budget. The court heard closing arguments on October 24. For an update and review see above story Appeal Filed with PA Supreme Court. FMI: See http://clsphila.org/NewsItem.aspx?id=277&newsArea=home. Concerning the October 24 hearing see http://www.witf.org/state-house-sound-bites/2012/10/judge-hears-arguments-over-request-to-halt-elimination-of-cash-grants-for-poor-other-changes.php and http://www.philly.com/philly/news/20120107_Suit_challenges_elimination_of_Pa__general_assistance.html.
ODP Providers Notified of Deadline for Filing of Year 5 Cost Reports

On October 25 the PA DPW Office of Developmental Programs (ODP) issued ODP Announcement 097-12 providing a reminder of a deadline for submission of ODP Year 5 Desk Review Procedures and Cost Reports. The announcement informs providers and administrative entities that the cost report desk review procedures have been posted to the ODP Consulting website for residential providers to reference as they are completing their cost report. The final deadline for submitting cost reports and supplemental schedules for Year 5 was Thursday, November 1, 2012 at 11:59 pm Eastern. FMI: See www.odpconsulting.net.


On October 23 the PA DPW Office of Developmental Programs (ODP) distributed ODP Memorandum 095-12 to announce the availability of the Individual Support Plan (ISP) Manual 2012 Update course and to provide direction on accessing the online learning opportunity. The training is required for Supports Coordinators (SCs) and SC Supervisors supporting individuals with an Intellectual Disability and provides four (4) credit hours for 2012 SC Required Training. Administrative Entity staff members responsible for waiver oversight, ISP approval and authorization are also required to view these webcasts. ODP strongly recommends that Provider staff view the webcasts in order to better understand the roles and responsibilities of all ISP team members involved in ISP development and implementation. The number of training credit hours offered for this course has changed to reflect the amount of content material and activity. This is a change of the information provided in ODP Announcement #074-12. However, the total number of ODP Required Training hours for Calendar Yr. 2012 (15 hours) is unchanged. This is a change of the information provided in ODP Announcement 074-12. However, the total number of ODP Required Training hours for 2012 (15 hours) is unchanged. FMI: See www.odpconsulting.net.

ODP Publishes Bulletin on Requirements for Individual Support Plans

On October 19 the PA Department of Public Welfare (DPW) Office of Developmental Programs distributed a final bulletin entitled, 00-12-05, Individual Support Plans (ISP), Effective July 1, 2012. The purpose of the bulletin is to establish the DPW Office of Developmental Programs’ requirements for Individual Support Plans (ISP) which are outlined in the ISP manual. The manual identifies services and definitions and the standardized processes for preparing, completing, documenting, implementing, and monitoring ISPs to ensure they are: (1) developed to meet the needs of an individual; (2) developed and implemented using the core values of Everyday Lives, Positive Approaches and Practices and Self Determination to result in an enhanced quality of life for every individual who receives intellectual disability services and supports in Pennsylvania; and (3) coordinated with the approved Consolidated and Person/Family Directed Support (P/FDS) Waivers and 55 Pa. Code Chapter 51 Office of Developmental Program's Home and Community Based Services regulations. FMI: For a copy of the bulletin see http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4862. See also www.dpw.state.pa.us and www.odpconsulting.net.
IRRC Scheduled to Act on Regulations from State Board of Physical Therapy

On November 15 the PA Independent Regulatory Review Commission (IRRC) at its regular meeting is scheduled to review State Board of Physical Therapy #16A-6514: Act 38 of 2008 Amendments. This rulemaking sets standards for required continuing education for all physical therapists and physical therapist assistants, not solely those physical therapists who are certified for direct access. The rulemaking sets standards for required professional liability insurance for all physical therapists, not solely those who are certified for direct access. The rulemaking also implements the relaxed standards for supervision of a physical therapist assistant by a physical therapist, including identifying the required level of supervision for practice settings not clearly specified in section 9.1(c)(3) of the act. Further, the rulemaking revises the language throughout the regulations to refer to certification, rather than the registration, of physical therapist assistants. See http://www.irrc.state.pa.us/regulation_details.aspx?IRRCNo=2910.

PARF Human Resources Committee Reviews FCRA Background Checks

At its October 24 meeting the PARF Human Resources Committee reviewed background-checking procedures and new forms required to ensure compliance with applicable federal and state laws. The new forms for Fair Credit Reporting Act (FCRA) Background Checks are effective January 1, 2013. The FCRA regulates employers that use credit reporting agencies to conduct background checks for hiring, promotion or other employment-related decisions. At the meeting PARF and invited members of the Pennsylvania Community Providers Association (PCPA) discussed the requirements of the new federal agency, the Consumer Financial Protection Bureau (CFPB) which has replaced the Federal Trade Commission (FTC) as the primary rulemaking and enforcement authority for background checking of individuals under the federal Fair Credit Reporting Act (FCRA). CFPB Summary of Consumer Rights form used by employers and forms used by consumer reporting agencies (CRA) were reviewed. Since no substantive changes have been made in the FCRA background-checking procedures, the new Summary of Consumer Rights must be provided as part of the Pre-Adverse Action Notice packet. The Summary of Consumer Rights must be given when disclosing the nature and scope of "investigative consumer reports," which are conducted via personal interviews by a CRA. Members agreed that employers should revisit their background-checking procedures and forms to ensure compliance with applicable federal and state laws. For more information on the PRAF Human Resources Committee and for the most recent PARF HR Committee packet, contact PARF at parfmail@parf.org.

Teleconference on Social Security Work Incentives on November 8

A Statewide Employment Community of Practice teleconference will be held on Thursday, November 8, 2012, beginning at 10:00 a.m. The focus of the call will be Social Security Work Incentives—What do I Need to Know? presented by John Miller, Vice President, AHEDD. The teleconference will use a power point that may be viewed online during the call. To call-in and log-in: Call Conference Bridge Number: 717-612-4788; Toll-free Bridge Number: 1-855-734-4390; and enter PIN Number: 465140. See Web Conference Provider: Open Scape Web Collaboration; URL: https://openscapedev.conf1.pa.gov/client/fastclient_i_r161246E5.exe. FMI: Contact Angela Roland at aroland@pa.gov or (717) 705-8280.
OLTL Provider Meeting Scheduled for November 27

The Commonwealth’s Office of Long-Term Living in conjunction with the Long Term Living Training Institute (LTLTI) will be hosting a provider meeting on November 27, 2012, at the Radisson Hotel Harrisburg in Camp Hill, PA. Registration starts at 8:00 am. Meeting times are 9:00 am - 4:00 pm. There is no fee, but pre-registration is required. The registration deadline is November 21, 2012. Mail completed form to LTLTI, 525 S. 29th Street, Harrisburg, PA 17104, or fax form to LTLTI at (717) 541-4217. The HCBS Provider Meeting will cover the following topics: updates on Office of Long-Term Living, Bureau of Individual Support, Bureau of Provider Support; Quality Management, Metrics and Analytics update; policy and finance updates; and the OIM Refresher. OLTL is limiting attendance to two representatives per agency. As space allows, OLTL will alert provider agencies of additional openings on a first requested, first granted basis. Breaks and lunches are provided. Fax completed form to 717-541-4217, or mail completed registration form to LTLTI, 525 S. 29th Street, Harrisburg, PA 17104. Cancellations must be received 96 business hours before each seminar. Inquiries or requests for special accommodations of any kind should be directed to the Long Term Living Training Institute at (717) 541-4214. Please call the Radisson at (717) 763-7117 for overnight room availability. FMI: Contact PARF at parfmail@parf.org.

Novitas Solutions Issues Alert on Recovery Audit Prepayment Review Demonstration

On October 23 the Medicare-intermediary Novitas Solutions issued an alert to providers concerning additional development requests (ADR) sent for the Recovery Audit Prepayment Review Demonstration. The ADR’s are developed and generated by the MAC in the same format as other prepay reviews, such as Medical Review ADR’s. Novitas noted that medical records requested in coordination with the Recovery Audit Prepayment Review Demonstration should be sent to the Recovery Auditor for the region. The address for submission of medical records is noted in the body of the documentation request. Novitas said that timely submission of the medical records to the Recovery Auditor will prevent unnecessary denials. Novitas asked providers to review all ADR’s to determine the correct contractor for review. It said that Recovery Auditor Prepayment Review Demonstration medical records should not be submitted to Novitas. See https://www.novitas-solutions.com/parta/info-alerts.html.

DOL Focus on Workplace Hazards and Healthcare Workers

Workplace hazards – blood-borne pathogens, needle sticks, falls, patient lifting, exposure to chemicals, etc. – and other safety concerns of front-line healthcare workers were the focus of a meeting on Frontline Hospital Workers and Worker/Patient Safety Relationships held at the U.S. Department of Labor (DOL) on October 25, 2012. About 70 attendees from hospitals, academia, government, unions and professional organizations heard discussions that touched on research, intervention, data gaps, policy opportunities and next steps towards improving the safety and health of patients and healthcare workers. View the slideshow at http://www.dol.gov/dol/media/photos/slideshows/20121025-frontline.htm. Visit the OSHA Healthcare Safety Page at http://www.osha.gov/SLTC/healthcarefacilities/safetyculture.html.
Medicare Coverage for Therapy & Skilled Care Based on Need, Not on Improvement

Attorneys from the Center for Medicare Advocacy, Vermont Legal Aid and the Centers for Medicare & Medicaid Services (CMS) have agreed to settle the "Improvement Standard" case, Jimmo v. Sebelius, No. 11-cv-17 (D. Vt.) which was filed January 18, 2011 in the United States District Court for the District of Vermont. The proposed settlement agreement was filed in federal District Court on October 16, 2012. The “Improvement Standard” refers to a standard that plaintiffs have alleged (but that CMS denies) exists under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, without regard to an individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment, care or services in question. Upon federal district court approval of the agreement, that standard by which patients are deemed eligible to receive therapy services will be significantly changed. The Medicare Benefit Policy Manual will be revised to correct any suggestion that continued coverage is dependent on improvement of the beneficiary, and CMS will undertake an educational campaign that is directed to providers, contractors, and adjudicators to inform them that they should not be basing coverage on potential for improvement but on need for skilled care. It is expected that the coverage of therapy and skilled nursing services for Medicare beneficiaries with chronic conditions or disabilities will be expanded. Providers, contractors, and adjudicators will be directed to recognize maintenance coverage and a beneficiary's need for skilled care that is performed or supervised by professional nurses and therapists. Manual revisions will clarify that skilled nursing facility and home health coverage of nursing care does not turn on the presence or absence of an individual’s potential for improvement from the nursing care, but rather on the beneficiary’s need for skilled care. However, the maintenance coverage standard for therapy as outlined in this section does not apply to therapy services provided in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF). Coverage of inpatient rehabilitation facility (IRF) care will be affected. The agreement indicates “manual revisions will clarify that an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.” See documents listed below for specific terms of the agreement. Although approval of the proposed agreement by the court (a process that will take several months), the Center for Medicare Advocacy advises: “As CMS recognizes, the settlement does not change the underlying law and regulations governing the Medicare program. Accordingly, since the Medicare standards of care are not changed, health care providers should implement the maintenance standard now.” FMI: To obtain a comprehensive analysis of the proposed settlement and its implementation see http://www.medicareadvocacy.org/wp-content/uploads/2012/10/Settlement-Agreement-for-Web-00011098.pdf. To review the brief and related documents see http://www.medicareadvocacy.org/medicare-info/improvement-standard-2/. To read the New York Times exclusive: "Settlement Eases Rules for Some Medicare Patients", by Robert Pear See NYT article at http://www.nytimes.com/2012/10/23/us/politics/settlement-eases-rules-for-some-medicare-patients.html?_r=1&.
CMS Updates Physician Fee Schedule and Hospital Outpatient PPS, ASC

On November 1 the Centers for Medicare and Medicaid Services (CMS) issued two final regulations updating Medicare payment rates and policies in CY 2013 for services furnished by physicians and other practitioners, and hospital outpatient departments and ambulatory surgical centers. They are: (1) CY 2013 Medicare Physician Fee Schedule (MPFS) rule and (2) CY 2013 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) rule. The final CY 2013 MPFS rule will be published on November 16, 2012. It will take effect January 1, 2013 with a comment period that closes on December 31, 2012. Final Rule is at http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpxz3owe4))/OFRUpload/OFRData/2012-26900_PI.pdf. The CMS Fact Sheet on the CY 2013 MPFS rule is at https://www.cms.gov/apps/media/press/release.asp?Counter=4469. The final CY 2013 OPPS and ASC rule will be published on November 15, 2012. It will take effect January 1, 2013 with a comment period that closes on December 31, 2012. The Final Rule with comment period is at: http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpxz3owe4))/OFRUpload/OFRData/2012-26902_PI.pdf. The CMS Fact Sheet on the Hospital OPPS and ASC rule is at: https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4470&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

CMS Posts Home Health PPS Rate Update and New Survey Rules for CY 2013

On November 2 the Centers for Medicare and Medicaid Services (CMS) placed on display Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies. The final rule was put on display at the Office of the Federal Register on November 2, 2012. For a copy of the Medicare Home Health PPS Update and rules see http://www.ofr.gov/(X(1)S(kg1kqmwmyporibvzemxjggrc))/OFRUpload/OFRData/2012-26904_PI.pdf. This final rule updates Medicare's Home Health Prospective Payment System (HH PPS) payment rates for CY 2013. Payments to home health agencies (HHAs) are estimated to remain virtually unchanged (decreasing by approximately 0.01 percent or -$10 million). This reflects the net effect of a 1.3 percent home health payment update, an updated wage index, an update to the fixed-dollar loss (FDL) ratio, and a case-mix coding adjustment intended to offset coding changes unrelated to changes in patient health needs. The rule also rebases and revises the home health market basket and allows additional regulatory flexibility regarding therapy reassessments and face-to-face encounter requirements. FMI: See www.cms.gov

DOL Disability.gov Launches Campaign: ‘What’s Your Connection?’

The Disability.gov website has launched "What's Your Connection?" to commemorate the site's 10th anniversary. The initiative emphasizes that disability is a natural part of the human experience and focuses on the integral role people with disabilities play in American society. Disability.gov is managed by the U.S. Department of Labor's Office of Disability Employment Policy in collaboration with 21 federal agency partners. People nationwide can participate in the campaign by submitting a captioned photograph or video that answers the question "What's your connection to disability?" Submissions will be accepted through July 31, 2013. See www.disability.gov
Parf News
Dateline: November 2, 2012

CMS Finalizes the Provisions for Bad Debt Reductions for All Medicare Providers

On November 2 Centers for Medicare and Medicaid Services (CMS) issued a final rule that focused on Medicare policies and payment rates for End-Stage Renal Disease (ESRD) facilities but also included a provision on bad debt reimbursement affecting all Medicare providers eligible to receive bad debt reimbursement. In the rule CMS is codifying the provisions of section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012 (Pub L. No 112-96) that require reductions in bad debt reimbursement to all Medicare providers eligible to receive bad debt reimbursement. These provisions are specifically prescribed by statute and thus, are self-implementing. The rule (CMS-1352-F) can be viewed on the ESRD Payment website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html?redirect=/ESRDPayment/PAY/list.asp. The rule is also at http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpz3owe4))/OFRUpload/OFRData/2012-26903_PI.pdf.

Medicare Audit Improvement Act of 2012 Introduced

On October 16 Representative Sam Graves (MO-6) introduced the Medicare Audit Improvement Act of 2012 (H.R. 6575) in the U.S. House of Representatives. The bill was referred to both the Committee on Ways and Means and the Committee on Energy and Commerce. No major action has been taken on the bill at this time, nor is any scheduled. The House of Representatives is currently in recess and will remain out until after the election. Although any major action on the bill is not expected in the closing days of this session, a similar bill or other initiative will likely be introduced once Congress reconvenes in January 2013. The bill is specifically aimed at limiting audits against hospitals and establishing some protections against abusive auditing. FMI: See www.house.gov.

NASUAD Publishes 4th Edition of State Medicaid Integration Tracker

National Association of States United for Aging and Disabilities (NASUAD) has published the Fourth Edition of The State Medicaid Integration Tracker, a report which summarizes state actions in managed care for people who receive Medicaid-funded Long-Term Services and Supports (LTSS), as well state initiatives relating to services for people who are dually eligible for Medicaid and Medicare. This report will be updated each month. FMI: See http://www.nasuad.org/medicaid_integration_tracker.html. The State Medicaid Integration Tracker focuses primarily on state actions in managed care for people who receive Medicaid-funded LTSS and on state initiatives relating to services and costs of services for people who are dually eligible for Medicaid and Medicare. Because so many states have informed the federal Center for Medicare and Medicaid Innovation that they intend to participate in the State Demonstrations to Integrate Care for Dual Eligible Individuals, the Tracker pays close attention to the status of state participation in this demonstration. The Tracker also includes updates on states participating in the Balancing Incentive Program (BIP), states developing or implementing Medicaid State Plan amendments under §1915(i), and states pursuing the Communities First Choice Option under §1915(k). The Integration Tracker can be found on the NASUAD website at http://www.nasuad.org/medicaid_integration_tracker.html. For a printable copy of the tracker, see http://www.nasuad.org/documentation/nasuad_materials/Medicaid%20Tracker/Medicaid%20Tracker%20-%20October%20Edition.pdf.