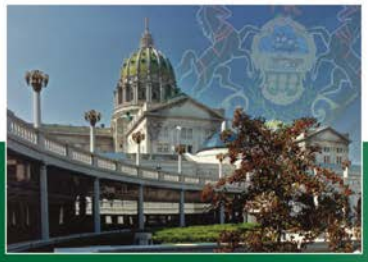


REPORT ON KEY ISSUES FROM THE HOUSE APPROPRIATIONS COMMITTEE

# BUDGET BRIEFING

DWIGHT EVANS, DEMOCRATIC CHAIRMAN

November 5, 2009

## 2009/10 Budget: Medical Assistance

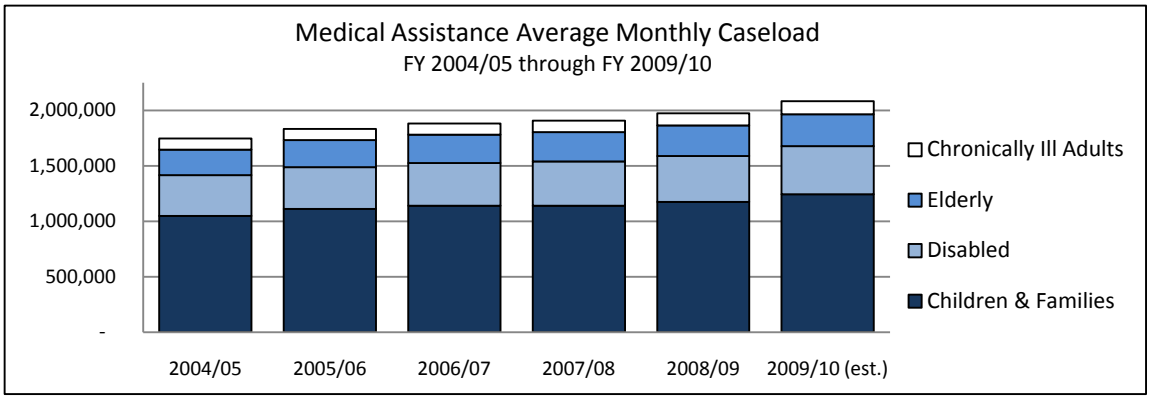
**Medical Assistance is the largest component of the Department of Public Welfare** (DPW) budget, consuming 47.5 percent of state General Funds and nearly 62 percent of total funds (state, federal and other). Medical Assistance (MA) is the name of Pennsylvania's Medicaid program. It provides federally-entitled Medicaid benefits to eligible individuals and state-funded General Assistance benefits for adults who do not qualify for Medicaid, but meet standards established by Pennsylvania.

MA eligibility is based on various factors such as income, financial resources (assets), age and health care needs. MA is an entitlement for those who meet eligibility requirements – entitlement means that people eligible for the program are guaranteed benefits and the state must pay for them.

- Medicaid groups entitled to coverage include: low-income pregnant women; low-income children; and persons receiving federal SSI benefits (low-income aged, blind, or disabled individuals). It also includes low-income families who are eligible for TANF benefits, regardless of whether they actually take the cash grant. In Pennsylvania, TANF eligibility is limited to the very poor with household income below 50 percent of the federal poverty level.
- General Assistance recipients are typically low-income adults without dependent children who have a permanent or temporary disability that precludes employment.

The greatest share of MA funding is for the elderly and people with disabilities, reflecting their intensive use of acute and long-term care services. **Although the elderly and disabled represent just over one-third of all recipients, they account for more than two-thirds of projected MA expenditures.** By contrast, low-income families represent the majority of MA recipients, yet they account for about one-fourth of all MA spending.

More than two million individuals (or **one out of six Pennsylvanians**) receive MA benefits. Average monthly eligibility is projected to be nearly 2,083,800 during 2009/10, an increase of 109,000 (or 5.5 percent) over 2008/09. Approximately 60 percent of MA recipients are low-income families and children, 21 percent are disabled individuals, 14 percent are elderly, and six percent are chronically ill adults.



The projected growth in MA caseload reflects the impact of rising unemployment during the current economic downturn. Pennsylvania's unemployment rate was 8.8 percent in September 2009 and according to IHS Global Insights (the economic forecasting firm for the Commonwealth), unemployment is expected to peak close to 9.1 percent in early 2010. With Pennsylvanians losing employer-sponsored insurance coverage and household incomes declining, an increasing number of individuals and their families will become eligible for MA benefits in 2009/10.

MA services are delivered either on a traditional fee-for-service basis or through managed care plans. Most MA recipients (an estimated 60 percent) receive coordinated health care services through the managed care program. The remaining MA recipients receive their care through the fee-for-service program.

Five appropriations account for most of MA spending and are the focus of this budget briefing. Managed care is funded through the **Capitation** appropriation. The fee-for-service program is funded through the **Outpatient** and **Inpatient** appropriations. Nursing facility and home-and community-based services are funded through **Long Term Care**. A new appropriation, **Payment to Federal Government – Medicare Part D**, was established in 2006/07 to fund the monthly payments that Pennsylvania is mandated to make to the federal government to help finance the Medicare Part D drug benefit which began in January 2006.

## Funding Sources

MA is jointly funded by the federal government and the state, with the federal government providing a match for state spending on Medicaid expenses. The 2009/10 budget for the five major MA appropriations totals $14.671 billion in state, federal and other funds. Federal Medicaid matching funds account for $9.254 billion (or 63 percent) of the MA budget -- $7.869 billion is the regular federal match and $1.386 billion is the enhanced ARRA FMAP.

- Each state's match, or Federal Medical Assistance Percentage (FMAP), is determined annually through a formula, specified in the Social Security Act, which is based on per capita income. Per this formula, each state's FMAP is adjusted every October 1. Pennsylvania's regular FMAP increased from 54.42 percent to 54.81 percent, effective October 1, 2009.
- The American Recovery and Reinvestment Act (ARRA) temporarily increases each state's FMAP for the nine quarters beginning October 2008 through December 2010. In accordance with formulas in the ARRA, Pennsylvania will receive a 6.2 percentage point increase plus an additional quarterly increase based on the growth in a state's unemployment rate. The budget assumed the enhanced ARRA FMAP will be 11.07 percentage points above the regular FMAP for the first quarter of 2009/10 and 11.04 percentage points above the regular FMAP for the remaining three quarters.

The **ARRA FMAP reflects state Medicaid expenditures that are temporarily shifted to the federal government under stimulus**. Consequently, each dollar of additional federal reimbursement reduces the need for state General Fund dollars to support the Medical Assistance program.

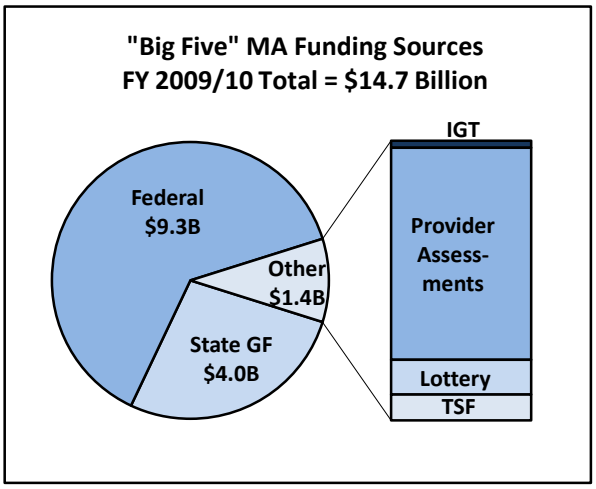
As a condition for receiving the enhanced ARRA FMAP, Pennsylvania could not reduce Medicaid income eligibility below what was in effect as of July 1, 2008 and had to meet federal requirements regarding the funding of home and community-based Medicaid Waiver programs for the elderly.

States can earn federal Medicaid matching funds by spending state, local and other non-federal dollars for covered services. Consequently, DPW uses revenue other than the state General Fund revenues to help finance the MA program. **The following revenues are budgeted in 2009/10 as the state match for federal funds:**

- $3.988 billion in **State General Fund** revenue, a $733 million decrease from 2008/09.
- $1.083 billion from the **assessments/taxes** levied on managed care organizations, nursing facilities and Philadelphia hospitals. This is a $253 million increase from 2008/09, due to the

October 1 implementation of a new Gross Receipts Tax on managed care organizations as a replacement for the previous assessment that was terminated September 30 in accordance with federal law.

- $178 million appropriated from the **Lottery Fund** for long-term care, a decrease of $122 million from 2008/09.
- $131 million in **Tobacco Settlement Fund (TSF)** revenue redirected to MA long term care, as detailed in a separate briefing entitled *2009/10 Budget: Tobacco Settlement Fund*, October 13, 2009.
- $36 million in county **Intergovernmental Transfer (IGT)** funds for long term care, a decrease of $79 million from 2008/09. While the IGT was phased-out after 2008/09, in accordance with federal rule changes, this represents IGT funds that were held in reserve and which will be used in 2009/10 to help pay the costs of county-operated nursing facilities.




## Major Initiatives

The enacted budget does not reduce MA eligibility nor does it reduce MA services. However, it includes the following cost containment initiatives which are anticipated to save $367 million in state funds ($453 million in total funds) during 2009/10:

- Replacement of the **managed care assessment** ($316 million state savings);
- Modifications to the **behavioral health managed care** system ($28 million state savings and $71 million total savings);
- Reduction in **hospital supplemental payments** ($16.1 million state savings and $44 million total savings); and
- Limitations on **other medical expenses** that can be included in determining MA eligibility for nursing home care ($7.5 million state savings and $21.9 million total savings).

Before explaining each of these four initiatives, we note that the enacted budget **does not** include the following initiatives that were proposed by the Administration:

- Carving out pharmacy from managed care (Smart Pharmacy);
- Expanding Medicaid estate recovery to include non-probate assets of seniors;
- Implementing a Medical Assistance Only False Claims Act; and
- Moving the MA long-term care program from DPW into a combined Department of Aging and Long Term Living.

### Managed Care Assessment

Due to changes in the federal Deficit Reduction Act of 2005, Pennsylvania's 5.5 percent assessment on MA-only managed care organizations (MCOs) was no longer in compliance with federal regulations and was terminated after September 30, 2009. The amount of this assessment was reimbursed to the MCOs through their monthly MA capitated rates and earned federal Medicaid matching funds, saving the state approximately $230 million in 2008/09.

To replace this lost revenue, the Governor's budget request had recommended a two percent statewide assessment on the premium income of all Pennsylvania managed care plans (other than Medicare) and estimated such assessment would generate state savings of $200 million in 2009/10. However, the General Assembly rejected the statewide assessment and instead, enacted a new

59 mill state Gross Receipts Tax on Medical Assistance MCOs.

Beginning October 1, 2009, both the physical health MCOs and behavioral health MCOs are subject to a 59 mill (or 5.9 percent) tax on payments received from DPW per their Medical Assistance contracts. Like the previous assessment, the MCOs will be reimbursed for the Gross Receipts Tax through their monthly capitated rates. The new Gross Receipts Tax is expected to generate additional federal Medicaid matching funds that will save the state $316 million during 2009/10.

## Behavioral Health Managed Care

DPW implemented three modifications to the county behavioral health managed care programs that will save the state $28 million in 2009/10 as the result of funds being returned to the Commonwealth.

- First, counties were required to return uncommitted funds and unspent reinvestment funds from their HealthChoices behavioral health programs. “Reinvestment funds” are capitation revenues from DPW and investment income that were not expended during the contract year, but which the county is authorized to reinvest in county behavioral health programs and services in accordance with a reinvestment plan approved by the department. Thirteen counties were affected by this modification.
- Second, DPW established a cap on reinvestment funds that all counties may retain and required counties to return any funds in excess of the cap.
- Third, DPW reduced the amount of allowable risk and contingency funds held by counties that have full risk contracts with managed care organizations. “Risk and contingency funds” are set aside by these counties for insolvency protection, providing a cushion in the event something happens with the contracts. Eleven counties were affected by this modification.

To institute the latter two modifications, DPW needed to amend the county contracts and receive approval by the federal Centers for Medicare and Medicaid Services (CMS).

## Hospital Supplemental Payments

The Governor’s Executive Budget request assumed a reduction of $20 million in state funding for the following hospital supplemental payments: **Outpatient Disproportionate Share; Medical Education;** and **Community Access Funds**. These payments are in addition to the regular payments that DPW makes to hospitals as reimbursement for services provided to Medical Assistance recipients. Because these payments earn federal Medicaid matching funds, the proposed state reduction meant the loss of federal funds resulting in a total payment reduction of $44 million to the hospitals ($20 million in state funds plus $24.2 million in federal match).

When the governor made his request in early February, federal stimulus had not yet been enacted and so the proposed state reduction in supplemental payments did not take into account the enhanced ARRA FMAP. The enacted budget reflects the impact of the ARRA FMAP in shifting expenses from the state to the federal government – and so while total payments are reduced by $44 million as proposed in the Governor’s request, the final state savings are $16.1 million due to the federal share of the savings increasing to $28.1 million.

## Other Medical Expenses

The enacted budget includes $7.5 million of state savings in the MA Long Term Care program, **pending changes to the Public Welfare Code** that further limit the deduction of other medical expenses (OME) in determining the amount of income that an MA recipient must pay towards the cost of his or her nursing home care. “Other medical expenses” are expenses which are incurred for medical or remedial care not subject to payment by a third party (for example, OME includes Medicare premiums).

The MA program pays nursing facility providers a per diem rate for each day of service it provides to an eligible MA recipient. Federal law and regulations require the MA recipient to pay a portion of his or her income to defray the cost of these services. For each additional dollar that a patient pays for his or her nursing home care, there is a corresponding decrease in the amount that the MA program must

pay to the nursing facility. Federal regulations specify how each recipient's payment amount is calculated, starting with the recipient's total gross monthly income less certain deductions.

Act 42 of 2005 had amended the Public Welfare Code to establish a $10,000 lifetime cap on the amount of OME that could be deducted along with provisions that authorized a waiver of the cap in hardship cases. However, when DPW submitted the OME cap to the federal CMS for its approval, CMS approved a more limited alternative which requires a legislative fix in order to comply with federal standards regarding the age of the expense and the reason for the expense. Specifically, the following OME limits would apply, provided they do not result in undue hardship:

- Medical expenses incurred six months or more prior to application for MA must be disallowed as a deduction from countable income.
- Medical or remedial expenses incurred as a result of a transfer of assets penalty are limited to zero. For example, if a nursing home resident had inappropriately transferred $35,000 of assets to a relative and DPW imposed a five-month disqualification period from MA eligibility, that person must pay $35,000 to the nursing home and can not deduct any expenses incurred during the disqualification period.

As of the date of this briefing, legislation amending the Public Welfare Code to comply with federal OME requirements has been passed in both chambers. However, concurrence is required before the legislation can be signed by the governor and DPW can implement the above OME limitations.

## Appropriation Detail

This section describes each of the "Big Five" MA appropriations, including an explanation of the program components supported by each appropriation, and analyzes the funding levels budgeted for 2009/10. The table below shows state General Funds and total funds budgeted for each of the five MA appropriations in 2009/10 compared to 2008/09. Altogether, state funds budgeted for the five appropriations decrease $773 million from 2008/09 while total funds (state, federal and other) decrease $417 million.

When comparing the two fiscal years, it is important to note the rollback of $826 million in total MA expenditures (including $285 million in state expenditures) from July 2009 to the 2008/09 fiscal year. As detailed on the following pages, the rollback impacts the appropriations for Outpatient, Inpatient, Capitation and Long Term Care. **The rollback is a budgetary maneuver that simply alters the year in which the expenditures are booked**. DPW will still pay MA providers for twelve months of claims during 2009/10; however, $826 million will be paid with prior year state and federal funds as the result of concomitant increases in supplemental appropriations for 2008/09.

A second factor to keep in mind when comparing the two fiscal years is the enhanced ARRA FMAP that Pennsylvania will receive for qualified expenditures during the federal stimulus period that began October 2008. Each additional dollar of federal Medicaid reimbursement received under the higher ARRA FMAP allows DPW to make a concomitant reduction in the state appropriations for Outpatient,

**Funds Budgeted for the "Big Five" MA Appropriations**

| | State General Fund ($ Millions) | | | Total Funds ($ Millions) | | |
|---|---|---|---|---|---|---|
| **MA Appropriations** | **2008/09** | **2009/10** | **Change** | **2008/09** | **2009/10** | **Change** |
| Outpatient | $ 555.1 | $ 438.2 | $ (116.9) | $ 1,724.0 | $ 1,762.4 | $ 38.4 |
| Inpatient | $ 426.8 | $ 373.5 | $ (53.3) | $ 1,117.3 | $ 1,047.1 | $ (70.3) |
| Capitation | $ 2,688.4 | $ 2,186.2 | $ (502.2) | $ 7,636.9 | $ 7,830.4 | $ 193.6 |
| Long Term Care | $ 672.6 | $ 540.3 | $ (132.3) | $ 4,191.3 | $ 3,581.0 | $ (610.2) |
| Payment to Federal Gov't for Medicare Drug Program | $ 418.6 | $ 450.2 | $ 31.6 | $ 418.6 | $ 450.2 | $ 31.6 |
| **TOTAL** | **$ 4,761.5** | **$ 3,988.4** | **$ (773.1)** | **$ 15,088.0** | **$ 14,671.1** | **$ (416.9)** |

Inpatient, Capitation and Long Term Care. **Most of the decrease in these four state appropriations can be attributed to the impact of the additional federal Medicaid reimbursement anticipated in 2009/10.** Specifically, the 2009/10 budget assumes $1.386 billion in ARRA FMAP (reflecting four quarters of federal stimulus), or $408 million more compared to the $978 million in ARRA FMAP assumed for the 2008/09 budget (reflecting three quarters of federal stimulus). Please note that the 2008/09 ARRA FMAP amounts are preliminary figures that may differ from the actual enhanced reimbursement that the Commonwealth receives after DPW submits final expenditure reports to the federal government.

## Outpatient

The Outpatient appropriation pays for primary physical health care and preventive services provided to approximately 900,000 individuals (or 40 percent of MA recipients) in the fee-for-service delivery system. This includes approximately 300,000 MA recipients age 21 or older who are dually eligible for federal Medicare benefits. **("Dual eligibles" are low-income elderly and disabled individuals who have substantial health care needs and rely upon both MA and Medicare for services.)**

In 2005, DPW implemented an enhanced primary care case management and disease management program called **Access Plus**. Under Access Plus, MA recipients who reside in the 42 counties without mandatory managed care may choose their own primary care providers, receiving the advantages of active care coordination and case management. Disease management services are provided to persons who have at least one of the following high-risk conditions: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure. More than 300,000 MA recipients are in Access Plus, including more than 44,000 recipients in the disease management component.

The Outpatient program is supported largely with state General Funds and federal Medicaid matching funds. Beginning January 2009, these funds are augmented by the revenue generated from a new assessment on Philadelphia hospitals. Spending in this line item is for the following:

- Outpatient services including: prescription drugs, physician, dental, psychiatric, EPSDT (for children), drug and alcohol treatment, hospital outpatient, ambulance, renal dialysis, hospice, home health services, durable medical equipment, and medical supplies.
- Outpatient Disproportionate Share (DSH) payments to hospitals that serve a disproportionate share of low-income or uninsured patients.
- Supplemental emergency room access payments to Philadelphia hospitals (funded with revenue generated from the assessment).
- Medicare Part B premiums, co-payments and deductibles for dual eligibles.

***($ in Millions)***

| Outpatient Funding Sources | 2008/09 Available | 2009/10 Budget | Change |
|---|---|---|---|
| State General Fund | $ 555.1 | $ 438.2 | $ (116.9) |
| Federal Funds | $ 1,118.3 | $ 1,222.4 | $ 104.1 |
| *Regular FMAP* | *1,018.4* | *1,061.2* | *42.8* |
| *ARRA FMAP* | *99.9* | *161.2* | *61.3* |
| Other Funds | $ 50.6 | $ 101.8 | $ 51.1 |
| **Total Funds** | **$ 1,724.0** | **$ 1,762.4** | **$ 38.4** |

For 2009/10, Outpatient funding totals $1.762 billion, including $438.2 million in budgeted state funds.

- This reflects the rollback of $66.6 million in total expenditures ($22.9 million state expenditures) from July 2009 to the 2008/09 fiscal year.
- The 2009/10 budget assumes $161.2 million of ARRA FMAP compared to $99.9 million in 2008/09, resulting in the shift of an additional $61 million of Outpatient expenses from the state to the federal government.
- The enacted budget also reflects the impact associated with annualizing the Philadelphia hospital assessment. The state share of the assessment revenue is projected to be $102 million in 2009/10 (for twelve months of assessment) compared to $51 million in

2008/09 (which had only six months of assessment).

The 2009/10 state General Fund appropriation represents a $117 million decrease from 2008/09. Most of the reduction ($61.3 million) is attributable to the additional ARRA FMAP. The expenditure rollback accounts for $45.9 million of the budgeted decrease in the state appropriation -- without the rollback, the 2009/10 state appropriation would have been $461.1 million (or $22.9 million higher) and the 2008/09 state appropriation would have been $532.1 million (or $22.9 million lower).

Another significant factor driving the decrease in the state appropriation is the increased savings associated with annualizing the Philadelphia hospital assessment. The assessment reduces the need for state funds, generating net state savings equal to the difference between the assessment revenue amount and the state share of the supplemental emergency room access payments made to Philadelphia hospitals. As a result of annualization, 2009/10 net savings to the state increased by approximately $27 million from 2008/09.

| Key factors driving 2009/10 decrease in Outpatient State General Funds | Impact ($ Million) |
|---|---|
| July 2009 expenses rolled back to 2008/09 | $ (45.9) |
| Additional ARRA FMAP to reduce state spending | $ (61.3) |
| Annualization of Philadelphia hospital assessment | $ (27.4) |

These decreases to the state appropriation (which total $134.5 million) are offset partially by the increased costs associated with greater utilization and eligibility in the Outpatient program, reflecting the projected growth in MA caseload.

2009/10 budget highlights for the Outpatient line item include the following:

- Provides $17.1 million in state funds ($50 million total funds) for **Outpatient Disproportionate Share** payments to qualifying hospitals. Per the cost containment initiative described in the previous section, this reflects a $5.1 million reduction in state funds ($15 million total funds) for this specific supplemental hospital payment.
- Maintains funding for **Act 152 drug and alcohol treatment services** at $16.2 million, the same level as prior years. Act 152 services are supported entirely with state funds; there is no federal match.
- Expands the disease management component of the **Access Plus** program by covering an additional 21 conditions including stroke, hypertension and neurological disorders.

## Inpatient

This appropriation pays for inpatient hospital services provided to the 900,000 MA recipients in the fee-for-service delivery system. It is supported with state General Funds and federal Medicaid matching funds. Spending in the Inpatient line item is for the following:

- Rates paid to acute care hospitals, private psychiatric hospitals, rehabilitation hospitals and residential treatment facilities.
- Supplemental payments made to qualifying hospitals (Inpatient Disproportionate Share, Medical Education, and Community Access Fund payments).
- Medicare Part A premiums, co-payments and deductibles for dual eligibles.

***($ in Millions)***

| Inpatient Funding Sources | 2008/09 Available | 2009/10 Budget | Change |
|---|---|---|---|
| State General Fund | $ 426.8 | $ 373.5 | $ (53.3) |
| Federal Funds | $ 690.5 | $ 673.6 | $ (16.9) |
| *Regular FMAP* | *624.1* | *575.6* | *(48.5)* |
| *ARRA FMAP* | *66.4* | *98.0* | *31.6* |
| **Total Funds** | **$ 1,117.3** | **$ 1,047.1** | **$ (70.3)** |

For 2009/10, Inpatient funding totals $1.047 billion, including $373.5 million in budgeted state funds.

- This reflects the rollback of $38 million in total expenditures ($14 million state expenditures) from July 2009 to the 2008/09 fiscal year.
- The 2009/10 budget assumes $98 million of ARRA FMAP compared to $66.4 million in

2008/09, resulting in the shift of an additional $31.6 million of Inpatient expenses from the state to the federal government.

The 2009/10 state General Fund appropriation represents a $53 million decrease from 2008/09. The additional ARRA FMAP accounts for $31.6 million of the reduction in the state appropriation, and the expenditure rollback accounts for $28.1 million of the budgeted decrease.

| Key factors driving 2009/10 decrease in Inpatient State General Funds | Impact ($ Million) |
|---|---|
| July 2009 expenses rolled back to 2008/09 | $ (28.1) |
| Additional ARRA FMAP to reduce state spending | $ (31.6) |

These decreases to the state General Fund appropriation are offset partially by the increased costs associated with greater utilization and eligibility in the Inpatient program, reflecting the projected growth in MA caseload.

The enacted budget does not fund an increase in the payment rates for hospitals. However, the Inpatient program includes the following funding:

- $35.7 million in state funds ($79 million total funds) for **Inpatient Disproportionate Share** payments to hospitals that serve a disproportionate share of low-income or uninsured patients.
- $21.9 million in state funds ($64 million total funds) for **Medical Education** payments to hospitals with teaching programs for doctors and nurses. Per the cost containment initiative described in the previous section, this reflects a $6.9 million reduction in state funds ($20.1 million total funds) for this specific supplemental hospital payment.
- $24 million in state funds ($49.3 million total funds) for **Community Access Funds** payments to hospitals that serve the uninsured. Per the cost containment initiative described in the previous section, this reflects a $4.1 million reduction in state funds ($9.1 million total funds) for this specific supplemental hospital payment.

## Capitation

The Capitation appropriation funds the health care costs for MA recipients enrolled in managed care. Each managed care organization (MCO) under contract with DPW agrees to provide a specified package of health services in exchange for an actuarially sound fixed rate per enrollee. MCOs may provide additional health services beyond the specified benefits, but they do so at their own cost. DPW pays the MCOs a monthly capitated rate for each member enrolled in their plans.

Approximately 1.16 million individuals (or 60 percent of all MA recipients) are in the **physical health managed care** program – depending upon the county of their residence, these individuals are enrolled in either mandatory or voluntary managed care. Approximately 1.7 million MA recipients are in the statewide HealthChoices **Behavioral Health managed care** program, which provides mental health services and drug and alcohol treatment services. Effective January 2006, MA recipients age 21 or older who are dually eligible for Medicare benefits were disenrolled from the physical health managed care program and moved to the fee-for-service delivery system for coverage of their physical health benefits. However, these dual eligibles may continue to receive behavioral health managed care.

**HealthChoices**, the name of DPW's mandatory managed care program, operates in three geographic zones and has just over 1 million enrollees who reside in 25 counties:

- The five-county **HealthChoices Southeast** zone was implemented in 1997 and includes Bucks, Chester, Delaware, Montgomery and Philadelphia counties.
- The ten-county **HealthChoices Southwest** zone was implemented in 1999 and includes Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington and Westmoreland counties.
- The ten-county **HealthChoices Lehigh/Capital** zone was implemented in 2001 and includes Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York counties.

The **voluntary managed care** program operates in 26 counties and had 72,000 enrollees as of June 2009. MA recipients who reside in the voluntary counties have the option to receive physical health care through a managed care organization or the fee-for-service system.

MA recipients enrolled in mandatory HealthChoices receive both physical health care and behavioral health care. For the physical health component, DPW contracts with three MCOs in each zone, giving MA recipients who reside in that zone a choice of plans in which they may enroll to receive their physical health care services. For the behavioral health component, DPW contracts separately with each county to provide services to MA recipients residing in that county. The county has the "right of first opportunity" to manage the behavioral health managed care component itself or may choose to subcontract with a behavioral health MCO. This county option recognizes the county's statutory role in administering local mental health and drug and alcohol programs.

Statewide expansion of behavioral health managed care (to the 42 counties without the mandatory HealthChoices program) was implemented in three phases. In July 2006, **HealthChoices Behavioral Health** managed care became operational in four Northeast counties (Lackawanna, Luzerne, Susquehanna and Wyoming). In January 2007, twenty-three counties which comprise the North/Central zone implemented HealthChoices Behavioral Health. The remaining fifteen counties implemented behavioral health managed care on July 1, 2007.

The managed care program is supported primarily with state General Funds and federal Medicaid funds. These funds are augmented by the revenues generated from the 5.5 percent assessment on MA MCOs through September 2009, and effective October 1, the new 59 mill Gross Receipts Tax on the MA MCOs. Spending in the Capitation line item is for the following:

- Monthly premiums for MA recipients enrolled in HealthChoices, both the physical health component and the behavioral health component.
- Monthly premiums for MA recipients enrolled in voluntary managed care plans.
- Special maternity payments to physical health MCOs for prenatal, delivery and post-partum services provided to female MA recipients.

*($ in Millions)*

| Capitation Funding Sources | 2008/09 Available | 2009/10 Budget | Change |
|---|---|---|---|
| State General Fund | $ 2,688.4 | $ 2,186.2 | $ (502.2) |
| Federal Funds | $ 4,556.1 | $ 5,016.1 | $ 460.0 |
| *Regular FMAP* | *4,051.6* | *4,268.1* | *216.4* |
| *ARRA FMAP* | *504.5* | *748.1* | *243.6* |
| Other Funds | $ 392.3 | $ 628.1 | $ 235.8 |
| **Total Funds** | **$ 7,636.9** | **$ 7,830.4** | **$ 193.6** |

For 2009/10, total funding for Capitation is $7.83 billion, including $2.186 billion in state funds.

- This reflects the rollback of $503.8 million in total expenditures ($173.4 million state expenditures) from July 2009 to the 2008/09 fiscal year.
- The 2009/10 budget assumes $748.1 million in ARRA FMAP compared to $504.5 million in 2008/09, resulting in the shift of an additional $243.6 million from the state to the federal government.
- The enacted budget also includes $528 million in revenue anticipated under the new 59 mill Gross Receipts Tax on MA MCOs, which took effect October 1, 2009 as a replacement for the old managed care assessment.

The 2009/10 state General Fund appropriation represents a $502 million decrease from 2008/09. The reduction in the state appropriation is due primarily to the expenditure rollback, which accounts for $346.7 million of the budgeted decrease, and the additional ARRA FMAP, which accounts for $243.6 million. **Another significant factor is the additional state savings associated with the new Gross Receipts Tax**.

As explained in the previous section on cost containment initiatives, the new Gross Receipts Tax is expected to earn $316 million in federal matching funds in 2009/10 and thereby generate state savings equal to that same amount. The old managed care

assessment saved the state approximately $230 million in 2008/09 and $63 million for the first quarter of 2009/10 (July 2009 through September 2009). For 2009/10, state savings are expected to total $379 million ($63 million from the managed care assessment plus $316 million from the Gross Receipts Tax), or approximately $149 million more than the savings realized in 2008/09 from the managed care assessment. Consequently, by implementing the Gross Receipts Tax effective October 1, the additional federal match results in a $149 million reduction to the state appropriation.

| Key factors driving 2009/10 decrease in Capitation State General Funds | Impact ($ Million) |
|---|---|
| July 2009 expenses rolled back to 2008/09 | $ (346.7) |
| Additional ARRA FMAP to reduce state spending | $ (243.6) |
| Replacing managed care assessment with Gross Receipts Tax | $ (149.0) |

However, these decreases to the state appropriation for Capitation (which total $739 million) are offset partially by the increased costs associated with greater enrollment in the managed care program, reflecting the projected growth in MA caseload. In addition, the 2009/10 budget provides funding for a statewide rate increase of approximately three percent for physical health MCOs and a statewide rate increase of two percent for behavioral health MCOs. However, the enacted budget does not fund pay for performance (P4P) payments to MCOs for meeting targeted outcomes.

## Long Term Care

The most costly MA program component is the Long Term Care appropriation, which **funds nursing home care as well as home and community-based services**. Pennsylvanians needing long term care include the elderly, who may require services due to physical and cognitive impairment that comes with aging, and the non-elderly, who may require a lifetime of services due to a disability or a degenerative disease. More than 112,000 elderly and disabled Pennsylvanians are expected to receive long-term care services in 2009/10.

Approximately 83,000 people will receive services in a nursing facility, including 7,200 persons who are under age 60. Another 29,000 individuals are expected to receive services in a home or community setting.

Nursing facility care is the most expensive part of long-term care, with annual costs averaging approximately $53,000 per MA resident. Nursing home residents generally have high care needs and complex medical conditions that require skilled nursing services. MA nursing home residents have an average of 8.1 medical conditions and need assistance or supervision with an average of 7.3 activities of daily living – ADLs include basic tasks such as taking medications, walking, completing grooming tasks like brushing their hair and teeth, taking a bath or shower, and using the toilet. For some individuals, nursing homes are a short-term stay for rehabilitation or recuperation from an acute condition (such as a broken bone or stroke).

To more efficiently manage its long term care resources, DPW continues to invest in the expansion of home and community-based care as an alternative to nursing facility care. Home and community-based care alternatives enable MA recipients to obtain services in a less restrictive environment, with annual costs averaging approximately $20,000 per user.

Home and community-based programs are often referred to as "waivers" because the federal government has to waive some of its rules in order for the state to provide services outside of a nursing facility. To obtain federal approval for a waiver, the state must ensure that services provided under the waiver are cost effective compared to the cost of nursing home care. The state must also ensure that it has safeguards to protect the health and welfare of people served in the waiver program. The Aging Waiver provides personal assistance services, home delivered meals, transportation, extended physician services, specialized medical equipment, and other services to people age 60 or older who otherwise would require nursing home care. As of 2008/09, approximately 19,600 seniors received these waiver services. The average waiver user had 6.3 medical conditions and required assistance with 6.2 ADLs.

LIFE (Living Independence for the Elderly) is a managed care program for frail elderly, aged 55 or older, who have been determined to need nursing facility level of care. LIFE provides a comprehensive package of services, including medical, social and supportive services (including all acute and nursing facility services covered by Medicare and Medicaid). The LIFE program is centered around an adult day health center where recipients receive most services. Transportation is provided to and from the centers and other services, with home care provided as needed. As of 2008/09, more than 2,100 persons were receiving services through the LIFE program.

Federal Medicaid funds are the predominant revenue source for Long Term Care. DPW uses the following revenues to earn federal matching funds: state General Funds; assessment revenue from nursing facilities; Lottery Funds; Tobacco Settlement Funds; and county Intergovernmental Transfers (IGT) held in reserve. Spending in this line item is for the following:

- The cost of home and community-based services for MA recipients.
- Rates paid to nursing homes for the care of MA residents.
- Supplemental payments that DPW pays to nursing facilities in return for their participation in the assessment program.

***($ in Millions)***

| Long Term Care Funding Sources | 2008/09 Available | 2009/10 Budget | Change |
|---|---|---|---|
| State General Fund | $ 672.6 | $ 540.3 | $ (132.3) |
| Federal Funds | $ 2,568.9 | $ 2,342.2 | $ (226.7) |
| *Regular FMAP* | *2,262.1* | *1,963.9* | *(298.2)* |
| *ARRA FMAP* | *306.8* | *378.3* | *71.5* |
| Other Funds | $ 949.7 | $ 698.5 | $ (251.2) |
| **Total Funds** | **$ 4,191.3** | **$ 3,581.0** | **$ (610.2)** |

For 2009/10, total funding for Long Term Care is $3.581 billion, including $540.3 million in state funds.

- This reflects the rollback of $217.6 million in total expenditures ($74.8 million state expenditures) from July 2009 to the 2008/09 fiscal year.
- The 2009/10 budget assumes $378.3 million in ARRA FMAP compared to $306.8 million in 2008/09, resulting in the shift of an additional $71.5 million from the state to the federal government.

The 2009/10 state General Fund appropriation represents a $132.3 million decrease from 2008/09. The decrease is due primarily to the expenditure rollback, which accounts for $149.7 million of the budgeted decrease. The additional ARRA FMAP accounts for another $71.5 million reduction in the state appropriation.

| Key factors driving 2009/10 decrease in Long Term Care State General Funds | Impact ($ Million) |
|---|---|
| July 2009 expenses rolled back to 2008/09 | $ (149.7) |
| Additional ARRA FMAP to reduce state spending | $ (71.5) |

However, these decreases to the state appropriation (which total $221 million) are offset partially by the need to replace $122 million of Lottery Fund revenues that were used in 2008/09 to help pay for long-term care but are not available in 2009/10.

The enacted budget does not provide a per diem rate increase for nursing homes. However, it provides for the quarterly acuity payment to nursing homes, which helps to fund the increasing costs associated with providing care for patients who increasingly require more staff, medications and medical supplies. In addition, the 2009/10 budget includes $6.4 million in state funds ($18.7 million total funds) to expand the Aging Waiver program so that an additional 2,000 seniors can receive services in their homes and communities as an alternative to nursing home care.

## Payment to Federal Government for Medicare Part D

This state-funded appropriation was established in 2006 to pay the mandated monthly payments that Pennsylvania must make to the federal government for the Medicare Part D program.

Effective January 1, 2006, the federal government began providing Medicare Part D drug benefits to

the dual eligible population. Prior to the January 2006 implementation of Medicare Part D, prescription drugs for Pennsylvania's dual eligibles were covered under the MA Outpatient program. ("Dual eligibles" are low-income elderly and disabled Pennsylvanians who qualify for both federal Medicare benefits and state MA benefits.)

Federal assumption of prescription drug coverage for the dual eligible population relieved Pennsylvania of substantial pharmacy costs in the MA program. However, rather than allowing states to keep their entire share of the savings, the federal government required states to pay most of their estimated savings to the Medicare program to help finance the Part D drug benefit. This "clawback" payment to the federal government is intended to reflect a portion of the expenditures that Pennsylvania would have incurred had it continued to pay for prescription drugs for dual eligibles through the Medical Assistance program.

The Medicare Modernization Act, which established the Part D program, specifies the formula used to determine the amount of each state's monthly payment for each dual eligible enrolled in Medicare Part D. The federal government annually notifies Pennsylvania of its per capita monthly rates for the forthcoming calendar year. Each month, DPW receives an invoice from the federal government for the cost of Pennsylvania dual eligibles enrolled in Medicare Part D.

*($ in Millions)*

| Part D Payment to Federal Gov't | 2008/09 Available | 2009/10 Budget | Change |
|---|---|---|---|
| State General Fund | $ 418.6 | $ 450.2 | $ 31.6 |

For 2009/10, $450.2 million in state funds are appropriated for twelve payments to the federal government for the Medicare Part D program, an increase of $31.6 million from 2008/09. This assumes average monthly enrollment in Medicare Part D is 294,321 dual eligibles, representing 2.6 percent growth over 2008/09. It also assumes the average monthly per capita rate in 2009/10 is $127.41, or 4.8 percent more than 2008/09.

## MA Budget by Program Area

The pie chart on the last page shows the distribution of total MA funding ($14.671 billion) in the enacted 2009/10 budget by major program area.

**Managed care** is the largest component of MA, accounting for $7.83 billion of all spending. 2009/10 monthly enrollment is expected to average nearly 1.2 million enrollees in physical health managed care and 1.7 million enrollees in behavioral health managed care.

Spending in the **fee-for-service** delivery system totals $1.97 billion for outpatient and inpatient services. Approximately 900,000 MA recipients are expected to be eligible for services during 2009/10.

On a per capita basis, **nursing home care** is the most expensive part of MA, with approximately $3.21 billion budgeted in 2009/10 for a program that is expected to serve 83,000 elderly and disabled.

**Home and community-based services** account for approximately $367 million of 2009/10 spending, with approximately 29,300 elderly projected to receive these services as an alternative to nursing home care.

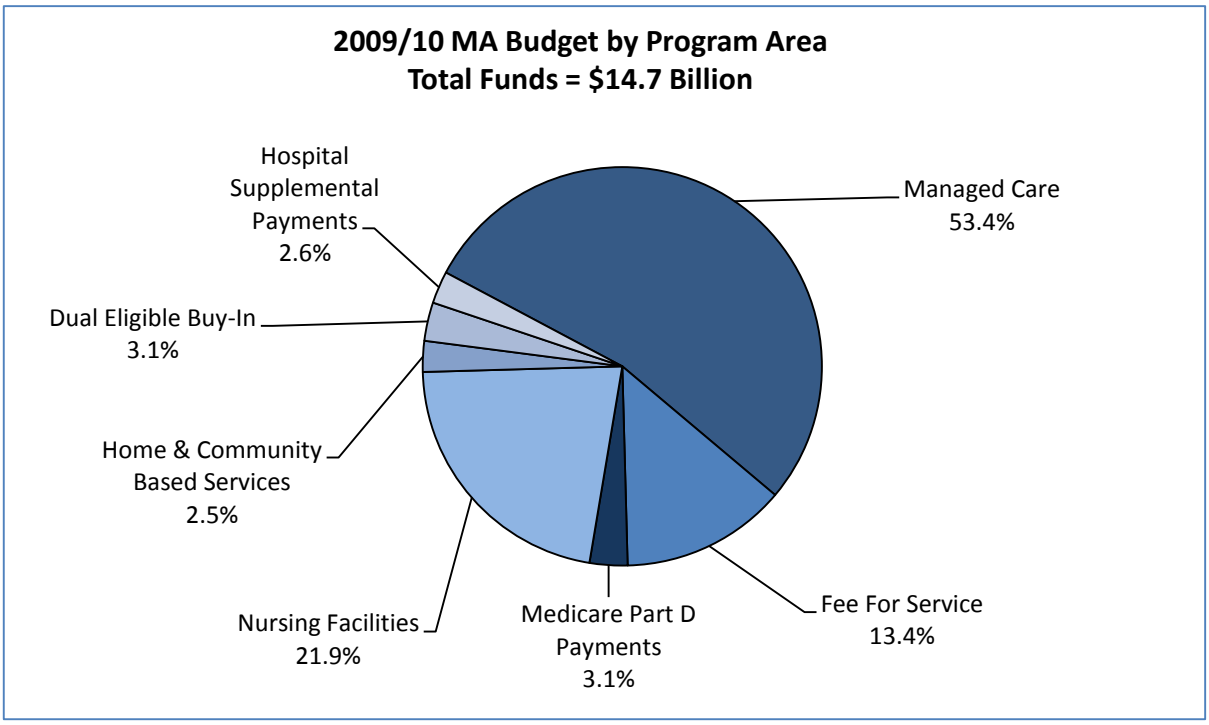
$459 million is budgeted to assist approximately 260,000 **dual eligibles** in paying their premiums, deductibles and co-pays for federal Medicare Part A (hospital insurance) and Medicare Part B (insurance for physician, outpatient, and preventative services). This financial assistance is federally-mandated.

**Medicare Part D payments** to the federal government are expected to cost Pennsylvania $450.2 million in 2009/10.

Total funds of $381 million are budgeted for **supplemental hospitals payments –** this includes the supplemental emergency room access payment for Philadelphia hospitals which is funded with the revenue generated from the Philadelphia hospital assessment. A total of $242 million is budgeted for the following supplemental payments to qualifying Pennsylvania hospitals:

- Outpatient Disproportionate Share (DSH);

- Inpatient Disproportionate Share (DSH);
- Community Access Fund; and
- Medical Education payments to hospitals with teaching programs for doctors and nurses.





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