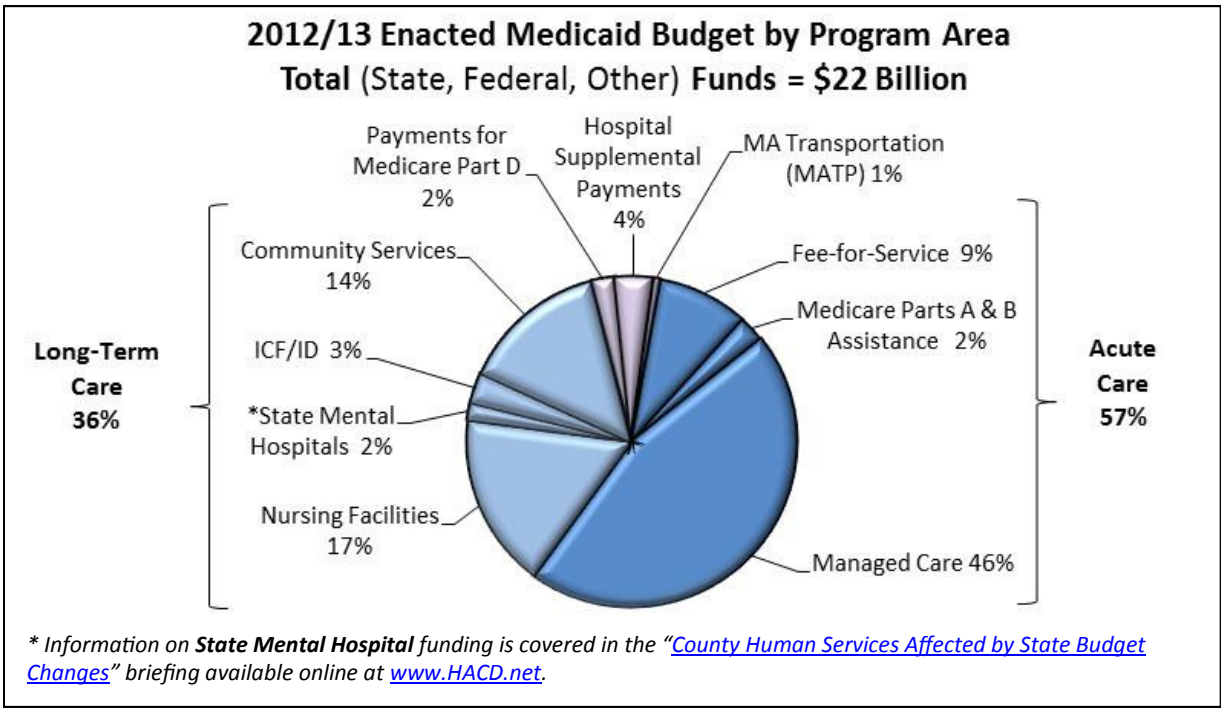
2012/2013 BUDGET BRIEFING
HOUSE APPROPRIATIONS COMMITTEE (D)
Report on Key Issues
HOUSE APPROPRIATIONS COMMITTEE (D)
JOE MARKOSEK, DEMOCRATIC CHAIRMAN
October 18, 2012

Medicaid Programs Help 1 in 6, Account for 80 Percent of DPW Budget

Medicaid programs provide a comprehensive array of ***health and long-term care services to more than 2.1 million Pennsylvanians of all ages*** *– beneficiaries include children, pregnant women, low-income families, people with disabilities and seniors. Spending on Medicaid programs account for 80 percent of the Department of Public Welfare's (DPW) $27.6 billion budget (including state, federal and other funds).*

The first part of this briefing provides an overview of the 2012/13 Medicaid budget, including the distribution of expenditures by major program area, a description of the various funding sources, and a summary of the major initiatives in the enacted state budget. The second part of the briefing is a detailed analysis of specific appropriations, ***including updated information provided in DPW's August rebudget.***



** Information on* ***State Mental Hospital*** *funding is covered in the "County Human Services Affected by State Budget Changes" briefing available online at www.HACD.net.*

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Medical Assistance Overview

Medical Assistance (MA) is the name of Pennsylvania's Medicaid program. MA is the largest component of the Department of Public Welfare (DPW) budget, consuming $7.4 billion of state General Funds and $22 billion of total funds (state, federal and other). 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.

Although the elderly and people with disabilities represent 38 percent of all recipients, they account for more than two-thirds of Medicaid expenditures.

MA eligibility is based on various factors such as income, financial resources (assets), age and health care needs. **More than 2.1 million individuals – or one out of every six Pennsylvanians – receive MA benefits**. In general, MA recipients fall into one of four groups: approximately 57 percent of recipients are low-income families and children, 23 percent are people with disabilities, 15 percent are elderly, and 5 percent are chronically ill adults.

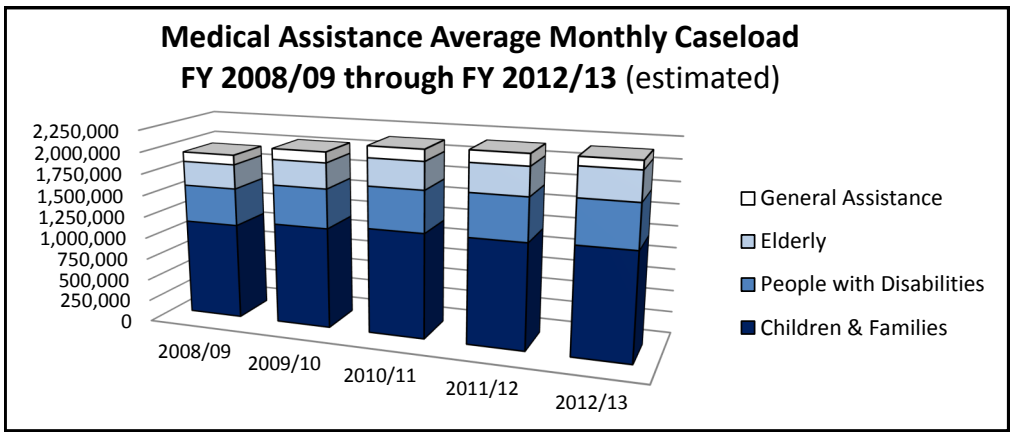
The enacted budget assumes the monthly caseload will average 2.167 million MA recipients in 2012/13, an increase of about 1,000 individuals (representing 0.04 percent growth) from 2011/12. This change in caseload reflects the net impact of the General Assistance revisions that will tighten MA eligibility for chronically ill adults, **cutting off services to approximately 35,000 individuals, a 27 percent reduction, per month in 2012/13.**

Pennsylvania's Medicaid program is designed to provide a comprehensive array of services to meet the diverse and complex needs of MA recipients.

- Health care coverage is provided to MA recipients for physical health as well as behavioral health services (treatment for mental health as well as substance abuse). The range and scope of health benefits vary, depending upon the eligibility group. Most MA recipients receive health care through the managed care program; the balance of recipients (including individuals in nursing homes and intermediate care facilities) receive their care through the fee-for-service program.
- Coverage for long-term care is provided to seniors, people with mental illness, individuals with physical and/or intellectual disabilities. Services range from institutional care to a variety of community-based services and supports that enable individuals to avoid institutionalization.

The greatest share of Medicaid spending is for the elderly and people with disabilities, reflecting their intensive use of acute and long-term care services. **Although the elderly and people with disabilities represent 38 percent of all recipients, they account for more than two-thirds of Medicaid expenditures.** By contrast, low-income families and children represent more than half of all MA recipients, yet they account for about one-fifth of all Medicaid spending.

Of particular interest are the roughly 400,000 MA recipients who are dually eligible for both Medicaid and Medicare. **"Dual eligibles"** – comprised of low-income seniors and non-elderly people with disabilities – have substantial health care needs and rely upon both programs for services. Medicare covers most basic health care needs, including physician services, prescription drugs, and hospital services; MA covers benefits that Medicare excludes or limits, including nursing home care and behavioral health services. MA also assists in paying their



premiums and cost-sharing for Medicare Part A and Medicare Part B – this assistance is federally-mandated.

The pie chart on page 1 shows the enacted 2012/13 Medicaid budget by major program area.

- **$12.6 billion for acute care**. This funds payments made to managed care organizations and fee-for-service providers (doctors, dentists, pharmacies, hospitals, etc.) for health care services provided to MA recipients. It also includes financial assistance provided to dual eligibles in paying their Medicare Part A and B premiums, co-pays and deductibles.
- **$7.9 billion for long-term care**. This funds payments to nursing facilities, state mental hospitals, and intermediate care facilities for individuals with intellectual disabilities (ICF/ID). It also pays for home and community-based services provided to individuals as an alternative to institutional care.
- **$0.8 billion for hospital supplemental payments.** These payments are targeted to specific hospitals, including safety net and teaching hospitals. Supplemental payments are in addition to the reimbursement rates paid to hospitals for services provided to MA recipients.
- **$511 million for Medicare Part D payments.** These are federally-mandated payments that Pennsylvania must remit to the federal government for approximately 327,500 dual eligibles enrolled in the Medicare Part D prescription drug program.
- **$145 million for MA Transportation.** These funds support county-based transportation services provided to MA recipients who do not have other transportation to and from their medical providers.

Funding Sources

Medicaid is jointly funded by the federal government and the state. The federal percentage of program expenditures, or Federal Medical Assistance Percentage (FMAP), varies by state and is determined annually through a formula (specified in the Social Security Act) that is based on per capita income. The annual FMAP is in effect during the 12-month period of the federal fiscal year which begins on Oct. 1.

The **FMAP rate for Pennsylvania** when the 2012/13 budget was passed was 55.07 percent and, per the statutory formula, **decreased to 54.28 percent on Oct. 1, 2012.** This annual FMAP applies to most services provided to Medicaid recipients. Certain Medicaid expenditures receive a different federal match – for example, the FMAP rate is 90 percent for family planning services and for the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program. For administrative costs, the FMAP rate is generally 50 percent, although some functions – such as the operation of Medicaid fraud control units – qualify for FMAP rates of 75 percent or more.

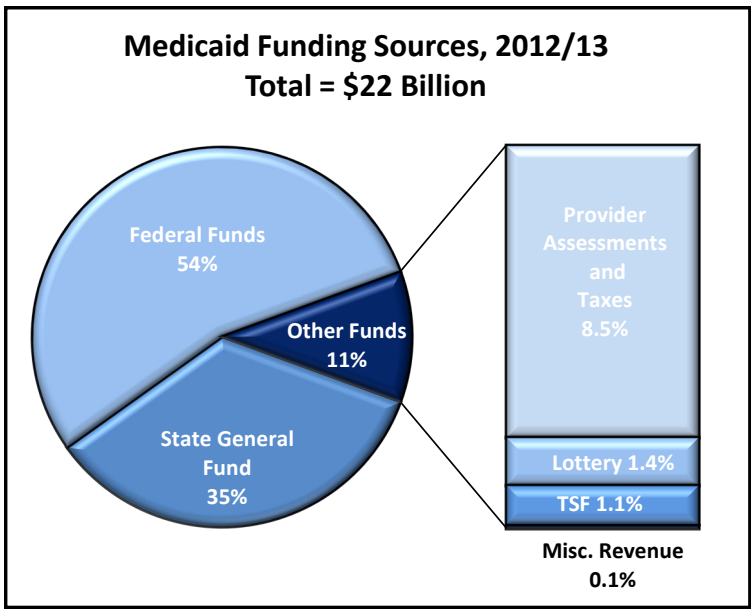
To receive federal Medicaid funds, DPW must adhere to federal requirements and rules that ensure a minimum level of health care coverage for those individuals who are entitled to Medicaid coverage. The mandatory Medicaid groups include: low-income families that are eligible for TANF (Temporary Assistance for Needy Families), low-income children, low-income pregnant women, and persons receiving federal SSI (Social Security Income) benefits (low-income aged or people with disabilities). The federal government does not reimburse services provided to individuals who do not fall into one of the federal categories; consequently, **Pennsylvania pays the full cost for residents who qualify for General Assistance benefits.**

DPW relies heavily upon revenue sources, other than the General Fund, to earn federal Medicaid matching funds and to reduce the amount of state General Funds required to pay for programs. These sources include special funds (Lottery Fund and Tobacco Settlement Fund) and revenues collected from assessments and taxes on providers. For 2012/13, other fund revenue totals $2.4 billion and accounts for 11 percent of the Medicaid budget. These revenue sources must meet certain statutory and regulatory requirements to qualify for federal match.

More than half of the 2012/13 Medicaid budget is comprised of federal funds, which total nearly $12 billion. For the most part, these are Medicaid matching funds ($11.8 billion). The remainder is

comprised of federal stimulus (American Recovery and Re-investment Act) funding for health information technology incentive grants to hospitals and other health care providers ($136 million) and Medicare funding ($27 million) for the state mental hospitals and ID state centers.

For 2012/13, the following funds are budgeted to pay the state share of Medicaid expenditures.



- **$7.617 billion is General Fund revenue.** This is an increase of $222 million from the revised 2011/12 budget, which included supplemental appropriations.
- **$1.869 billion is assessment/tax revenues** collected from hospitals, nursing homes, managed care organizations, and intermediate care facilities (state and private) for persons with intellectual disabilities. All revenues generated from the various provider assessments/taxes are used exclusively for their respective programs (for example, the assessment on nursing facilities is used to fund nursing home care while the gross receipts tax on managed care plans is used to fund the managed care program).
- **$309 million is Lottery Fund revenue** appropriated for nursing facility care.
- **$252 million is Tobacco Settlement Fund revenue** used for nursing facility care, community waiver services for seniors (as an alternative to nursing facility care), Medical Assistance for Workers with Disabilities, and uncompensated care payments to hospitals. For more detail, see the Tobacco Settlement Fund (TSF) briefing online.
- **$21 million is revenue from various sources**, including attendant care fees, and revenues collected by the state mental hospitals and ID state centers.

Key Budget Factors and Cost Containment

Medicaid expenditures are determined by MA caseload, benefits offered to recipients, service utilization (the volume and type of services consumed by recipients), and rates paid to providers.

Additional factors that increased General Fund spending in the 2012/13 Medicaid budget are summarized below.

- The **FMAP rate reduction** is estimated to cost the state approximately $130 million due to the federal share of Medicaid expenditures decreasing from 55.07 percent to 54.28 percent on Oct. 1, 2012.
- **Replacing non-recurring revenues** used by DPW to pay 2011/12 Medicaid expenditures required $123 million of state funds. Specifically, the 2011/12 budget used the following revenue which is no longer available for DPW to spend: $84 million of enhanced federal matching funds claimed for two months of managed care payments and $39 million of prior year federal funds to offset managed care expenditures. (Prior year federal funds result from a state Medicaid expenditure being determined eligible for federal reimbursement after the close of the fiscal year.)
- **One-time savings initiatives** that were implemented in 2011/12 account for $54 million of increased state spending. Specifically, managed care expenditures were reduced temporarily in 2011/12 as the result of DPW accelerating the collection of available federal rebates, amounting to $28.6 million, and capping the amount of behavioral health reinvestment funds retained by county governments, saving the state $25.8 million.

General Assistance – Changes in MA Eligibility

The Medical Assistance program provides state-funded General Assistance (GA) health care to low-income, chronically ill adults who do not qualify for federal Medicaid coverage. During 2011/12, **an average of 136,900 adults received GA-related medical assistance each month**.

The Public Welfare Code establishes MA eligibility standards for two GA groups – categorically needy and medically needy.

- The **"categorically needy"** group averaged 105,000 recipients per month during 2011/12 and is comprised of low-income adults, age 21 through 64 years, who meet any of the following:

  1) they have a documented physical or mental disability which precludes employment;
  2) they are caring for a child under age 13 or another person with an illness or disability;
  3) they are undergoing drug and alcohol treatment; or
  4) they are a victim of domestic violence.

- The **"medically needy"** group is comprised largely of low-income adults who have incurred high medical expenses, commonly due to hospital care, and "spend down" to qualify for coverage. The number of medically needy adults receiving GA-related Medical Assistance averaged 31,900 recipients per month during 2011/12.

The enacted budget reflects changes for determining MA eligibility in both GA categories. For "categorically needy" adults, DPW will tighten its standards and the process used to determine whether adults have a qualifying temporary disability that allows them to receive MA benefits. For "medically needy" adults, the Public Welfare Code was amended to require custodial parents, age 21 through 58 years, with dependent children to work at least 100 hours per month earning at least the minimum wage in order to receive GA-related Medical Assistance – previously, this work requirement only applied to non-custodial parents, age 21 through 58.

The eligibility changes are expected to reduce MA enrollment by 35,000 adults per month in 2012/13. Resulting state savings of $170.3 million are assumed in the enacted budget – $150.8 million is associated with categorically needy and $19.5 million with medically needy.

DPW data show 107,881 adults received GA-related Medical Assistance in January 2012. Based on the January data, 9 out of 10 "categorically needy" adults have a disability and would be subject to the new MA eligibility standards. More than half of all "medically needy" adults are custodial parents of a dependent child and would have to meet the 100 hour per month work requirement.

GA-Related Medical Assistance
Recipients by Category of Eligibility
Analysis of January 2012 Enrollment

Categorically Needy		**88,576**
With a disability	83,652	
In a drug and alcohol program	2,831	
Victim of domestic violence	239	
Other	1,854	
Medically Needy		**19,305**
Custodial parent with dependent child	10,425	
Age 21-58, working 100 hours per month	3,475	
Age 59-64, no work requirment	3,668	
Qualified alien, age 65 and older	1,737	
Total GA Recipients - January 2012		**107,881**

- **Cash flow adjustments**, resulting from DPW's return in 2011/12 to a "prudent payment" standard, increased MA expenditures by $86.5 million. Federal regulations require states to pay 90 percent of clean Medicaid claims submitted by providers within 30 days of receipt. Under the prudent payment standard, claims are held so that they are paid no sooner than within 30 days. During the federal stimulus period of October 2008 through June 2011, DPW dropped prudent pay and reduced the number of days it held onto claims in order to comply with the payment standards set forth in the American Recovery and Reinvestment Act (ARRA). With the expiration of the ARRA provisions, DPW resumed prudent payment, extending the MA claims process by approximately a week – this change in processing claims delayed payments to providers and thereby reduced 2011/12 expenditures.

To contain the growth in General Fund spending, the enacted 2012/13 budget included the following initiatives and measures:

- Tightening **General Assistance eligibility** for Medical Assistance benefits *(see page 5).* The eligibility changes are expected to reduce state spending by $170.3 million in 2012/13 **by dropping approximately 35,000 recipients.**

- Conducting **high-cost case reviews** to better coordinate and manage care for high-cost MA recipients. DPW teams will be created to provide intensive clinical review and case management for select cases to better manage their care for all services – both acute care and long-term care – and avoid more costly medical interventions. DPW reports that care for the top 3,500 MA consumers cost approximately $400 million annually; high-cost case reviews are assumed to reduce state expenditures by $45 million in 2012/13. The savings are reflected in the Medical Assistance fee-for-service program and the community-based long-term care programs that serve the elderly and individuals with disabilities.

- **Increasing the MAWD (Medical Assistance for Workers with Disabilities) premium** that workers with disabilities must pay DPW each month for Medical Assistance coverage. The increase in premium payments to fund the MAWD program is expected to reduce state expenditures by $10 million.

- Changing the **hospital application process** so that people who enter Medical Assistance as the result of a hospital admission will remain in the fee-for-service program until the time of their MA eligibility redetermination. Previously, people who reside in one of the HealthChoices managed care counties and enter the MA program as the result of a hospital admission (e.g., due to an accident or injury) were automatically enrolled in a managed care plan after 30 days. The change means that these individuals will, in general, remain in the fee-for-service program for 6 months rather than just 30 days. This initiative is expected to reduce state expenditures by $10 million in 2012/13 – the savings represent the difference between what DPW would pay monthly to managed care organizations for these MA recipients versus paying fee-for-service claims.

- Implementing a **prepayment audit system of MA claims** is expected to save the state $5.5 million in 2012/13. The new audit system will review claims on the front end (before payments go out to providers) to ensure claims are appropriate for the service provided and eliminate the need to recoup improper payments after they occur.

- Utilizing **additional special fund revenue** to further reduce state spending on nursing facility care, which is financed through the Long-Term Care appropriation. Revenues appropriated from the Lottery Fund and the Tobacco Settlement Fund represent a net increase of $89.8 million compared to 2011/12. Specifically, the enacted budget appropriates $309.1 million from the Lottery Fund, which is a $130.6 million increase from 2011/12; and $121.7 million from the Tobacco Settlement Fund, which is a $40.9 million decrease.

In addition to these new initiatives, the enacted budget reflects a **four-year extension of the nursing facility assessment,** which was set to expire after June 30, 2012, through June 30, 2016. The assessment was first enacted as part of the 2003/04 budget as a new revenue source to pay for nursing facility rates, reducing the need to spend state General Funds. For 2012/13, the nursing facility **assessment is expected to save the state $201 million.**

Medical Assistance: Managed Care and Fee-For-Service

Medical Assistance (MA) health care services are delivered either through the managed care program or on a traditional fee-for-service basis. In the DPW budget, managed care is funded through the "Capitation" appropriation and fee-for-service is funded through the "Outpatient" and "Inpatient" appropriations.

MA has two capitated managed care programs: **physical health managed care** and **behavioral health managed care**.

- In June 2012, nearly 1.3 million MA recipients received physical health care services through Managed Care. **This included 1.2 million people enrolled in *HealthChoices,*** the name of the mandatory physical health managed care program operated in three geographic zones covering 25 counties. An additional 71,000 individuals were enrolled in the voluntary managed care program operating in 25 counties – MA recipients who reside in the voluntary counties had the option to receive physical health care through a managed care organization or the fee-for-service system.
- More than **1.9 million individuals received behavioral health services through the HealthChoices Behavioral Health** managed care program, which provides mental health and drug and alcohol treatment services to MA recipients in all 67 counties.

The fee-for-service delivery system provides payment on a per-service basis for health care services provided to eligible MA recipients who are not in capitated managed care. DPW contracts with more than 67,000 health care providers – such as doctors, hospitals, and pharmacies – and pays for each service in accordance with promulgated fee schedules or rates of reimbursement. During 2011/12, approximately 865,000 MA recipients received services through the fee-for-service system. This included the following groups:

- **340,000 individuals who resided in the 42 "non-HealthChoices" counties and received their physical health care through the Access Plus program.** Access Plus was established in 2005 to provide enhanced primary care case management and disease management to eligible MA recipients.
- **525,000 individuals statewide who are automatically in fee-for-service (but not in Access Plus) and are specifically excluded from participating in managed care.** These include: newly eligible MA recipients while they are awaiting enrollment in a managed care organization, dual eligibles who are age 21 or older, nursing home residents, individuals with intellectual disabilities who are admitted to intermediate care facilities, and women enrolled in the Breast and Cervical Cancer Prevention and Treatment Program.

As shown below, the enacted budget includes $4.3 billion in state General Fund revenues and $13.1 billion in total funds (state, federal and other) for the Capitation, Outpatient and Inpatient appropriations. Compared to 2011/12, state General Funds increase by $74 million and total funds increase $90 million.

Funds budgeted for these three appropriations are impacted by two major initiatives:

- **Expansion of the HealthChoices physical health mandatory managed care program** to all 67 counties is anticipated to move approximately 338,000 MA recipients from fee-for-service to managed care during 2012/13 – this change is reflected in the shifting of funds to the Capitation appropriation from the Outpatient and Inpatient

Funds Budgeted for Medical Assistance Managed Care and Fee-For-Service Programs

	State General Fund ($ Millions)			Total Funds ($ Millions)		
DPW Appropriation	2011/12 *	2012/13	Change	2011/12 *	2012/13	Change
MA - Capitation	$3,301.1	$3,780.7	$479.6	$9,345.2	$10,080.8	$735.6
MA - Outpatient	$645.1	$360.1	-$285.0	$1,980.7	$1,528.8	-$451.8
MA - Inpatient	$325.7	$204.7	-$121.0	$1,688.0	$1,494.1	-$193.9
Total	**$4,271.9**	**$4,345.5**	**$73.6**	**$13,013.8**	**$13,103.7**	**$89.8**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

HealthChoices Expansion

Statewide expansion of the HealthChoices physical health mandatory managed care program will be phased in during 2012/13 to encompass the 42 counties in which the HealthChoices physical health program had not previously operated.

Approximately **409,000 MA recipients residing in these 42 counties will be required to join a HealthChoices** physical health managed care organization (PH MCO) – this includes approximately 338,000 individuals enrolled in the ACCESS Plus program and 71,000 individuals enrolled in voluntary managed care. Recipients who do not select one of the HealthChoices PH MCOs serving their region will be automatically assigned to one of the new PH MCOs

Expansion of HealthChoices will occur in three stages, with the phase-in scheduled to be completed by March 2013. Effective July 1, 2012, seven of the 42 counties were incorporated into two of the existing HealthChoices zones. The remaining 35 counties will be divided into two new HealthChoices zones. Effective Oct. 1, 2012 the new HealthChoices West Zone began operating in 13 counties located in the northwest region – implementation was set initially for Sept. 1, but had to be postponed one month to give sufficient time for MCOs to build their provider networks and to address concerns regarding outreach and education of consumers being moved to managed care. Effective March 1, 2013 the new HealthChoices East Zone is scheduled to begin operating in 22 counties located in the northeast and northcentral regions.

As HealthChoices is implemented in the 42 counties, the ACCESS Plus Enhanced Primary Care Case Management program and the Voluntary Managed Care program will end.

Physical Health Mandatory Managed Care - HealthChoices Zones and Counties	
HealthChoices Southeast Zone	**Implemented February 1997** in the following 5 counties: Bucks, Chester, Delaware, Montgomery and Philadelphia
HealthChoices Southwest Zone	**Implemented January 1999** in the following 10 counties: Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington and Westmoreland
	Expanded July 2012 to include the following 4 counties: Bedford, Blair, Cambria and Somerset
HealthChoices Lehigh/Capital Zone	**Implemented October 2001** in the following 10 counties: Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York
	Expanded July 2012 to include the following 3 counties: Franklin, Fulton and Huntingdon
HealthChoices New West Zone	**Implemented October 2012** in the following 13 counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren
HealthChoices New East Zone	**Scheduled implementation March 2013** in the following 22 counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, TIoga, Union, Wayne and Wyoming

appropriations. Specifically, this initiative accounts for a $363 million increase in state General Funds for Capitation, and state funding decreases of $241 million for Outpatient services and $120.5 million for Inpatient services. Similarly, total funds (state and federal) increase by $789 million for Capitation, and decrease by $524 million for Outpatient and $262 million for Inpatient.

- **General Assistance revisions**, which are expected to save the state $170 million in 2012/13, contained the growth in General Fund spending on MA health care coverage. That is, without the General Assistance revisions, the increase in state General Fund spending would have been $244 million, rather than the $74 million increase budgeted for 2012/13.

MA 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 (capitated) rate per enrollee. MCOs may provide additional health services beyond the specified benefits, but they do so at their own cost.

Spending in the Capitation appropriation includes the following:

- Monthly capitated rates paid to physical health MCOs and behavioral health MCOs for each enrolled member.
- Special maternity payments to physical health MCOs for prenatal, delivery and post-partum services provided to female MA recipients.
- Pay for performance (P4P) bonus payments made to MCOs for meeting certain quality targets.
- Enhanced capitation payments (per the statewide hospital assessment program) to hospitals.

The managed care program is supported primarily with state General Funds and federal Medicaid funds appropriated in the annual state budget. These appropriated funds are augmented by the revenues generated from the Gross Receipts Tax on the Medical Assistance MCOs (implemented in 2009) and the statewide hospital assessment (implemented in 2010).

Nearly $10.1 billion is budgeted for Capitation in 2012/13. This includes $3.78 billion in state General Funds, an increase of nearly $480 million from 2011/12 which included a $29.5 million supplemental increase.

Approximately $230 million (or nearly half) of the increased state General Fund spending is required to address the following budgetary factors: replacing non-recurring federal funds that paid for 2011/12 expenditures, filling the budget gap associated with one-time savings initiatives that reduced 2011/12 expenditures, and adjusting for the FMAP rate decrease effective Oct. 1, 2012.

The state General Fund **appropriation reflects the net affect of the following program initiatives** on 2012/13 Capitation expenditures:

- HealthChoices expansion to 42 counties – the estimated state cost is $363.2 million.
- General Assistance eligibility changes – the anticipated state savings are $142.1 million.
- Hospital application process revision – the anticipated state savings are $32.4 million.

While the enacted budget funded the P4P payments to the MCOs, it did not provide additional funds for increasing managed care rates in 2012/13.

Funds Budgeted for MA Capitation

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$3,301.1	$3,780.7	$479.6
Federal Medicaid Funds	$5,210.7	$5,456.3	$245.5
Other Revenue:			
MCO Gross Receipts Tax	$642.8	$627.6	-$15.2
Statewide Hospital Assessment	$190.4	$216.2	$25.8
TOTAL FUNDS	**$9,345.1**	**$10,080.8**	**$735.7**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

MA Outpatient

The Outpatient appropriation funds primary health care and preventive services for MA recipients in the fee-for-service program. This appropriation pays for the following expenses:

- Outpatient services including prescription drugs, EPSDT (for children), physician, dental, psychiatric, drug and alcohol treatment, hospital outpatient, ambulance, renal dialysis, hospice, home health services, and medical equipment/supplies.
- Supplemental payments to qualifying hospitals, including the Outpatient Disproportionate Share (DSH) payment to hospitals that serve a disproportionate share of low-income or uninsured patients.
- Medicare Part B premiums, copayments and deductibles for dual eligibles.

Outpatient services are paid primarily with state General Funds and federal Medicaid funds appropriated in the annual state budget. These appropriated funds are augmented by the revenues generated from the Philadelphia hospital assessment (implemented in 2008) and, to a lesser extent, from the statewide hospital assessment (implemented in 2010).

More than $1.5 billion is budgeted for Outpatient services in 2012/13. This includes $360.1 million in state General Funds, a decrease of $285 million from 2011/12 which included a $3.3 million supplemental appropriation decrease.

The state General Fund appropriation **reflects several new initiatives proposed in the 2012/13 budget as well as several changes implemented as part of the 2011/12 budget through Act 22 of 2011.** Act 22 amended the Public Welfare Code to give the DPW secretary unprecedented rulemaking authority to impose co-pays for services, change reimbursement rates paid to service providers, and make other MA program changes. Act 22 also authorized DPW to implement

Act 22 of 2011: Pharmacy Payments and Copayments for Services

The 2012/13 enacted budget includes the savings associated with changes made by DPW, per its Act 22 expedited rulemaking authority, to reduce pharmacy payments and to increase the copayments imposed on MA recipients. It also includes savings associated with the statutory provision in Act 22 authorizing DPW to implement copayments for MA services provided to **"loophole" children** with disabilities whose household income is above 200 percent of the federal poverty level.

On April 14, DPW issued final regulations that reduced dispensing fees paid to pharmacies from $4 to $2 for non-compounded drugs and from $5 to $3 for compounded drugs; for instances in which an MA recipient has a primary third party payor covering his pharmacy benefit, a $0.50 dispensing fee will be paid to cover the cost of the transaction. The regulations also revised the payment methodology by changing the formula used to develop the estimated acquisition cost of drugs. The pharmacy provisions took effect April 14.

Additionally, on April 14, DPW issued final regulations that update the sliding scale copayments for MA services by providing for an inflationary adjustment. As permitted by the federal Deficit Reduction Act of 2005, DPW increased copayment amounts to reflect the growth in the medical care component of the consumer price index since 2006. The regulation also allows DPW to adjust annually the copayment amounts based on the percentage increase in the medical care component of the consumer price index. Regulations increasing sliding scale copayments took effect May 15.

Due to complexities associated with implementing "loophole" copayments that comply with federal requirements, DPW was forced to delay this Act 22 statutory provision nearly one year beyond the date initially assumed in the 2011/12 budget. **Approximately 45,000 "loophole" children receive MA services** – these are children with disabilities who do not qualify for federal SSI (Social Security Income) because their parental income is too high, but who qualify for MA benefits because Pennsylvania only uses the child's income in determining MA eligibility (parental income is not counted). DPW estimates the Act 22 copayment provisions will affect approximately 38,000 loophole children. In the Aug. 11 *Pennsylvania Bulletin*, DPW published the copayments for specific MA services and identified the services exempt from the copayment requirement – the aggregate amount of the copayments is capped at 5 percent of the family's annual income, prorated and applied on a monthly basis. Copayments were implemented Oct. 1, 2012 for newly eligible recipients and were to be implemented Nov. 1, 2012 for current recipients. **UPDATE: On Oct. 5, 2012 DPW decided to delay the copayment initiative "until further notice."**

copayments for MA services provided to **"loophole" children** from higher income families; however, DPW announced on Oct. 5, 2012 that the copayments were on hold until further notice.

Specifically, 2012/13 Outpatient state **expenditures reflect the net affect of the following** new initiatives and Act 22 changes:

- HealthChoices expansion to 42 counties – the estimated reduction is $241 million.
- General Assistance eligibility changes – the anticipated reduction is $10 million.
- High-cost case reviews – the anticipated reduction is $26.8 million.
- Hospital application process revision –- the estimated increase is $14.5 million.
- Audit enhancements – the anticipated savings are $3.4 million.
- Loophole copayments authorized in Act 22 – the estimated reduction is $4.2 million. *(Actual savings will depend on if and when copayments are implemented)*.
- Pharmacy payment changes per Act 22 regulations – the anticipated reduction is $8.7 million in 2012/12, an increase of $5.7 million over the partial year savings in 2011/12.
- Increased copayments per Act 22 regulations – the anticipated reduction is $0.8 million in 2012/13, an increase of $0.6 million over the partial year savings in 2011/12.

Funds Budgeted for MA Outpatient

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$645.1	$360.1	-$285.0
Federal Medicaid Funds	$1,204.1	$1,015.1	-$189.0
Other Revenue:			
Statewide Hospital Assessment	$5.7	$5.3	-$0.4
Philadelphia Hospital Assessment	$125.7	$148.3	$22.5
TOTAL FUNDS	**$1,980.7**	**$1,528.8**	**-$451.8**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

MA Inpatient

The Inpatient appropriation funds inpatient hospital care provided to MA recipients in the fee-for-service program. In July 2010, the General Assembly passed legislation (Act 49 of 2010) authorizing DPW to implement a statewide hospital assessment – known as the Quality Care Assessment program – for three years, beginning in 2010/11. This statewide assessment enabled DPW to modernize hospital fee-for-service rates by implementing a payment system, known as the APR -DRG system, which more appropriately supports the levels of service unique to MA patients.

A portion of the assessment revenue is retained by DPW to pay Inpatient expenditures, reducing the need to spend state General Funds. The remaining revenues from the assessment are used to pay for the following costs:

- higher reimbursement rates under the APR-DRG system;
- increased reimbursement for hospital inpatient services through the HealthChoices managed care program;
- existing supplemental payments made to hospitals; and
- new supplemental payments established under the Quality Care Assessment program.

The following expenses are paid from the Inpatient appropriation:

- Reimbursement rates paid to acute care hospitals, private psychiatric hospitals, rehabilitation hospitals and residential treatment facilities for inpatient services provided to MA recipients.
- Supplemental payments made to qualifying hospitals, including Inpatient Disproportionate Share, Medical Education, Community Access Fund payments, and the various supplemental payments funded under the Quality Care Assessment program.
- Medicare Part A premiums, copayments and deductibles for dual eligibles.

Inpatient services are paid primarily with state General Funds and federal Medicaid funds appropriated in the annual state budget. These appropriated funds are augmented by the revenues generated from the statewide hospital assessment.

Nearly $1.5 billion is budgeted in 2012/13 for

Inpatient services. This includes $204.7 million in state General Funds, a decrease of $121 million from 2011/12 which included a $39 million supplemental appropriation decrease.

The 2012/13 state General Fund appropriation reflects the net affect of the following program initiatives on Inpatient expenditures:

- HealthChoices expansion to 42 counties — the estimated reduction is $120.5 million.
- General Assistance eligibility changes — the anticipated state savings are $18.1 million.
- High-cost case reviews — the anticipated reduction is $4.7 million.
- Hospital application process revisions — the estimated state cost is $7.9 million.
- Audit enhancements — the anticipated state savings are $2.1 million.

Act 22 of 2011: Normal Newborn Payments

The enacted budget rejected the Act 22 regulation that eliminated the payment to hospitals for care provided to normal (healthy) newborn babies and added the necessary funding to fully restore the payment.

Final regulations published April 14 by DPW, per its Act 22 expedited rulemaking authority, ended the APR-DRG payment for all healthy newborns discharged after May 1, 2012. Eliminating the payment was projected to reduce state payments by $5.3 million in 2012/13; the total reduction in hospital payments (state and federal dollars) was estimated at $11.6 million.

In accordance with an amendment to the Fiscal Code (Act 87 of 2012) providing for the continuation of normal newborn payments to hospitals, DPW modified its payment system on July 13 to resume paying for normal newborn care; all previous hospital claims that were denied by DPW have been reprocessed.

Funds Budgeted for MA Inpatient

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$325.7	$204.7	-$121.0
Federal Funds:			
Medicaid Match	$860.6	$783.1	-$77.5
ARRA Health Information Tech.	$128.3	$135.8	$7.6
Other Revenue:			
Statewide Hospital Assessment	$373.5	$370.5	-$3.0
TOTAL FUNDS	**$1,688.0**	**$1,494.1**	**-$72.9**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

The enacted 2012/13 budget rejected Gov. Corbett's proposed 4 percent cut in hospital reimbursement rates, adding $12.5 million in state funds to restore the state funding Gov. Corbett wanted to eliminate. However, this rate restoration was offset by a $15 million reduction in hospital reimbursements, resulting from a retroactive adjustment to July 2011 of the case mix index used to determine individual hospital rates.

Other Medical Assistance Appropriations

This section focuses on other MA appropriations, beginning with the individual lines that fund specific hospital supplemental payments. Also included is a brief discussion of the Medical Assistance for Workers with Disabilities (MAWD) program, the MA transportation program, the Medicare Part D payment that Pennsylvania is mandated to make to the federal government, and funding for medical schools.

Hospital Supplemental Payments

In addition to the various supplemental payments funded through the Inpatient and Outpatient appropriations, the enacted 2012/13 budget includes five other supplemental payments – four are funded through state General Fund appropriations and one is funded with Tobacco Settlement Fund revenue through an executive authorization. Each of these payments qualify for federal Medicaid matching funds.

The table on page 13 details the funds budgeted for the following hospital payments:

- Obstetric and Neonatal Services payments made to qualifying hospitals that provide obstetric and neonatal services to MA recipients;
- Critical Access Hospital payments made to rural hospitals that meet Medicare's definition for "critical access" hospitals;

Funds Budgeted for Supplemental Payments to Hospitals						
	State General Fund ($ Millions)			**Total Funds** ($ Millions)		
DPW Appropriation	**2011/12**	**2012/13**	**Change**	**2011/12**	**2012/13**	**Change**
Obstetric and Neonatal Services	$3.7	$3.7	$0.0	$9.1	$8.5	-$0.6
Critical Access Hospitals	$3.6	$4.1	$0.5	$8.9	$9.3	$0.5
Trauma Centers	$8.7	$8.7	$0.0	$21.5	$20.0	-$1.5
Hospital Based Burn Centers	$3.8	$3.8	$0.0	$9.4	$8.7	-$0.7
	Tobacco Settlement Fund ($ Millions)			**Total Funds** ($ Millions)		
Executive Authorization	**2011/12**	**2012/13**	**Change**	**2011/12**	**2012/13**	**Change**
Uncompensated Care	$25.3	$25.9	$0.5	$56.6	$56.5	-$0.1

- Trauma Center payments made to Pennsylvania's accredited trauma centers;
- Hospital-Based Burn Center payments made to certified burn centers; and
- Uncompensated Care payments made to qualifying hospitals as partial reimbursement for costs incurred in treating patients with inadequate or no insurance.

The enacted **budget restored the 10 percent cut that Gov. Corbett proposed in state funding for Obstetric and Neonatal Services, Trauma Centers, and Hospital Based Burn Centers** – for each of these payments, state General Funds are appropriated at the same level as 2011/12.

For Critical Access Hospitals, the 2012/13 **budget restored the 10 percent cut that was proposed by Gov. Corbett** and provided an additional $500,000 for state payments to these hospitals.

Tobacco Settlement Funds allocated to the Uncompensated Care program is determined in accordance with statutory provisions in the Tobacco Settlement Act (Act 77 of 2001), as modified by amendments to the Fiscal Code (Act 87 of 2012). For 2012/13, the $0.5 million increase in Tobacco Settlement Fund revenue for Uncompensated Care is due to an increase in the payments that Pennsylvania received from tobacco manufacturers. (For more information, see the separate budget briefing on the Tobacco Settlement Fund online.)

Although **state-only funding** is no less than the 2011/12 level, the reduction in Pennsylvania's FMAP rate (from 55.07 percent to 54.28 percent, on Oct. 1) decreased the federal Medicaid matching funds that can be claimed for each state dollar spent in 2012/13. Consequently, **total funds budgeted** for supplemental payments – other than Critical Access Hospitals — are less than 2011/12.

MAWD

Medical Assistance for Workers with Disabilities (MAWD) is a Medical Assistance purchase program for working Pennsylvanians, age 16 to 64, who have a disability and whose income is less than 250 percent of the federal poverty level. Enrollees purchase their Medical Assistance coverage by paying DPW a monthly premium.

The Tobacco Settlement Act (Act 77 of 2001) created the MAWD program and provided for an annual allocation from the tobacco payments received each year by Pennsylvania to pay for the program. However, due to the ever increasing number of MAWD participants, the annual allocation from the Tobacco Settlement Fund is not sufficient to cover program expenditures and so the shortfall is made up with an appropriation from the state General Fund. Funding for MAWD earns federal Medicaid matching funds.

The enacted budget appropriates $33.5 million in state General Funds for MAWD. This is $6.2 million, or nearly 23 percent, above 2011/12 which included a $9.5 million supplemental appropriation increase. Increased funding for MAWD is driven by rising program enrollments. The 2012/13 budget anticipates that MAWD enrollment will average 30,838 people per month, which represents 13 percent growth from the 2011/12 monthly average of 27,178 enrollees.

The 2012/13 budget includes a new initiative that

Funds Budgeted for MAWD (Dollars in Millions)			
Revenue Source	**2011/12 ***	**2012/13**	**Change**
Tobacco Settlement Fund	$62.0	$63.2	$1.2
State General Fund	$27.3	$33.5	$6.2
Federal Medicaid Funds	$113.8	$126.4	$12.6
TOTAL FUNDS	**$203.1**	**$223.2**	**$20.0**
* 2011/12 funds include supplemental appropriation.			

increases the monthly premium MAWD enrollees must pay to DPW for their MA coverage. Act 77 of 2001 stipulated that MAWD enrollees pay DPW a monthly premium equal to five percent of their monthly income; however, the General Assembly amended the Fiscal Code this year to authorize DPW to increase the percentage of income that enrollees must pay as their monthly premium.

Medical Assistance Transportation

The Medical Assistance Transportation Program (MATP) provides non-emergency medical transportation services to MA recipients who cannot meet their own transportation needs. Emergency ambulance transportation is funded separately through the Outpatient appropriation.

Non-emergency transportation is available for most health care services covered by MA, including transportation to and from doctor appointments, pharmacies for prescriptions, hospitals for tests, drug and alcohol clinics, mental health centers, and medical suppliers. MATP services may include tickets or tokens to ride public transportation, paratransit door-to-door services (for example, in a van), or mileage reimbursement for use of a private car.

MATP is funded with state General Fund revenue and federal Medicaid matching funds. DPW allocates MATP funding to counties, which may either provide the service directly or contract with a provider. For Philadelphia, DPW contracts with an independent transportation agency to administer the program.

The enacted budget includes nearly $73 million in State General Funds for MATP. This represents a $3.6 million, or 5.2 percent, increase from 2011/12 which included a $4 million supplemental appropriation increase to address county funding shortfalls. The appropriation is projected to fund more than 12 million rides, an increase of 500,000 rides compared to 2011/12.

Act 22 of 2011: MATP Copayments

The enacted budget does not impose copayments on riders, reflecting DPW's decision to remove proposed Medical Assistance Transportation Program (MATP) copayments from the final regulations published April 14, 2012 per its Act 22 expedited rulemaking authority.

DPW's draft regulations, issued in February 2012, included new copayments of $2 for each one-way ride and $4 for each round-trip. The enacted 2011/12 budget had assumed state savings of $8 million as a result of the new MATP copayments. The affect of the proposed copayments would be to reduce MATP funding allocations to each county, leaving the county MATP providers responsible for collecting the copayments from riders.

After reviewing comments opposing the co-payments, including opposition from several county MATP programs, DPW decided not to implement the copayments.

Medicare Part D Payment

"Payment to Federal Government - Medicare Drug Program" is a state appropriation that funds the monthly payments Pennsylvania must make to the federal government for each dual eligible resident enrolled in Medicare Part D. Each month, DPW receives an invoice from the federal government showing the amount Pennsylvania owes for each dual eligible resident in the Part D program. As explained below, the amount of the monthly payment – also known as the "clawback" payment – does not reflect actual Part D costs; instead, it is based on a formula in federal law that uses factors unrelated to Medicare spending.

Prior to the January 2006 implementation of Medicare Part D, each state's Medicaid program covered the prescription drugs for its dual eligible residents. Federal assumption of drug coverage for the dual eligibles relieved the states of substantial pharmacy costs in their Medicaid programs – for Pennsylvania, dual eligible pharmacy coverage was costing MA approximately $400 million per year. However,

Funds Budgeted for MA Transportation

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$69.2	$72.8	$3.6
Federal Medicaid Funds	$68.6	$71.9	$3.3
TOTAL FUNDS	**$137.8**	**$144.7**	**$6.9**

* 2011/12 funds include supplemental appropriations.

Funds Budgeted for Medicare Part D Payments to the Federal Government			
	State General Fund ($ Millions)		
DPW Appropriation	2011/12 *	2012/13	Change
Payment to Federal Gov't - Medicare Part D	$472.3	$510.9	$38.7
* 2011/12 funds include supplemental appropriation.			

rather than allowing states to keep their savings, the federal government required states to pay most of the savings to the Medicare program to help finance the Part D drug benefit. This payment requirement became known as the "clawback" to signify the federal government grabbing a share of the state savings. The calculation of the monthly "clawback" payment is stipulated in the Medicare Modernization Act of 2003, which established the Part D drug program, and is designed to reflect a portion of expenditures that the state would have incurred had it continued to pay the prescription drug costs for dual eligibles through Medicaid.

The enacted budget appropriates $510.9 million for the state payments to the federal government for Medicare Part D, an increase of $38.7 million from 2011/12 which included a supplemental appropriation decrease of $8.3 million.

Increased funding in 2012/13 reflects anticipated growth in the number of dual eligible residents enrolled in Part D and higher monthly per capita costs. The number of average monthly eligibles is projected to increase to 327,508 individuals in 2012/13, up from 318,400 in 2011/12. The average per capita monthly payment is $130 in 2012/13, compared to $123.62 in 2011/12.

Medical Schools

Two appropriations in the Medicaid budget – Academic Medical Centers and Physician Practice Plans – fund medical schools. To earn federal Medicaid matching funds for state payments made to medical schools through these two appropriations, DPW must submit plans and receive approval from the federal government.

The Academic Medical Centers appropriation provides for supplemental payments to state-affiliated academic medical centers to assure the continuation of the critical services they provide to the Medical Assistance population. These payments are also intended to help offset the Medical Assistance share of medical education costs incurred by these hospitals.

- This appropriation initially applied only to Temple University, Penn State University (Hershey Medical Center), and the University of Pittsburgh. Prior to the implementation of this program on July 1, 2005, Pennsylvania supported these three academic medical centers as non-preferred appropriations funded with state General Funds. Payments to these schools receive federal matching funds.

- Beginning in 2011/12, the budget added $3 million in state funds for three additional academic medical centers in Erie, Scranton, and Philadelphia. These payments do not earn federal matching funds.

The 2012/13 enacted budget for the Academic Medical Centers maintains state payments at the 2011/12 level, with $9.6 million for Temple, Penn State and Pitt – or half of what these three schools received in 2010/11 – and $3 million for the schools in Erie, Scranton and Philadelphia. The reduction in total funds is attributed directly to the FMAP rate decrease on Oct. 1 which will reduce federal Medicaid matching funds that Pennsylvania may claim in 2012/13.

The Physician Practice Plans appropriation provides for payments to university-affiliated physician practice plans to help ensure that the critical services they provide to Medical Assistance recipients will continue. This appropriation initially applied only to Drexel University, Thomas Jefferson University, and University of Pennsylvania. Prior to the implementation of this program on Jan. 1, 2009, these three medical schools were supported through non-preferred appropriations from the state General Fund.

Funds Budgeted for Academic Medical Centers and Physician Practice Plans						
	State General Fund ($ Millions)			Total Funds ($ Millions)		
DPW Appropriation	2011/12	2012/13	Change	2011/12	2012/13	Change
Academic Medical Centers	$12.6	$12.6	$0.0	$28.2	$27.7	-$0.5
Physician Practice Plans	$6.4	$7.9	$1.5	$14.4	$17.4	$3.1

The enacted budget for Physician Practice Plans also maintains state payments for the medical schools – Drexel, Thomas Jefferson, and the University of Pennsylvania – at the 2011/12 level (half the 2010/11 level). However, total payments to these three medical schools will decrease due to the FMAP rate reduction. Increased funding in 2012/13 is attributed to the addition of $1.5 million in state funds for a physician practice plan operated by Mercy Philadelphia.

Long-Term Living System

Medicaid is a major payer for long-term care services provided to the elderly and individuals with disabilities. When first implemented in the 1960s, Medicaid only paid for long-term services provided in institutions such as nursing facilities and intermediate care facilities. Over the decades, the Medicaid program has evolved to include an array of home and community supports that enable individuals to live safely in their homes and other community settings as an alternative to institutional long-term care.

Many community services are provided through Medicaid Home and Community–Based Services (HCBS) waivers *(see box on page 17)*. To participate in an HCBS waiver program, an individual must meet the state's financial eligibility requirements for Medicaid and the state's clinical eligibility for long-term care. That is, they require the level of care provided in an institution.

This section focuses on Pennsylvania's long-term living system, which provides services to elderly individuals and to non-elderly adults with physical disabilities. As detailed in the table below, the enacted budget includes nearly $1.3 billion in state General Funds and $4.9 billion in total funds (state, federal and other) for the five appropriations that support the long-term living system.

The **most expensive, and restrictive, component of the long-term living system is nursing facility care**, which is funded through DPW's Long-Term Care appropriation. Pennsylvanians receiving nursing facility 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. **In 2011/12, more than 84,000 people received nursing facility care**, including approximately 8,200 people under age 60.

DPW administers two community-based programs that provide **more than 27,000 older Pennsylvanians** an alternative to nursing facility care.

- ***Aging Waiver*** is an HCBS waiver program that provides services to people age 60 or older who require nursing facility level of care. The *Aging Waiver* is funded through the Home and Community-Based Services appropriation.
- ***LIFE*** is a managed care program that provides a comprehensive package of services – including medical, social and supportive services – for people, aged 55 or older, who have been determined to need nursing facility level of care. *LIFE* is funded through the Long-Term Care-Managed Care appropriation.

DPW also administers five community-based programs that allow more than 17,000 non-elderly Pennsylvanians with physical disabilities to avoid institutionalization.

Funds Budgeted for Long-Term Living Services for Elderly and Individuals with Disabilities

	State General Fund ($ Millions)			Total Funds ($ Millions)		
DPW Appropriation	2011/12 *	2012/13	Change	2011/12 *	2012/13	Change
Long-Term Care (nursing facilities)	$737.4	$765.9	$28.6	$3,579.9	$3,750.6	$170.8
Home & Community-Based Services	$175.2	$174.5	-$0.7	$413.2	$471.3	$58.1
LTC - Managed Care	$65.6	$75.9	$10.3	$154.2	$175.1	$21.0
Services for Persons with Disabilities	$164.0	$167.4	$3.4	$364.0	$366.9	$2.9
Attendant Care	$102.7	$98.9	-$3.8	$187.0	$189.5	$2.5

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

- The **Community Services Program for Persons with Physical Disabilities** (CSPPPD) is comprised of **three HCBS waiver programs** for adults with severe physical disabilities – such as cerebral palsy and traumatic brain injury – and who do not have intellectual disabilities or a major mental disorder as a primary diagnosis. The three waiver programs are organized around specific target groups, with each waiver having its own eligibility requirements and offering services specifically tailored to meet the health care needs and supports necessary for these individuals to live in the community. CSPPPD is funded through the Services for Persons with Disabilities appropriation.

- **Attendant Care** provides in-home personal care to mentally alert adults, age 18 through 59, who have a physical disability and need assistance to carry out functions of daily living, self-care and mobility. **Attendant care is available through two programs:** an HCBS waiver program which serves individuals who meet Medicaid eligibility, and a state-funded program for individuals not eligible for Medicaid.

The local Area Agencies on Aging conduct a comprehensive evaluation to determine whether MA recipients meet clinical eligibility for long-term care and may participate in one of the waiver programs. Each waiver participant receives services pursuant to an Individualized Service Plan (ISP) that reflects their goals, preferences, strengths and needs. DPW does not impose co-payments or other charges upon participants for waiver services.

Long-Term Care

The Long-Term Care appropriation funds nursing facility care provided to MA recipients. State regulations implemented in 1996 establish a case-mix payment methodology for determining the per diem rates paid each year by DPW to nursing

Home and Community-Based Services (HCBS) Waivers

HCBS Waivers are programs that use federal Medicaid funds for community services as an alternative to institutional care. The name "waiver" comes from the fact that the federal government waives, or sets aside, its Medicaid rules so that states can receive federal Medicaid matching funds for expenditures that would otherwise not qualify for federal participation. To obtain federal approval for a waiver, the state must ensure that waiver services are cost effective compared to the cost of institutional care. The state must also demonstrate that it has safeguards to protect the health and welfare of persons served in the waiver program.

States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted elderly or people with disabilities who are at risk of being placed in a nursing facility or a facility for individuals with intellectual disabilities. The state is permitted to offer various services to waiver participants provided that these services are specified in an individualized written plan of care and are necessary to keep a person from being institutionalized. Waiver programs may provide both traditional medical services, such as skilled nursing services, and non-medical services, such as personal care assistance and respite. Examples of HCBS Waiver services include: therapies and counseling; nursing; personal care services; homemaker/home health aide services; respite care; case management; rehabilitation services; supported employment and training; adaptive appliances and equipment; and home accessibility adaptations.

Additionally, states have the discretion to choose the number of consumers to serve in an HCBS waiver program. This ability to set enrollment caps differentiates wavier programs from the open-ended entitlement in the traditional Medicaid program, which obligates states to serve everyone who qualifies.

Funds Budgeted for Long-Term Care

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$737.4	$765.9	$28.6
Federal Medicaid Funds	$2,044.5	$2,090.1	$45.6
Other Revenue:			
Tobacco Settlement Fund	$162.6	$121.7	-$40.9
Lottery Fund	$178.4	$309.1	$130.6
Assessment Revenue	$456.9	$463.9	$7.0
TOTAL FUNDS	**$3,579.8**	**$3,750.6**	**$170.9**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

facilities. Under case-mix, residents are periodically classified into categories based on the intensity of care they require, with nursing facilities paid more for services provided to residents with higher care needs. Rates generated by the case mix system are not capped – as the case mix index for a nursing facility increases, so do the rates paid to that facility. Beginning in fiscal year 2005/06, the General Assembly amended the Public Welfare Code, authorizing DPW to apply a budget adjustment factor (BAF) to cap rates and ensure MA payments to nursing homes do not exceed the amount appropriated in the budget.

Federal Medicaid funds are the predominant revenue source for Long-Term Care. In addition to State General Funds, DPW uses the following revenues to earn federal matching funds: Lottery Funds; Tobacco Settlement Funds, and revenue generated from the assessment on nursing facilities.

These funds pay for the following:

- Rates paid to nursing facilities for the care of MA residents, which account for approximately 80 percent of budgeted funds.
- Supplemental payments that DPW makes to nursing facilities in return for their participation in the assessment program, which account for approximately 15 percent of budgeted funds.

Total funds budgeted for Long-Term Care is $3.75 billion. This includes $766 million in state General Funds, an increase of $29 million from 2011/12 which included a $7.1 million supplemental appropriation increase.

The increased 2012/13 state General Fund appropriation reflects the impact of the FMAP rate reduction, effective Oct 1, 2012. It also reflects the net affect of the following budgetary factors related to cash flow and the availability of Special Fund revenues to pay for 2012/13 expenditures:

- Returning to the prudent payment standard in 2011/12 – this shifted $77 million of payments to the 2012/13 fiscal year.
- Using additional revenue from special funds to offset the need to spend state General Fund revenue – while Tobacco Settlement Funds for Long-Term Care decreased nearly $41 million compared to 2011/12, Lottery Funds increased $130.6 million resulting in a $90 net increase of special funds to pay nursing facility expenditures in 2012/13.

The enacted budget level funds nursing facility rates. In his February 2012 budget proposal Gov. Corbett requested 4 percent cut in per diem rates; however, the General Assembly added $46.5 million in state funds ($102 million state and federal) to restore the funding eliminated by Gov. Corbett.

Long-Term Care – Managed Care

The ***LIFE* managed care program** provides comprehensive medical and support services to adults, age 55 or older. An interdisciplinary team – comprised of a physician, nurse, therapists, social workers, personal care attendants and other professionals – assesses a person's needs, develops care plans, and delivers all services. The *LIFE* program is centered around an adult day health center where recipients receive most services; however, services such as personal care and meals are also provided in the home as needed.

LIFE is funded with state General Fund revenue and federal Medicaid matching funds. These revenues pay the monthly capitated rates paid to approved *LIFE* providers for each enrollee. In 2011/12, the program had 18 *LIFE* providers operating 30 sites and serving more than 3,400 enrollees.

A total of $175 million is budgeted for the *LIFE* managed care program. This includes $75.9 million in state General Funds, an increase of $10.3 million from 2011/12 which included a $7.4 million supplemental appropriation decrease.

Funds Budgeted for Long-Term Care — Managed Care

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$65.6	$75.9	$10.3
Federal Medicaid Funds	$88.6	$99.3	$10.7
TOTAL FUNDS	**$154.2**	**$175.1**	**$21.0**

* 2011/12 include supplemental state appropriation.

The enacted budget assumes the addition of two new *LIFE* facilities in 2012/13 and approximately 400 more individuals receiving services. Rates paid to *LIFE* providers are flat for 2012/13.

Home and Community-Based Services

The Aging Waiver program operates statewide, providing home and community-based services to seniors, age 60 or older. Services include home health, personal assistance, home delivered meals, specialized medical equipment/supplies, respite services, home modifications, and supports coordination. DPW pays for each waiver service in accordance with fee schedules and reimbursement rates recently established by the department under its Act 22 rulemaking authority.

The Home and Community-Based Services appropriation is funded primarily with state General Funds and federal Medicaid matching funds. Additional revenues are provided from the Tobacco Settlement Fund in accordance with provisions in Act 77 of 2001 which allocate a portion of the tobacco payments received each year by Pennsylvania to expand home and community-based services for seniors.

For 2012/13, total funds budgeted for Home and Community-Based Services is $471 million. This includes $174.5 million in state General Funds, a decrease of $0.7 million from 2011/12 which included a $14.8 million supplemental appropriation increase.

The 2012/13 budget also includes $41 million of Tobacco Settlement Fund revenue, an increase of $31.7 million compared to 2011/12. This

Funds for Home & Community-Based Services

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$175.2	$174.5	-$0.7
Tobacco Settlement Fund	$9.4	$41.1	$31.7
Federal Medicaid Funds	$228.7	$255.7	$27.0
TOTAL FUNDS	**$413.2**	**$471.3**	**$58.1**

* 2011/12 funds are the amounts reported in DPW's 2012/13 rebudget request and include supplemental appropriations.

Act 22 of 2011 – Long-Term Living Home and Community-Based Services (HCBS)

The enacted long-term living budget reflects the new HCBS payment provisions and provider qualifications established by DPW under its Act 22 expedited rulemaking authority. These new **HCBS regulations affect approximately 2,000 providers** who deliver services through the Aging Waiver, Attendant Care Waiver, COMMCARE Waiver, Independence Waiver, the OBRA Waiver and the Act 150 Attendant Care Program *(see descriptions on page 20).*

On May 19, 2012, DPW published final-omitted regulations that established payment rates, fee schedules and payment methodologies for home and community-based services. The regulations created two payment methods: fee schedule rates and cost-based reimbursements. Fee schedule rates were established for most HCBS services using a new rate-setting methodology, with rates adjusted regionally to take into account the differences in costs based on the characteristics of each region – counties were categorized into four regions, each with its own set of rates. Cost-based reimbursements (payment of actual costs) were continued for a limited number of "vendor" goods and services such as durable medical equipment and non-medical transportation. Prior to these changes, DPW paid for many services through locally-negotiated rates between providers and public and private local entities.

- The rates for HCBS services, other than service coordination services, took effect June 1, 2012.
- The rate for service coordination services took effect July 1, 2012, after DPW received the necessary federal approvals.

The final regulations also instituted conflict free service coordination, beginning July 1, 2012. Prior to this regulation, service coordination agencies, which are responsible for developing and monitoring the service plan for individuals, could prescribe waiver services and also provide those services. The new regulation generally prohibits service coordinators from providing any waiver or Act 150 program services other than service coordination. However, service coordination entities may provide direct services under the following circumstances: the entity is providing the service as an organized health care delivery system; it is providing financial management services to a participant; or it is providing community transition services to a participant transferring from a nursing facility.

Moreover, the new regulations allow DPW's Office of Long-Term Living to limit the number of service coordination units available to participants in the waiver programs and Act 150 program.

increase in tobacco funding reflects the administration's decision to move funding from the Department of Aging so that DPW receives the entire annual allocation of tobacco payments for home and community-based services.

- Historically, this allocation was shared between DPW and the Department of Aging – in 2011/12, DPW received $9.4 million compared to $32.2 million for the Department of Aging. DPW used its allocation to pay for services provided through the Aging Waiver; the Department of Aging used its allocation to pay for the administrative costs associated with the Aging Waiver and the Nursing Home Transition program which assists individuals who want to move from a nursing facility back into the community.
- In his February 2012 budget proposal, Gov. Corbett distributed the tobacco allocation between the two agencies. However, the enacted budget reflects the administration's subsequent decision to move the entire allocation to DPW, together with the expenditures associated with administering the Aging Waiver program and the Nursing Home Transition program. *(For more information, see the separate budget briefing on the Tobacco Settlement Fund.)*

Consequently, the 2012/13 Home and Community-Based Services appropriation pays for the following:

- Rates paid to providers for services furnished to Aging Waiver enrollees.
- Administrative costs associated with the waiver – this is a new expenditure to DPW which follows the tobacco funds moved over from the Department of Aging.
- Expenses for the Nursing Home Transition program – this is a new expenditure to DPW which follows the tobacco funds moved over from the Department of Aging.

The enacted budget anticipates Aging Waiver services will be expanded to serve an additional 166 seniors per month, with waiver users averaging 18,884 seniors per month in 2012/13.

The reduction in the state General Fund appropriation reflects Aging Waiver savings associated with the 2012/13 initiative to conduct high-cost case reviews. It also reflects the annualized savings associated with changes to the long-term living system that were implemented in the 2011/12 budget under the Act 22 rulemaking authority given to the DPW secretary *(see box on page 19)*.

- High-cost case reviews are anticipated to save the state $3.2 million.
- Rates developed per Act 22 regulations are estimated to save the state $2.8 million in 2012/13, which is an increase of $2.7 million compared to the $0.1 million partial year savings in 2011/12.

Services to Persons with Disabilities

The Community Services Program for Persons with Physical Disabilities (CSPPPD) is comprised of three HCBS waiver programs.

- **OBRA Waiver** provides services to persons age 18 or older with severe developmental physical disabilities – such as cerebral palsy, epilepsy or similar conditions – that require an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care. Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22 and are likely to continue indefinitely.
- **Independence Waiver** provides services to persons age 18 or older who are physically disabled – but not with intellectual disability or have a major mental disorder as a primary diagnosis – and who are clinically eligible for nursing facility care.
- **COMMCARE Waiver** provides services to adults with traumatic brain injury who are age 21 or older and require nursing facility level of care.

Services provided under the three waivers include: personal assistance, home health, respite, therapeutic and counseling services, community transition services, financial management services,

Funds for Services for Persons with Disabilities

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$164.0	$167.4	$3.4
Federal Medicaid Funds	$200.0	$199.5	-$0.5
TOTAL FUNDS	**$364.0**	**$366.9**	**$2.9**

* 2011/12 funds include supplemental appropriations.

supports coordination, supported employment, and accessibility adaptations/equipment/ technology/ medical supplies. In addition, both the OBRA and COMMCARE waiver programs offer prevocational services and habilitation services. DPW pays for each waiver service in accordance with fee schedules and reimbursement rates recently published by the department under its Act 22 rulemaking authority.

CSPPPD is funded with state General Fund revenue and federal Medicaid matching funds. A total of nearly $367 million is budgeted for 2012/13. This includes $167.4 million in state General Funds, an increase of $3.4 million from 2011/12 which included a $28.3 million supplemental appropriation increase.

The enacted budget anticipates waiver services will be provided, on average, to 7,933 individuals per month – this represent an increase of 573 individuals compared to 2011/12.

- *OBRA Waiver* users are expected to average 1,393 individuals per month, down 100 from 2011/12.
- *Independence Waiver* users are expected to average 5,953 individuals per month, up 682 from 2011/12.
- *COMMCARE Waiver* users are expected to average 587 individuals per month, down 9 from 2011/12.

The reduction in the state General Fund appropriation for these waiver programs reflects the savings associated with the 2012/13 initiative to conduct high-cost case reviews. It also reflects the annualized savings resulting from changes to the long-term living system that were implemented in the 2011/12 budget under the Act 22 rulemaking authority given to the DPW secretary *(see box on page 19)*.

- High-cost case reviews are anticipated to save the state $2.7 million.
- Rates and service coordination provisions established in the Act 22 regulations are estimated to save the state $7.8 million in 2012/13, which is an increase of $7.3 million compared to the $0.5 million partial year savings in 2011/12.

Attendant Care

The Attendant Care program provides **in-home personal care to mentally alert adults, age 18 through 59, who have a physical disability and need assistance to carry out functions of daily living, self-care and mobility.** To be eligible for attendant care services, the disability must be a medically determined physical impairment which can be expected to last continuously for at least 12 months or that may result in death.

- Individuals who are Medicaid eligible receive services through the *Attendant Care Waiver Program*. The waiver program is funded with state General Funds and federal Medicaid matching funds.
- Adults with disabilities who are not Medicaid eligible receive basic services through the *Act 150* program, named after the 1986 act which established attendant care services in Pennsylvania. The *Act 150* program is funded with state dollars; there is no federal funding. Although most *Act 150* participants do not pay for their services, individuals with higher incomes may be assessed a co-payment for services based on a sliding scale fee.

Attendant care services include assistance with bathing, dressing, personal hygiene, meal preparation, housekeeping and other daily living functions. Other available services include supports coordination, financial management services, personal emergency response system, and community transition services (for waiver participants only). DPW pays for each service in accordance with fee schedules and reimbursement rates recently published by the department under its Act 22 rulemaking authority.

Attendant Care is funded primarily with state General Funds and federal Medicaid matching

Funds Budgeted for Attendant Care

(Dollars in Millions)

Revenue Source	2011/12 *	2012/13	Change
State General Fund	$102.7	$98.9	-$3.8
Federal Medicaid Funds	$83.3	$89.6	$6.3
Other Revenues	$1.0	$1.0	-
TOTAL FUNDS	**$187.0**	**$189.5**	**$2.5**

* 2011/12 includes supplemental state and federal appropriations.

funds. These revenues are augmented with other funds from parking fees and patient fees generated in the Act 150 program.

A total of $189.5 million is budgeted in 2012/13 for Attendant Care. This includes $98.9 million in state General Funds, a decrease of $3.8 million from 2011/12 which included a $0.8 million supplemental appropriation decrease.

The reduction in the state General Fund appropriation for these Attendant Care programs reflects the savings associated with the 2012/13 initiative to conduct high-cost case reviews. It also reflects the annualized savings resulting from changes to the long-term living system that were implemented in the 2011/12 budget under the Act 22 rulemaking authority given to the DPW secretary *(see box on page 19)*.

- High-cost case reviews are anticipated to save the state $2.1 million.
- Rates and service coordination provisions established in the Act 22 regulations are estimated to save the state $5.9 million, which is an increase of $5.8 million compared to the $0.1 million partial year savings in 2011/12.

The enacted **budget anticipates attendant care will be provided to approximately 7,881 adults per month, an increase of 184 compared to 2011/12.** The average number of *Attendant Care Waiver* users is anticipated to increase by 571 users to 6,789 adults per month; however, the average number of *Act 150* users is anticipated to decrease by 387 users, to 1,092 adults per month. This change in program participants is due, in part, to certain *Act 150* users meeting Medicaid eligibility during 2012/13 and being switched over to the *Attendant Care Waiver* program, where the federal government will pay for more than half of their service costs.

Intellectual Disability (ID) and Autism Programs

Pennsylvania's intellectual disability (ID) system provides both institutional care and community-based services for people with intellectual disabilities.

- Institutional care is provided through state centers operated directly by DPW and private intermediate care facilities under contract with the department. These are funded through two separate appropriations in DPW's budget, ID-State Centers and ID-Intermediate Care Facilities.
- Community-based services are available through two appropriations: ID Community Waiver Program and ID Community Base Program. The ID Community Waiver Program funds two HCBS waiver programs for people who meet Medicaid eligibility. The ID Community Base Program provides services to people who are not eligible for the waiver programs as well as those Medicaid eligible individuals who are not yet enrolled in a waiver (for information on the base program, see the Aug. 15, 2012 human services budget briefing.)

DPW operates five state centers and contracts with 181 private intermediate care facilities (ICFs/ ID). Both types of institutions provide 24-hour residential care and specialized health and habilitation services to individuals with intellectual disabilities. The state centers and private providers are licensed and certified by federal ICF/ID regulations – they must meet minimum services and safety standards to maintain federal certification and receive federal Medicaid funding. During 2011/12, the state centers served

Funds Budgeted for Programs Serving People with Intellectual Disabilities and Autism

	State General Fund ($ Millions)			Total Funds ($ Millions)		
DPW Appropriation	2011/12	2012/13	Change	2011/12	2012/13	Change
ID - State Centers	$106.3	$109.9	$3.6	$301.3	$303.9	$2.6
ID - Intermediate Care Facilities *	$143.8	$143.0	-$0.8	$362.2	$358.7	-$3.5
ID - Community Waiver Program	$854.9	$919.9	$65.0	$1,804.5	$1,923.0	$118.5
Autism Intervention and Services	$13.5	$13.0	-$0.5	$29.3	$25.2	-$4.0

* 2011/12 total funds include a supplemental federal appropriation.

approximately 1,160 people and the private ICFs/ID served approximately 2,500 people.

DPW operates two HCBS Waiver programs: the *Consolidated Waiver* and the *Person/Family Directed Support (PFDS) Waiver*. These programs are available to individuals who are at least 3 years old and who, based on a medical evaluation, meet the functional criteria for ICF/ID eligibility – that is, they would otherwise require the level of care provided in an institution for persons with intellectual disabilities. **More than 27,000 people received waiver services in 2010/11**, including 16,104 individuals who were enrolled in the *Consolidated Waiver* and 11,206 people who were enrolled in the *PFDS Waiver (see description on page 24).*

To utilize program funding more efficiently, DPW encourages private ICF/ID providers to convert to the community waiver program as an alternative to institutionalization. These conversions shift funding from the ICF/ID program to the ID Waiver programs.

In addition to these ID programs, DPW has specifically designed two community-based programs for adults with autism: the ***Adult Autism Waiver*** and the ***Adult Community Autism Program (ACAP)***. Both programs serve adults, age 21 or older who have a diagnosis of autism spectrum disorder, meet financial eligibility for Medical Assistance, and require the level of care for an intermediate care facility. Together, these two programs have the capacity to serve 500 adults. Priority is given to enrolling adults who are not currently receiving services – that is, they are not enrolled in another HCBS waiver or not residing in a state ID center, intermediate care facility, state mental hospital or nursing facility. These programs are funded through the appropriation for Autism Intervention and Services.

ID — State Centers

This appropriation pays the staff, operating expenses, and fixed assets (i.e., maintenance equipment and office equipment) needed by DPW to effectively run five state centers — Ebensburg, Hamburg, Polk, Selinsgrove and White Haven.

The state centers are funded primarily with state General Funds and federal Medicaid funds. Beginning in 2004/05, Pennsylvania instituted a provider assessment on all ICFs/ID, including the state centers, to generate more revenues to support Pennsylvania's ID system. In addition to federal Medicaid reimbursements, DPW receives some federal funds from Medicare billings — these Medicare payments account for less than $1 million of annual revenue for the centers. Remaining revenues are comprised largely of institutional collections.

Total funding for the state centers is nearly $304 million in 2012/13. This includes nearly $110 million in state General Funds, which is a $3.6 million increase compared to 2011/12. The increased state funding is driven by higher personnel costs (wage and benefit increases for staff) and the lower FMAP rate effective Oct. 1, 2012 which will reduce federal Medicaid reimbursements.

Funds Budgeted for ID State Centers

(Dollars in Millions)

Revenue Source	2011/12	2012/13	Change
State General Fund	$106.3	$109.9	$3.6
Federal Funds:			
Medicaid Match	$166.2	$165.0	-$1.2
Medicare Payments	$0.8	$0.7	-$0.1
Other Revenue:			
ID Assessment	$17.5	$17.9	$0.4
Other	$10.6	$10.5	-$0.1
TOTAL FUNDS	**$301.3**	**$303.9**	**$2.6**

ID — Intermediate Care Facilities (ICF/ID)

This appropriation funds the per diem rates paid to 181 private ICF/ID providers under contract with DPW. These private facilities are located throughout the commonwealth and vary in size – 161 are small facilities that serve 4 to 8 people; 20 are larger facilities that serve more than 8 people (the largest facility serves 260 people).

The ICFs/ID are supported primarily with state General Funds and federal Medicaid funds. These appropriated funds are augmented by the revenues generated from the ICF/ID assessment that was implemented in fiscal year 2004/05.

Total funding for the private ICFs/ID is $358.7 million in 2012/13. This includes $143 million in state General Funds, which is $0.8 million less than

2011/12. The decrease reflects the conversion of 84 beds from the ICF/ID to the community *Consolidated Waiver* program.

Funds Budgeted for ICF/ID (Dollars in Millions)			
Revenue Source	**2011/12 ***	**2012/13**	**Change**
State General Fund	$143.8	$143.0	-$0.8
Federal Medicaid Funds	$199.8	$195.9	-$3.9
Other Revenue:			
ID Assessment	$18.6	$19.8	$1.2
TOTAL FUNDS	**$362.2**	**$358.7**	**-$3.5**
* 2011/12 federal funds include supplemental appropriations.			

ID — Community Waiver Program

This appropriation funds the rates paid to providers that furnish services to individuals enrolled in two waivers: the Consolidated Waiver and the Person/Family Directed Support (PFDS) Waiver.

- **Consolidated Waiver** provides both residential and non-residential services for individuals who require high levels of support and monitoring. Most participants receive residential services, often in small group homes.
- **PFDS Waiver** only serves people who live in their own home or their family's home. The waiver provides non-residential services and caps individual expenditures at $26,000 per year.

Residential services provide an alternative to institutionalization and include the following: community residential services in licensed homes for 3-4 people, supports to individuals renting or owning their own homes, and family living (also known as life sharing) in which 1 or 2 people receive services in the licensed family home of an unrelated adult.

Non-residential services provide the necessary supports for individuals to remain with their families, live independently, or live in other community settings. Examples of services include day support services, employment services, in-home supports such as companion services, adaptive equipment and respite care.

Individuals who are eligible for ID waiver services are enrolled in the programs, provided there is sufficient funding and capacity. Otherwise, they are placed on a county waiting list and receive community services provided by the counties through the ID-Community Base Program. Counties use the PUNS (Prioritization of Urgency of Need for Services) process to collect information on individuals with intellectual disabilities who are waiting for services, including the types of services they need and the urgency of their need. April 2012 PUNS data indicated 15,420 Pennsylvanians were on county waiting lists – this included 3,790 individuals who were on the Emergency Waiting List and in immediate need of services.

Total funding for the ID waiver programs is $1.9 billion in 2012/13 – approximately $1.7 billion is budgeted for the *Consolidated Waiver* and $200 million for the *PFDS Waiver.* The enacted budget includes nearly $920 million in state General Funds, which is a $65 million increase compared to 2011/12.

The increased 2012/13 state General Fund **appropriation reflects the waiting list initiative added by the General Assembly in the enacted budget** – this initiative will provide services to 1,130 additional people during 2012/13, including 700 special education graduates and 430 individuals with aging caregivers who are on the county emergency waiting list. It also reflects the conversion of ICF/ID beds to the *Consolidated Waiver* program, which will add 84 people to the waiver. These two initiatives increase ID Waiver expenditures as follows:

- Waiting list initiative expanding services for 1,130 additional people – state funding increased $17.8 million.
- Conversion of 84 people from the ICF/ID program – state funding increased approximately $3 million.

Other factors driving the increase in state spending are the FMAP decrease, which will reduce federal reimbursements for the waiver program,

Funds for ID Community Waiver Programs (Dollars in Millions)			
Revenue Source	**2011/12**	**2012/13**	**Change**
State General Fund	$854.9	$919.9	$65.0
Federal Medicaid Funds	$949.6	$1,003.1	$53.5
TOTAL FUNDS	**$1,804.5**	**$1,923.0**	**$118.5**

and the annualization of costs (to reflect a full year of services) for 199 individuals who were moved to waiver programs during 2011/12, including: 114 people converted from the ICF/ID program, 50 people moved from state ID centers, and 35 people moved from state mental hospitals.

Autism Intervention and Services

This appropriation pays for various programs that support individuals with autism and their families. The major expenditures under this appropriation include:

- Rates paid to providers that furnish services for adults in the **Adult Autism Waiver**.
- The capitated rate paid for each adult enrolled in **Adult Community Autism Program (ACAP)**.
- Funding for the mini-grant program that supports families and individuals with autism. Grants of up to $500 may be used for respite/child care, summer camp, recreational or community programs, home safety modifications, and conferences/workshops.
- Funding for three regional autism centers – Penn State University/Hershey, Children's Hospital of Philadelphia/University of Philadelphia, and University of Pittsburgh Medical Center. The regional autism centers focus on improving access to quality services and interventions, providing information and support to families, training professionals in best practices, and research.

Most of the budgeted spending is for the costs associated with the two programs that serve adults with autism: the **Adult Community Autism Program (ACAP)** and the **Adult Autism Waiver**. Both programs, which required federal approval, are the first of their kind in the nation and earn federal Medicaid matching funds.

The Adult Autism Waiver is a traditional fee-for-service HCBS waiver program designed to provide long-term services and supports for community living. The waiver program operates statewide and has the capacity to serve 300 adults. Unlike ACAP, this program does not offer medical service; as with the other HCBS waivers, individuals receive their physical and behavioral health through the Medical Assistance program.

- Available waiver services include: behavioral specialist services, therapies (occupational, speech and language), habilitation services, assistive technology, environmental modifications, family training, respite, community transition services, temporary crisis services, job assessment, job finding, supported employment, and transitional work services.

ACAP is a managed care program that provides community service as well as medical services, both physical health and behavioral health. *ACAP* is offered in four counties – Dauphin, Lancaster, Cumberland, and Chester – and has the capacity to serve 200 adults. A single managed care entity (Keystone Autism Services) is responsible for integrating and coordinating services for *ACAP* participants. DPW pays Keystone a capitated rate (per person per month payment) for each *ACAP* enrollee.

- **Medical services** available under ACAP include: physician, certified registered nurse, optometrist, chiropractor, audiologist, dentist, outpatient psychiatric clinic services, medical supplies and durable medical equipment.
- Available **community services** include: behavioral support services, therapies (occupational, speech and language, counseling), habilitation services, personal assistance, homemaker/chore services, assistive technology, visiting nurse, hospice, family counseling, respite, environmental modifications, community transition services, pre-vocational services, supports coordination, crisis intervention services, non-medical transportation and supported employment.

The 2012/13 budget provides total funding of $25.2 million for Autism services. This includes $13 million in state General Funds, which represents a $0.5 million decrease from 2011/12. However, when comparing the 2012/13 budget with the prior year, it is important to note that the 2011/12 appropriations included $1.3 million in state funds that were lapsed and approximately $5 million of

Funds for Autism Intervention and Services

(Dollars in Millions)

Revenue Source	2011/12	2012/13	Change
State General Fund	$13.5	$13.0	-$0.5
Federal Medicaid Funds	$15.7	$12.2	-$3.5
TOTAL FUNDS	**$29.3**	**$25.2**	**-$4.0**

excess federal appropriations that were not spent. If you take into account these two factors, state spending will actually increase by $0.8 million and total spending will increase by $2 million.

The enacted budget includes the following;

- $4.8 million in state funds ($10.3 million total funds) for the *Adult Autism Program*, an increase of $1.3 million compared to 2011/12 spending – DPW anticipates the waiver will serve an average of 290 people per month in 2012/13.
- $3.9 million in state funds ($8.5 million total funds) for *ACAP*, an increase of $0.5 million compared to the 2011/12 spending – DPW anticipates ACAP will operate near full capacity of 200 people per month in 2012/13.
- $500,000 for family mini-grants, a decrease of $278,000 from 2011/12.
- $2.28 million for the three regional autism centers ($760,000 per center), which is a decrease of $120,000 from 2011/12 (a cut of $40,000 per center).
- $240,000 for the Center for Autism and Developmental Disabilities at Philhaven, the same as 2011/12.
- $240,000 for autism education and diagnostic curriculum at the Kinney Center at St. Joseph's University – this is a new initiative.

Glossary of Key Terms

Capitation – A payment method for health services in which a provider is paid a fixed amount for each individual served, usually on a monthly basis, without regard to the actual number of services provided to the individual.

Dual Eligibles – Individuals who are entitled to Medicare and who are also eligible for Medicaid benefits.

Federal Medical Assistance Percentage (FMAP) – Percentage used to determine the amount of federal matching funds for state Medicaid expenditures.

Home and Community-Based Services (HCBS) Waiver – Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to alter Medicaid rules so a state may offer special services to elderly or disabled individuals who are at risk of being placed in a nursing facility or facility for individuals with intellectual disabilities. These HCBS Waiver services, which otherwise would not be covered with federal Medicaid matching funds, include: case management, personal care services, homemaker/home health aide services, rehabilitation services, and respite care.

Managed Care Organization (MCO) – An entity that provides certain benefits to Medical Assistance recipients for a monthly capitation payment for each enrollee as set forth in a state contract. Medical Assistance MCOs only provide services to Medical Assistance recipients; they do not serve commercial or Medicare enrollees.

Supplemental Security Income (SSI) – A federal entitlement program, established in Title XVI of the Social Security Act, that provides cash assistance to low-income aged, blind and people with disabilities.

Temporary Assistance for Needy Families (TANF) – This is the federal block grant program, established by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which provides cash assistance and work opportunities to needy families. TANF replaced the earlier cash entitlement program known as Aid to Families with Dependent Children (AFDC). In Pennsylvania, the income limit for families to qualify for TANF benefits is generally about 50 percent of the federal poverty level.