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Pennsylvania Medical Assistance Budget for 2007-08: Issues and Analysis

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Pennsylvania Medical Assistance Budget for 2007-08: Issues and Analysisⁱ

Introduction

The Pennsylvania Medicaid program, called Medical Assistance, is the Commonwealth's health care safety net. It provides access to primary, preventive, emergency and long-term care services for low-income families with children, the elderly, individuals with disabilities and adults with chronic illness. Medicaid is a federal entitlement program; individuals who meet income, asset and other eligibility requirements are qualified to enroll in Medicaid and receive health care services.ⁱⁱ Medicaid is jointly funded by the federal government and the states according to a federal formula that is adjusted annually.ⁱⁱⁱ Medical Assistance is managed by Pennsylvania's Department of Public Welfare (DPW).

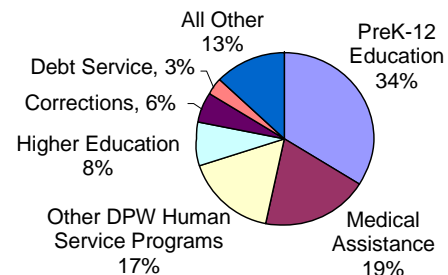
In fiscal year 2008 (FY08) the period from July 1, 2007, through June 30, 2008, Pennsylvania will spend \$14.4 billion in state, federal and other funds on the Medical Assistance program. After basic education, Medical Assistance is the largest spending category in the state's general fund budget (see *Figure 1*). It affects the lives of 1.9 million Pennsylvania citizens and is also an important source of revenue for Pennsylvania's health care institutions, which are a critical and growing segment of Pennsylvania's economy.

The formal budget process begins each year in February when the governor delivers a budget proposal to the General Assembly. The budget identifies expected state and federal funding sources

for the year, outlines proposed appropriations for all state general fund programs and details policy and program initiatives. Then the General Assembly reviews the governor's proposed budget, considers the potential impact on member districts and weighs the varied and often conflicting views of interest groups. The General Assembly enacts statutory changes necessary to implement policy and spending proposals and, in most cases, approves the final budget before the new fiscal year begins on July 1. By August, agencies receive guidance from the governor's office and begin preparing their budgets for the following year.

This report will examine Pennsylvania's Medical Assistance budget for state FY08, which was approved July 17, 2007. It begins by presenting some background information to set the stage for the FY08 budget deliberations. It then discusses budget and policy initiatives proposed by Governor Rendell in February 2007 as well as the disposition of those initiatives. Finally, it will look ahead to explore budget and policy initiatives likely to be proposed for FY09.

Figure 1: Pennsylvania FY08 State General Fund Expenditures



Background

Medical Assistance is one of the Commonwealth's most important programs and it is also one of the most expensive. For almost 20 years, the Medical Assistance budget has reflected a delicate balance between maintaining services, meeting new demands and controlling costs. Health care costs generally increase more quickly than the overall rate of inflation, and Medical Assistance enrollment growth was particularly brisk between 2000 and 2006. A decline in employer-sponsored health insurance, rising prescription drug costs and increased demand for long-term care services each contributed to a 50 percent increase in expenditures from \$9.3 billion to

ⁱ The financial information used throughout this report comes from the Commonwealth of Pennsylvania Governor's Executive Budget for 2007-08 which can be found at: http://www.budget.state.pa.us/budget/lib/budget/budget_presentation/2007_08_budget_document.2.pdf.

ⁱⁱ Medical Assistance is the term that Pennsylvania uses to describe its Medicaid program. In this report, we use the term Medical Assistance when we are referring specifically to Pennsylvania. We use the term Medicaid when we are referring to the Medicaid population generally.

ⁱⁱⁱ In 2007, federal funding accounted for 53 percent of Pennsylvania's Medical Assistance budget.

\$14.1 billion between FY00 and FY07. Higher enrollment, medical inflation and growing concern over health care access, coupled with the loss of important non-federal funding sources, shaped the choices available to state policymakers in FY08.

The federal government gives the states great flexibility in designing their Medicaid programs, as well as wide discretion in setting spending levels. In preparing Pennsylvania's Medical Assistance budget, lawmakers identify the state funds that they are prepared to allocate to Medical Assistance services, balancing the need for additional health care spending with the demands of other state services, including education, prisons, parks and libraries.

Most state Medical Assistance dollars come from the state general fund or general tax dollars. However, escalating Medical Assistance program costs, coupled with limited state tax revenue, have prompted lawmakers to seek other revenue to support the Medical Assistance program. This includes reallocations of dedicated funds (such as lottery or tobacco settlement funds) as well as non-state taxpayer sources, such as Intergovernmental Transfers (IGTs) and health care provider assessments (see discussion below). State funds are used to draw down federal matching dollars according to a formula set by the Centers for Medicare and Medicaid Services (CMS). The resulting federal share, known as the Federal Medical Assistance Percentage (FMAP), ranges across the states from 50 percent to 83 percent depending on state personal income and is adjusted annually. Pennsylvania's FMAP rate is 54.08 percent in FY08.^{iv}

A number of factors influenced the development of the FY08 Medical Assistance budget: higher enrollment, a shift to service delivery through managed care, expanding demand for long-term care services and movement toward community-based services, prescription drug costs, declining IGT funds and pay for performance initiatives. Each is discussed in more detail below.

ENROLLMENT

Beginning in 2000, Medical Assistance enrollment increased significantly in Pennsylvania and across the country. The economic recession of 2001-02 raised unemployment rates, increasing the number of individuals eligible for Medical Assistance, and began what would be a steady decline in employment-based coverage.^v In 2002, the Commonwealth made a modest increase in income eligibility for the elderly and adults with disabilities.^{vi} While enrollment growth slowed in FY07, total enrollment was 34 percent higher in 2007 than in 2000.

FINAL IMPLEMENTATION OF MANAGED CARE

The Commonwealth has attempted to control the costs of Medical Assistance by moving from a fee-for-service system to a managed care system for both physical and behavioral health care services. Between 1997 and 2001, Pennsylvania phased in its managed care program for physical health, known as HealthChoices, to beneficiaries in 25 counties in eastern and southwestern Pennsylvania and offered it as an option for individuals in 17 other counties. Beginning in 1997, Pennsylvania began to deliver behavioral health services to its Medical Assistance recipients through county-based behavioral health managed care organizations. By July 2007, managed behavioral health care was implemented in all 67 counties.

LONG-TERM CARE SERVICES

Long-term care services continue to grow as Pennsylvania's population ages; these services represented 28 percent of total Medical Assistance expenditures in FY07. Pennsylvania has the third highest proportion of seniors of any state in the nation and a rapidly increasing population of adults over 85 years of age. Research suggests that seniors would prefer to age in place, but Pennsylvania has traditionally funded nursing home care and has moved more slowly than many states in providing

^{iv} Federal Funds Information Service, Issue Brief 7-15: Updated FY 2009 FMAP Projections, March 28, 2007.

^v The number of non-elderly Pennsylvanians covered by an employer declined from 75.9 percent in 2000 to 70.6 percent in 2006.

^{vi} Eligibility for seniors increased from 75 percent of the Federal Poverty Level (FPL) to 100 percent of FPL.

services to seniors in their homes or communities.^{vii} In 2006, the Rendell administration created the Pennsylvania Office of Long-Term Living to consider strategies for moving from the traditional reliance on nursing home care toward expanded services in home and community settings. In 2007, 70 percent of long-term care recipients received care in institutions, and only 30 percent received care in home- and community-based settings. The Rendell administration has set a goal of changing that balance to 50-50 by 2010 and has increased funding for noninstitutional programs to support that goal.

CONTROLLING DRUG COSTS

The cost of prescription drugs has risen significantly since 2000, and Pennsylvania has worked hard to control these costs through better oversight of beneficiary utilization and through implementation of a Preferred Drug List (PDL). A PDL saves money in two ways: First, it promotes the use of lower-cost generic drugs and requires preapproval for many expensive brand-name drugs; second, it allows the state to negotiate with drug manufacturers to receive discounts, known as supplemental rebates,^{viii} for drugs that are on the PDL.

Several budget issues arose during the transition to the PDL. Initially, the Commonwealth proposed implementing the PDL in both its fee-for-service program and its managed care plans, requesting permission to do so from CMS in 2003. The budget for FY06 reflected the expected savings from the use of the PDL in both programs. However, CMS approved the waiver in 2005 and limited the PDL to the fee-for-service program only. This created an unanticipated \$45 million increase in Medical Assistance program costs in FY06, a cost that the Commonwealth is grappling with addressing to this day.

MEDICARE PART D PRESCRIPTION DRUG SERVICES

The Medicare Modernization Act of 2003 (MMA) created a new prescription drug program for elderly

Medicare recipients called the Medicare Part D drug benefit. Before January 2006, low-income elderly citizens who were enrolled in both Medicare and Medicaid, known as dual eligibles, received prescription drug benefits through Medicaid. In January 2006, drug coverage for these individuals was switched to Medicare Part D. This shift was expected to result in prescription drug savings for states. The MMA required states to rebate a majority of this savings back to the federal government through what is known as the Part D “clawback payment.” The states’ estimates of the savings resulting from the shift of drug costs to Medicare were much lower than the estimates of the federal government, and states, including Pennsylvania, disputed the original savings estimates. The federal government revised the estimates downward in response to the states’ requests, but the costs are still significant: \$338 million in FY07. In September 2007, Pennsylvania rebated \$120 per month per dual eligible to the federal government.

The Commonwealth determined that it was no longer necessary for managed care organizations to coordinate the remaining benefits available to dual eligibles once prescription drug coverage was transferred to Medicare and moved this group to the fee-for-service program for health care.^{ix} All dual eligibles continue to receive behavioral health services in managed care.

DECREASING FEDERAL EXPENDITURES

Pennsylvania’s FMAP has been declining – it was reduced from 55.05 percent in FY06 to 54.08 percent in FY08. This reduced federal funds by \$23 million in FY07 and by a projected \$36 million in FY08.

INTERGOVERNMENTAL TRANSFERS AND PROVIDER ASSESSMENTS

States have used a variety of funding arrangements to raise additional non-state tax dollars both to replace state general fund dollars and to supplement state general fund dollars to increase the amount of federal Medicaid matching funds. Beginning in 1991, the Commonwealth increasingly relied on a funding source known as Intergovernmental Transfers (IGTs)

^{vii} These services are called home- and community-based or waiver services because the state must receive a waiver from CMS to pay for services outside of institutional settings.

^{viii} The Commonwealth also participates in the federal drug rebate program established under federal law in 1990, which passes cost savings on to the states for prescriptions in the formulary.

^{ix} However, under the MMA, special needs plans may be developed under the Medicare Advantage component. Many of these special needs plans are offered to dual eligibles.

in which publicly owned nursing homes provide the dollars necessary to earn federal matching funds. In essence, funds provided by publicly owned nursing homes were used to draw down federal matching funds and this enabled the state to reduce state general fund contributions to Medical Assistance. In FY03, IGT funds accounted for \$1.8 billion dollars, or 17 percent of the total Medical Assistance budget. However, a CMS ruling in 2000 has forced Pennsylvania to phase out the use of IGT funds by FY10. As a replacement, the Commonwealth instituted assessments^x on nursing homes and managed care organizations in 2005 and reauthorized nursing home assessments in 2007. Managed care assessments are scheduled to terminate in October 2009. In this case, Pennsylvania will need to find replacement revenue through either additional general fund contributions or some other funding source to avoid imposing limits on Medical Assistance eligibility or reducing provider payments.

OTHER APPROACHES TO COST SAVINGS

Faced with growing enrollments, many states cut Medicaid eligibility to control costs. Pennsylvania policymakers, led by Governor Rendell, rejected this approach, opting instead to implement additional cost sharing and benefit limitations on beneficiaries. The Medical Assistance redesign program that was adopted in FY06 limited physical health and behavioral health services for adult Medical Assistance recipients and reduced payments to managed care organizations.^{xi} The state also

x Private nursing facilities are assessed quarterly based on the number of licensed beds and the number of non-Medicaid resident days. County nursing homes and Veterans Affairs nursing homes are exempt. All assessment revenue from nursing homes is deposited into a restricted account in the general fund and used exclusively for payments to nursing homes. Managed care organizations are assessed 6 percent of total premiums annually.

xi Pennsylvania Act 42 of 2005 authorized DPW to impose service limits on physical and behavioral health services for adult Medical Assistance recipients and General Assistance enrollees in the fee-for-service program. These include limiting acute and rehab hospital stays to one per year and limiting outpatient health services, including doctor and clinic visits, to 18 per year (exempting visits to a primary care physician, inpatient physician services and consultations, dialysis, radiation planning and treatment and outpatient occupational and physical therapy). Pregnant women and children are exempt from these limitations. Managed care organizations were not required to impose these restrictions, but the capitation payments to managed care organizations were revised to reflect the service limits. Managed

redirected some of the state lottery funds and tobacco settlement dollars to pay for long-term care.

INCENTIVE PAYMENTS FOR HEALTH OUTCOMES (PAY FOR PERFORMANCE)

In FY06, the Commonwealth began to offer incentives to providers for improving their performance. The state offered incentive payments to physicians in the fee-for-service program to expand preventive services and improve patient health outcomes. DPW established 10 targets, including prenatal care, breast and cervical cancer screening, adolescent well visits and cholesterol and diabetes control. The FY06 budget allocated \$10 million for this program and paid out \$4 million in bonuses. In FY07, these incentives were increased as incentive payments were introduced for hospitals.

The FY08 Budget

OVERVIEW

The FY08 budget marks the second consecutive year of slower budgeted spending growth in the Medical Assistance program in Pennsylvania. Total spending from all sources is budgeted to increase by only 1 percent, from \$14.2 billion to \$14.4 billion. State general fund spending is projected to decline by \$38 million, or 8 percent. Medical Assistance enrollment is projected to grow by 62,000 recipients to 1,968,000, a 3 percent increase. It is worth noting that the budget includes the costs of both federal Medicaid (health expenditures for individuals enrolled in Medical Assistance and eligible for the federal match) and General Assistance recipients. Currently, the federal government does not match the cost of health care expenditures for General Assistance recipients.

Budgeted spending growth slowed for three primary reasons. First, Medical Assistance enrollment growth has slowed significantly since the early part of the decade. Second, cost savings from full implementation of managed care and from initiatives to control prescription drug costs have

care organizations that did not impose service limits or only modified the limits absorbed those costs. Behavioral health services were limited to 30 days of inpatient psychiatric hospitalization, 540 hours of partial hospitalization and 10 hours of outpatient therapy services. Savings were projected at \$24 million the first year and \$31 million the second year.

been realized. Finally, the budget includes several cost savings measures, including one-time budgetary savings and initiatives, such as receiving federal match for General Assistance recipients that can only be implemented with CMS approval.

In order to put the final budget in context, this report first looks at the major initiatives that were proposed by the governor and then examines the revenues and expenditures for the program.

PROPOSED AND ACTUAL INITIATIVES FOR FY08

In the proposed budget for FY08, Governor Rendell identified \$446 million in potential savings from one-time budget measures and the reconfiguration of certain Medical Assistance services. The major proposals are discussed below.

Budgetary and one-time savings. The governor's budget proposed \$315 million in one-time savings measures for FY08, all of which were approved by the General Assembly.

Prior to FY08, managed care organizations received monthly capitation payments at the beginning of the month. The FY08 budget proposed moving payments to the end of the month, in effect moving one payment to state fiscal year FY09. This change in the timing of payments to managed care organizations would result in \$200 million in savings. In addition, the governor proposed taking advantage of a February start date for Medicare Part D clawback payments to shift one monthly payment into July 2008^{xii} for a savings of \$34 million. Finally, the proposed budget included supplemental appropriations from FY07 of \$218 million, a portion of which is proposed to use to prepay FY08 obligations. This is reflected as a savings, including a savings of \$77 million in outpatient services.

Programmatic saving. As previously discussed, in FY07, the Commonwealth continued to grapple with a gap of \$45 million in funding related to the failure of its request to include managed care organizations in its preferred drug list. The governor's budget included two proposals to eliminate this deficit.

Consolidating prescription drug services. Pennsylvania DPW currently manages the prescription drug program for 800,000 individuals in the fee-for-service program and has been able to achieve significant savings through improved oversight and use of the Preferred Drug List. In an effort to find additional savings, DPW again proposed taking over or "carving out" management of the prescription drug component of the managed care programs to take advantage of savings from supplemental drug rebates not available to managed care organizations and savings from the Preferred Drug List. This proposal was not accepted by the General Assembly.

Elimination of voluntary managed care. The governor proposed to move about 71,000 Medical Assistance recipients from the voluntary managed care program to the fee-for-service program. This would allow the Commonwealth to save an estimated \$23 million through access to supplemental rebates not available to managed care organizations and through additional oversight of pharmaceutical utilization. To reflect this proposal, the outpatient budget would increase by an additional \$300 million, and the capitation budget, which funds the managed care programs, would decline by \$320 million. Managed care organizations delivering services in the voluntary counties and legislators representing those counties opposed the change, arguing that the savings were overestimated—that they would be only \$7 million—and that managed care participants were satisfied with their services. The General Assembly rejected this cost savings measure.

General Assistance savings. Pennsylvania currently provides health services to 57,000 General Assistance recipients using state only dollars. The budget includes \$72 million in savings from a proposed waiver to allow the Commonwealth to receive federal matching dollars for this state-funded program. The legislature approved the budget with the projected savings, although final approval from CMS must be secured.

Medicare crossover payments. The governor proposed and the General Assembly approved a plan that will reduce the costs to the Commonwealth for medical services for low-income seniors who are enrolled in both Medical Assistance and Medicare (dual eligibles) for a savings of \$13.75 million.

^{xii} DPW expects this change will be acceptable to federal auditors monitoring DPW's financial procedures. If the change does not occur, DPW will have to change payment procedures for next year.

Specifically, Medical Assistance pays for a number of services for dual eligibles, including Medicare Part B premiums, behavioral health services, vision screening, hearing aids and other services. Previously, Medical Assistance paid the Medicare rate for these services, but beginning in FY07, Medical Assistance will pay providers in the fee-for-service program the Medical Assistance rate—which is lower than the Medicare rate—for these services.

Behavioral health managed care. Full implementation of behavioral health managed care was completed in July 2007. Counties, or contractors engaged by counties, will deliver all behavioral health services in all 67 Pennsylvania counties. The proposed budget for the capitation program increased by \$29.6 million to reflect a full year of behavioral health managed care in 15 additional counties. Some of the decrease in outpatient and inpatient costs reflects this shift.

Provider rates. Over the past two years, the issue of provider rates for nursing homes has been somewhat contentious. In FY06, as a cost savings measure, Governor Rendell proposed to change the method by which nursing home rates are determined, a change that the General Assembly rejected.^{xiii}

While the governor did not reintroduce changes to the nursing home reimbursement methodology for FY08, the budget proposed a 2 percent rate increase for hospitals (\$13.5 million) and nursing homes (\$33.2 million). The governor also proposed a \$198 million increase in rates for managed care organizations, including \$38.6 million in performance incentive payments and \$11.7 million in incentives for improved disease management, preventive intervention and treatment of childhood obesity.

^{xiii} Currently, rates are specific to each nursing home and are determined each month by assessing the health status of each resident in that facility. Governor Rendell proposed conducting the health status assessments on a quarterly basis instead. The nursing home industry argued that this methodology does not reflect actual costs incurred for patient care, while the governor argued that Pennsylvania's nursing home rates are among the highest in the nation and that the change could be absorbed by the industry. The General Assembly rejected the governor's approach and, in 2006, passed legislation mandating a return to the original case-mix methodology. The governor vetoed this legislation.

The General Assembly opted instead to increase nursing home reimbursement rates from 2 percent to 3 percent for FY08. Hospitals will receive a 2 percent rate increase, while rates for managed care organizations will rise by 3 percent.

Incentive payments for health outcomes. The proposed budget expanded the initiative started in FY06 to offer incentive payments to physicians in the fee-for-service program. As noted above, DPW established health outcome targets in 10 areas, including prenatal, breast and cervical cancer screening, adolescent well visits and cholesterol and diabetes control, and agreed to pay bonuses to physicians meeting the targets. DPW added two additional targets for FY08: early childhood lead screenings and cholesterol management in diabetes patients. In FY08, \$10 million was allocated for physician incentive payments.

The final budget expanded incentive payments to managed care organizations by offering a higher reimbursement rate—up to 2.5 percent for progress toward performance targets. The same performance targets apply in the managed care pay-for-performance program, and specific outcome measures will be negotiated this fall. However, the managed care organization incentive payments will not be paid until after the end of FY08, resulting in a one-time savings of \$38.6 million.

Rebalancing Long-Term Care Services. The Commonwealth took a major step toward its rebalancing effort with the passage of legislation defining and regulating assisted living facilities. Under current law, nursing homes or facilities that provide medical services are defined, regulated and eligible to receive Medical Assistance payments, but nonmedical facilities are not. This legislation is a starting point for the creation of standards for the delivery of care—setting some requirements for staff training, for example—but most of the specifics will be defined in regulation.

Home- and community-based services. The proposed budget for FY08 allocated an additional \$26 million to expand home- and community-based services to 2,100 additional seniors and reflected anticipated savings of \$2.5 million from reductions in the number of nursing home beds. The rebalancing program has proven to be challenging, as nursing home beds have not been taken out of service at the

same rate as community services have expanded. The Pennsylvania legislature did not agree with the administration's assessment of potential cost savings, and as a result, they are not included in the final budget.

The Prescription for Pennsylvania. One of the largest and most significant initiatives proposed by the Rendell administration in FY07 is the Prescription for Pennsylvania, a comprehensive health care reform package designed to reduce costs, increase access and improve the quality of health care services for Pennsylvanians.

One significant component of the Prescription for Pennsylvania is Cover All Pennsylvanians, which would expand Medicaid eligibility to adults earning up to 300 percent of the Federal Poverty Level (FPL). Section 1115 of the Social Security Act gives CMS authority to grant waivers to states for demonstration projects or to provide federal matching payments for services that are not otherwise allowable if states can demonstrate budget neutrality. Vermont and Massachusetts have used this authority to expand health insurance coverage to adults. Cover All Pennsylvanians proposes to expand health insurance coverage to almost 431,000 uninsured Pennsylvania adults in four years. Medicaid funding would account for one-third of Cover All Pennsylvanians program funds in the first year. Additional funding would come from premiums from individuals and employers, an increase in the state tobacco tax and an assessment of 3 percent of payroll on employers with more than 50 employees who do not offer health insurance.

MEDICAL ASSISTANCE REVENUES

The Medical Assistance budget consists of four revenue streams. The state *general fund* provides revenues from state taxes and fees. *Special funds* provide allocations from two separate, dedicated state funding sources to the Medical Assistance program, which include the state's lottery and tobacco settlement funds. *Federal funds* are the federal Medicaid matching dollars. And, as noted above, the Commonwealth has sought to identify *other state-based funding sources* that could be used to draw down federal matching funds. These include provider assessments and IGT funds.

In FY08, the Commonwealth continued to reduce the increases in general fund appropriations for Medical Assistance by adding funds from other state sources that would replace state general fund dollars. In FY07, \$249 million in funding from the state lottery was allocated to the Medical Assistance long-term care program. This allocation will continue at the same level in FY08. In FY07, the statutory allocation of state tobacco settlement funds was changed to direct additional funds into the Medical Assistance long-term care program. In FY08, the state Tobacco fund allocation for long-term care will change again, increasing from \$66 million to \$105 million, as the legislature has moved funds from smoking cessation programs and the health investment insurance (adultBasic) account into long-term care. Finally, as noted above, the state increased provider assessments from \$663 million in FY07 to \$684 million in FY08. Furthermore, in FY07, the General Assembly reauthorized nursing home assessments through June 2012.^{xiv}

Table 1 shows total Pennsylvania Medical Assistance revenues from FY06 through FY08. Budgeted revenues will increase about 1 percent from FY07 to FY08.

Table 1: Medical Assistance Revenues (in 000s) from FY06 through FY08

	FY06 Actual	FY07 Available	FY08 Budget	Change FY07 - FY08	%
Federal Funds	\$7,403,155	\$7,603,376	\$7,884,783	\$281,407	3.7%
State Funds					
General Fund	\$4,862,514	\$5,089,163	\$5,050,820	(\$38,343)	-0.8%
Special Funds	\$106,369	\$372,716	\$397,465	\$24,749	6.6%
Other Funds	\$1,507,441	\$1,154,484	\$1,038,785	(\$115,699)	-10.0%
Total	\$13,879,479	\$14,219,739	\$14,371,853	\$152,114	1.1%

Source: Author's analysis of budget documents

Federal funds will increase by almost 4 percent in FY08, including \$72 million in new federal dollars that DPW expects to draw down for Medical Assistance-eligible General Assistance recipients.^{xv}

^{xiv} Rates may increase each year, subject to a rate cap. The reauthorization gave DPW authority to expand the assessments to include county nursing homes.

^{xv} General Assistance is a state-funded program for low-income adults with a chronic disease or disability who are ineligible for Temporary Assistance for Needy Families (TANF) or federal Supplemental Security Income (SSI) benefits. General Assistance recipients must have a physical or mental disability or be undergoing substance abuse treatment in an approved program. In August 2007, there were 57,315 individuals receiving General Assistance in the Commonwealth.

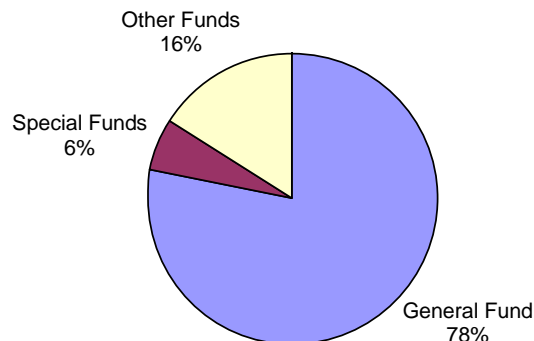
However, this payment is contingent on CMS approval. The budget also includes federal matching funds for state funds allocated in FY07 that will be spent in FY08.^{xvi}

State general fund revenues will decline slightly by less than 1 percent, which reflects both the \$72 million in replacement federal funds for the General Assistance program (discussed above) and additional cost savings that will be discussed below. Special funds will increase slightly, reflecting the increased allocation from the state tobacco settlement fund and the state lottery discussed above. Other funds include provider assessments and IGT funds. Provider assessments will increase slightly, but IGT funds, which are being phased out, declined from \$492 million in FY07 to \$355 million in FY08.

As discussed above, *Table 1* reflects the Commonwealth's efforts to slow general fund spending for Medical Assistance and increase use of special funds. The impact of declining IGT funds is noted in the "other funds" category.

Figure 2 shows Medical Assistance revenues for FY08 from state funding sources. Allocations from the general fund make up 78 percent of state funds allocated to Medical Assistance. Special funds—tobacco settlement and lottery dollars—consist of 6 percent of state funds, and other funds (including IGT) are 16 percent of the total, down from 18 percent in FY07.

Figure 2: State Sources of Medical Assistance Funds FY08



MEDICAL ASSISTANCE EXPENDITURES

The Medical Assistance budget has six major expenditure categories:

- Inpatient and outpatient: Services by health care providers operating on a fee-for-service basis are reflected in the inpatient and outpatient allocations.
- Capitation: Medical Assistance services delivered through Medical Assistance managed care organizations, HealthChoices and Behavioral HealthChoices are funded through the capitation program.
- Long-term care: Services for the elderly, disabled and individuals with degenerative diseases—including nursing home care and home- and community-based services—are reflected in the long-term care appropriation.
- Transportation: Services for beneficiaries seeking to access Medical Assistance-eligible services are funded through the Medical Assistance Transportation Program (MATP).
- Medicare Part D "clawback" payments: Monthly payments to the federal government for the Medicare Part D prescription drug program because the costs of the drugs for "dual eligibles" were shifted from the Medicaid program to the Medicare program.
- Miscellaneous: A variety of smaller programs, ranging from special payments to academic medical centers and trauma hospitals to special services for individuals with HIV/AIDS and family planning services for women, are reflected in the miscellaneous category. Some of the miscellaneous programs reflect gubernatorial priorities, and some reflect state legislative priorities.

Total Appropriations. *Table 2* shows how Medical Assistance spending from all state and federal sources has been allocated among the different

^{xvi} The Commonwealth had a \$200 million supplemental appropriation for Medical Assistance in FY07 and did not use all of the money. Therefore, those funds are available to pay for a portion of FY08 program costs and will draw down additional federal funds as well.

spending lines since FY06. As previously discussed, the outpatient and inpatient lines have declined, and the capitation line has increased, reflecting the shift from fee-for-service to managed care delivery. (The main difference between the proposed and actual budgets for outpatient and managed care is due to the decision by the legislature not to eliminate the voluntary managed care program as initially proposed by the governor.) Long-term care funding will decline slightly in FY08, while transportation and miscellaneous programs will increase. Medicare Part D clawback payments will increase by almost 4 percent in FY08.

Table 2: Medical Assistance Appropriations

(all sources)	FY06 Actual	FY07 Available	FY08 Proposed Budget	FY08 Enacted Budget	% Change FY07 to Enacted FY08
Outpatient	\$2,011,568	\$1,687,246	\$2,359,411	\$1,592,347	-5.6%
Inpatient	\$1,134,341	\$1,088,737	\$1,035,099	\$1,026,008	-5.8%
Capitation	\$6,251,860	\$6,607,098	\$6,212,446	\$6,975,566	5.6%
Long-Term Care	\$4,167,016	\$4,140,524	\$4,097,045	\$4,054,761	-2.1%
Medicare Drug Program	\$0	\$338,500	\$325,029	\$351,008	3.7%
Transportation	\$94,266	\$104,260	\$119,655	\$118,155	13.3%
Miscellaneous	\$220,428	\$253,374	\$213,308	\$254,008	0.3%
Total MA Funding	\$13,879,479	\$14,219,739	\$14,361,993	\$14,371,853	1.1%

FY09 Budget Preview

Medical Assistance spending growth has decreased during the past two years, because of slow enrollment growth and as a result of one-time budgetary savings initiatives. Enrollment increased by only 2.7 percent in FY07 (less than projected) and increased by 1.2 percent during the first quarter of FY08.^{xvii} Still, easy fixes and one-time savings will be more difficult to come by in the next fiscal year.

Pennsylvania will need to replace IGT funds that are being phased out. It will also need to replace or reshape its managed care assessments, which are due to terminate in October 2009.

The FY08 budget relies upon a CMS waiver for matching funds for General Assistance recipients. However, that waiver is still under discussion at CMS and has not yet been approved.

The adoption of the Cover All Pennsylvanians program is a priority for the governor in the FY08 legislative session, and legislation is making its way through the Pennsylvania House. Cover All Pennsylvanians would result in a large expansion of

Medicaid-eligible adults and would draw down an estimated \$485 million in additional federal funds within five years if current plans to enroll adults up to 300 percent of the FPL are adopted by the legislature and approved by CMS.^{xviii}

The Commonwealth is likely to continue its effort to redirect long-term care funding toward home- and community-based programs and reduce reliance on institutional and nursing home care. That effort has proved challenging, as current efforts to take nursing home beds out of service as funds are shifted to waiver services have not been successful and have met with some resistance from nursing home providers.

Medical Assistance reimbursement rates are generally lower than Medicare, the Children’s Health Insurance Program (CHIP) or private rates, thus limiting the number of providers willing to accept Medical Assistance clients. There is some discussion of increased reimbursement rates in the context of the Prescription for Pennsylvania that could impact the budget for FY09.

The Rendell administration is unlikely to pursue efforts to “carve out” the administration of the prescription drug program from managed care. Legislation pending in Congress would allow managed care organizations to participate in the federal drug rebate program, making the shift unnecessary.

The Prescription for Pennsylvania included a series of ideas to improve the quality of health care through a series of new pay-for-performance initiatives. Current legislative proposals would create patient safety standards and award incentive payments to hospitals meeting those standards. In addition, hospitals would no longer receive payment from other state sources or private insurers for medical errors. In August 2007, Medicare announced that, beginning in October 2008, it would no longer reimburse hospitals for eight medical errors. The Commonwealth is looking at adjusting its Medicaid policies to bring them in line with the new Medicare rules.

^{xvii} Author’s calculations Pennsylvania Department of Public Welfare, Bureau of Program Evaluation, *Medical Assistance Eligibility Statistics, October 2007* (accessed November 30, 2007),DPW

^{xviii} Private communication, Governor’s Office of Health Care Reform estimate, August 2007.

The Commission on Chronic Care Management, Reimbursement and Cost Containment, created by executive order in May 2007, held its first meeting in September 2007. The commission is expected to examine the treatment of chronic conditions and the payment system for chronic care and then make recommendations to the governor and the legislature. While the commission is empanelled for three years, its deliberations may have some impact on the Medical Assistance budget for FY09.

Conclusion

Pennsylvania's Medical Assistance program provides access to health care services for 1.9 million Pennsylvanians, almost 16 percent of the state's population. It provides screenings for the early detection of illnesses, access to life-saving prescriptions and treatment of chronic and debilitating diseases. It ensures that Pennsylvania children are born healthy and allows the elderly to live their lives in their homes and communities. It is among the most important of all state services.

The budget sets out the amount of money that will be allocated to the Medical Assistance program. While it is important to look at total Medical Assistance revenues, it is the state funding sources within the control of the governor and the General Assembly that determine the federal matching dollars that the state is able to secure. If state funds decline, federal funds proportionately decline. The challenge for policymakers is to find sufficient state funds to draw down federal dollars to support the health care services that Medical Assistance provides.

The year to come, FY09, will offer policymakers great challenges and opportunities. The Commonwealth will need to identify new funding sources to replace declining IGT funds and, potentially, provider assessments or be faced with difficult choices, such as reducing services, reducing eligibility or increasing taxes or fees. A budget is a reflection of the priorities of the lawmakers who create it and of the communities they represent. Today, Pennsylvania's budget reflects the importance of a healthy citizenry.

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