

DHS BUDGET REQUEST FOR FY 2016-2017
(\$ Amounts in Thousands)

Page # of Governor's Executive Budget:
Pp. A1.20, C1.9, E30.5, E30.9, E30.14-E30.16,
E30.36, E30.37, E30.38

APPROPRIATION:
Medical Assistance - Fee-for-Service

I. SUMMARY FINANCIAL DATA

	2014-2015 Actual	2015-2016 Available	2016-2017 Budgeted
State Funds Total	\$564,772	\$392,918	\$489,972
State Sources Itemized			
<i>Medical Assistance - Fee-for-Service</i>	\$0	\$392,918 ¹	\$489,972
<i>Medical Assistance - Outpatient</i>	\$351,391	\$0	\$0
<i>Medical Assistance - Inpatient</i>	\$213,381	\$0	\$0
Federal Funds Total	\$1,780,240	\$2,061,904	\$1,873,560
Federal Sources Itemized			
<i>Medical Assistance - Fee-for-Service</i>	\$0	\$1,981,904	\$1,793,560
<i>Medical Assistance - Outpatient</i>	\$874,179	\$0	\$0
<i>Medical Assistance - Inpatient</i>	\$813,301	\$0	\$0
<i>ARRA - MA- Health Information Technology</i>	\$92,760	\$80,000	\$80,000
Other Funds Total	\$598,614	\$609,769	\$616,676
Other Fund Sources Itemized			
<i>Statewide Hospital Assessment</i>	\$395,302	\$469,517 ²	\$476,424 ³
<i>Hospital Assessment</i>	\$203,312	\$140,252	\$140,252
Total	\$2,943,626	\$3,064,591	\$2,980,208

IA. REQUESTED SUPPLEMENTALS (Included above)

State Funds Total	(\$35,117)
State Sources Itemized	
<i>Medical Assistance - Fee-for-Service</i>	(\$35,117)
Federal Funds Total	\$0
Total	(\$35,117)

¹ Reflects a recommended appropriation reduction of \$35.117 million. Appropriation Act 10-A of 2015 provided \$428.035 million for this program in Fiscal Year 2015-2016.

² The amount shown is more than the \$463.317 million shown in the Governor's Executive Budget to reflect an updated estimate of the Statewide Hospital Assessment for Fiscal Year 2015-2016.

³ The amount shown is more than the \$470.225 million shown in the Governor's Executive Budget to reflect an updated estimate of the Statewide Hospital Assessment for Fiscal Year 2016-2017.

II. DETAIL BY MAJOR OBJECT (\$ Amounts in Thousands)		APPROPRIATION: Medical Assistance - Fee-for-Service			
	2014-2015 Actual	2015-2016 Available	2016-2017 Budgeted	Change Budgeted vs. Available	Percent Change
PERSONNEL					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$0	\$0	\$0	\$0	0.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Personnel	\$0	\$0	\$0	\$0	0.00%
OPERATING					
State Funds	\$16,603	\$18,339	\$18,339	\$0	0.00%
Federal Funds	\$24,463	\$28,252	\$28,252	\$0	0.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Operating	\$41,066	\$46,591	\$46,591	\$0	0.00%
FIXED ASSETS					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$0	\$0	\$0	\$0	0.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Fixed Assets	\$0	\$0	\$0	\$0	0.00%
GRANT & SUBSIDY					
State Funds	\$548,169	\$374,579	\$471,633	\$97,054	25.91%
Federal Funds	\$1,641,552	\$1,558,125	\$1,730,058	\$171,933	11.03%
Other Funds	\$598,614	\$609,769	\$616,676	\$6,907	1.13%
Total Grant & Subsidy	\$2,788,335	\$2,542,473	\$2,818,367	\$275,894	10.85%
NONEXPENSE					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$114,225	\$88,290	\$115,250	\$26,960	30.54%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Nonexpense	\$114,225	\$88,290	\$115,250	\$26,960	30.54%
BUDGETARY RESERVE					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$0	\$387,237	\$0	(\$387,237)	-100.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Budgetary Reserve	\$0	\$387,237	\$0	(\$387,237)	-100.00%
UNCOMMITTED					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$0	\$0	\$0	\$0	0.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Uncommitted	\$0	\$0	\$0	\$0	0.00%
OTHER					
State Funds	\$0	\$0	\$0	\$0	0.00%
Federal Funds	\$0	\$0	\$0	\$0	0.00%
Other Funds	\$0	\$0	\$0	\$0	0.00%
Total Other	\$0	\$0	\$0	\$0	0.00%
TOTAL FUNDS					
State Funds	\$564,772	\$392,918	\$489,972	\$97,054	24.70%
Federal Funds	\$1,780,240	\$2,061,904	\$1,873,560	(\$188,344)	-9.13%
Other Funds	\$598,614	\$609,769	\$616,676	\$6,907	1.13%
Total Funds	\$2,943,626	\$3,064,591	\$2,980,208	(\$84,383)	-2.75%

APPROPRIATION:
Medical Assistance - Fee-for-Service

III. HISTORY OF LAPSES (\$ Amounts in Thousands)	<u>2013-2014</u>	<u>2014-2015</u>	<u>2015-2016 Estimated</u>
State Funds	\$799	\$0	\$0

IV. COMPLEMENT INFORMATION	<u>12/31/2014</u>	<u>12/31/2015</u>	<u>2016-2017 Budgeted</u>
State/Federally Funded			
<i>Authorized</i>	N/A	N/A	N/A
<i>Filled</i>	N/A	N/A	N/A
Federally Funded			
<i>Authorized</i>	N/A	N/A	N/A
<i>Filled</i>	N/A	N/A	N/A
Other Funded			
<i>Authorized</i>	N/A	N/A	N/A
<i>Filled</i>	N/A	N/A	N/A
Total			
<i>Authorized</i>	N/A	N/A	N/A
<i>Filled</i>	N/A	N/A	N/A
Benefit Rate	N/A	N/A	N/A

V. DERIVATION OF REQUEST / LEGISLATIVE CITATIONS / DISBURSEMENT CRITERIA

Derivation of Request:

Funding projections are derived from actuarial forecasting models developed on the basis of persons estimated to be eligible for Medical Assistance by recipient aid category, incidence of service utilization and cost per service by recipient aid category, and adjustments to service unit costs to reflect inflation and/or technical adjustments to reimbursements. Estimates also include impacts of changes in program policies, cash flow adjustments, estimates of refunds and contracts.

Detail on the appropriation request is outlined in Section VI entitled "Explanation of Changes" on the following pages.

Legislative Citations:

62 P.S. § 443.1 (1) and (4)

Disbursement Criteria:

The provider of service must be enrolled in the Medical Assistance program; the recipient of service must be deemed eligible for Medical Assistance benefits; and the service provided must be a covered Medical Assistance benefit. Reimbursement of covered services must be in accordance with promulgated fee schedules and rates of reimbursement. Payments are disbursed upon successful completion of prepayment screens and edits, and availability of funding.

VI. EXPLANATION OF CHANGES
(\$ Amounts in Thousands)

APPROPRIATION:
Medical Assistance - Fee-for-Service

	<u>State \$</u>	<u>Federal \$</u>	<u>Other \$</u>	<u>Total \$</u>
OPERATING				
1. Contracted Services				
A. Provides for the continuation of contracts for claims validation and processing, case management, clinical consultants, maintenance of Interqual, revenue maximization and radiology management:	\$0	\$0	\$0	\$0
Subtotal Operating/Contracted Services	\$0	\$0	\$0	\$0
GRANT & SUBSIDY				
1. Unit Cost				
A. Provides for a projected increase of 4.51 percent in the average cost per claim for prescription drugs:	\$4,921	\$685	\$0	\$5,606
2. Utilization/Caseload				
A. Impact of changes in utilization and eligibility resulting from an anticipated 2.53 percent increase in Medical Assistance (MA) eligibility including the annualization of newly eligible clients under Medicaid Expansion:	\$20,110	\$96,980	\$0	\$117,090
B. Impact of the change in the enhanced Federal Medical Assistance Percentage (FMAP) from 100 percent to 95 percent, effective January 1, 2017:	\$5,016	(\$5,016)	\$0	\$0
3. Other PROMISe Program Expenditures				
A. Impact of nonrecurring Fiscal Year 2014-2015 payments made in Fiscal Year 2015-2016:	(\$3,320)	(\$3,558)	\$0	(\$6,878)
B. Net impact of changes in assessment related MA Dependency and Rehabilitation payments and revenue:	\$0	\$10,284	\$6,118	\$16,402
C. Impact of the loss of enhanced Federal funding associated with the Balancing Incentive Program which expired on September 30, 2015:	\$619	(\$619)	\$0	\$0
D. Impact of the Critical Access Hospitals and Obstetric and Neonatal Services disproportionate share hospital payments to be paid directly out of the Medical Assistance - Fee-for-Service appropriation beginning in Fiscal Year 2015-2016. The State portion of these payments will be funded by the Statewide Hospital Assessment:	\$0	\$0	\$0	\$0
Subtotal Other PROMISe Program Expenditures	(\$2,701)	\$6,107	\$6,118	\$9,524
4. Non-PROMISe Program Expenditures				
A. Provides for a projected increase in monthly Medicare Part A premium payments. The monthly rate is estimated to increase from an average rate of \$401.01 to an average rate of \$407.00; the number of average monthly premiums is expected to increase by 418 (from 29,070 to 29,488):	\$1,984	\$2,146	\$0	\$4,130

VI. EXPLANATION OF CHANGES

(\$ Amounts in Thousands)

APPROPRIATION:
Medical Assistance - Fee-for-Service

	<u>State \$</u>	<u>Federal \$</u>	<u>Other \$</u>	<u>Total \$</u>
B. Provides for a projected increase in monthly Medicare Part B premium payments. The monthly rate is estimated to increase from an average rate of \$117.50 to an average rate of \$127.89; the number of average monthly premiums is expected to increase by 5,251 (from 332,847 to 338,098):	\$23,808	\$25,754	\$0	\$49,562
C. Impact of the increase in the premium for the Medicare Part B payments for Qualifying Individuals (QI) who apply for MA under the Healthy Horizons Categorically Needy eligibility requirements:	\$0	\$3,700	\$0	\$3,700
D. Impact of the change in the Federal Medical Assistance Percentage (a decrease from 52.01 percent to 51.78 percent, effective October 1, 2016):	\$2,303	(\$2,303)	\$0	\$0
E. Administrative Cash/Flow Impacts				
1) Impact of the projected decrease in the transfer of expenditures to the MA for Workers with Disabilities program:	\$281	\$265	\$0	\$546
2) Impact of an estimated increase in Health Insurance Premium Payments (HIPP):	\$2,164	\$2,341	\$0	\$4,505
3) Provides for an increase in the expenditure adjustment to claim federal funding for recipients in Institutions for Mental Diseases:	(\$120)	\$120	\$0	\$0
4) Net impact of a rollback of funds from Fiscal Year 2015-2016 to Fiscal Year 2014-2015:	\$39,333	\$42,627	\$0	\$81,960
5) Impact of miscellaneous adjustments:	\$0	(\$891)	\$789	(\$102)
Subtotal Administrative Cash/Flow Impacts	\$41,658	\$44,462	\$789	\$86,909
F. Impact of the anticipated increases in provider recoveries and refunds:	(\$536)	(\$582)	\$0	(\$1,118)
Subtotal Non-PROMISe Program Expenditures	\$69,217	\$73,177	\$789	\$143,183

NONEXPENSE

1. Provides for an increase in the claims related to the Memorandum of Understanding with the Department of Education for reimbursement of Title XIX claims for School Based Health Services for MA eligible children:	\$0	\$26,960	\$0	\$26,960
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BUDGETARY RESERVE

1. Impact of excess Federal appropriation authority in Fiscal Year 2015-2016:	\$0	(\$387,237)	\$0	(\$387,237)
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VI. EXPLANATION OF CHANGES
 (\$ Amounts in Thousands)

APPROPRIATION:
 Medical Assistance - Fee-for-Service

	<u>State \$</u>	<u>Federal \$</u>	<u>Other \$</u>	<u>Total \$</u>
FISCAL YEAR 2016-2017 INITIATIVES				
GRANT & SUBSIDY				
1. Human Services Funding Restoration				
A. Provides funding to restore one-third of the cut to seven human services appropriations to offset Fiscal Year 2012-2013 funding cuts:				
	<u>\$491</u>	<u>\$0</u>	<u>\$0</u>	<u>\$491</u>
Operating Total	\$0	\$0	\$0	\$0
Grant & Subsidy Total	\$97,054	\$171,933	\$6,907	\$275,894
Nonexpense Total	\$0	\$26,960	\$0	\$26,960
Budgetary Reserve Total	<u>\$0</u>	<u>(\$387,237)</u>	<u>\$0</u>	<u>(\$387,237)</u>
GRAND TOTAL	<u><u>\$97,054</u></u>	<u><u>(\$188,344)</u></u>	<u><u>\$6,907</u></u>	<u><u>(\$84,383)</u></u>

Medical Assistance - Fee-for-Service
Fiscal Year 2016-2017 Governor's Executive Budget
Fiscal Year 2015-2016

PROVIDER TYPE	Total	Federal	State	Claims	Cost Per Claim
<u>INPATIENT PROVIDERS</u>					
Acute Care Hospital	\$510,999,288	\$312,029,620	\$198,969,668	119,098	\$4,290.59
Private Psychiatric Hospital	\$17,677,208	\$1,961,153	\$15,716,055	4,180	\$4,229.47
Inpatient Facility; Medical Rehab Hospital	\$8,741,141	\$5,158,840	\$3,582,301	1,099	\$7,955.28
Residential Treatment Facility (JCAHO Certified)	\$2,385,940	\$1,239,375	\$1,146,565	463	\$5,150.98
Inpatient Medical Rehab Unit	\$7,895,629	\$4,446,030	\$3,449,599	850	\$9,286.45
Inpatient Drug & Alcohol Hospital	\$281,195	\$235,954	\$45,241	135	\$2,075.68
Private Psychiatric Unit	\$19,734,995	\$12,927,211	\$6,807,784	5,171	\$3,816.46
Drug & Alcohol Rehab Unit	\$138,226	\$109,754	\$28,472	56	\$2,447.23
Subtotal Inpatient Providers	\$567,853,622	\$338,107,937	\$229,745,685	131,052	\$4,333.03
<u>OUTPATIENT PROVIDERS</u>					
Prescription Drugs	\$96,278,719	\$52,257,930	\$44,020,789	2,632,316	\$36.58
Public Schools	\$74,321,759	\$74,321,759	\$0	3,250,091	\$22.87
Inpatient Facility	\$39,249,951	\$24,256,169	\$14,993,782	2,085,886	\$18.82
Ambulatory Surgical Center	\$1,869,909	\$996,578	\$873,331	25,566	\$73.14
Home Health	\$16,247,614	\$8,615,511	\$7,632,103	45,198	\$359.48
Hospice	\$6,722,358	\$3,624,127	\$3,098,231	10,637	\$631.98
Clinic	\$19,437,767	\$10,820,600	\$8,617,167	286,410	\$67.87
Mental Health/Substance Abuse	\$2,809,951	\$1,481,574	\$1,328,377	30,268	\$92.84
Psychologist	\$1,053,573	\$548,738	\$504,835	17,935	\$58.74
Pharmacy Non-Drug	\$7,907,620	\$4,135,395	\$3,772,225	202,662	\$39.02
DME/Medical Supplies	\$41,920,335	\$21,907,250	\$20,013,085	1,253,523	\$33.44
Transportation	\$6,570,383	\$3,965,559	\$2,604,824	66,084	\$99.42
Dentist	\$28,930,503	\$15,309,698	\$13,620,805	528,636	\$54.73
Laboratory	\$3,274,752	\$1,920,710	\$1,354,042	250,489	\$13.07
Renal Dialysis Center	\$6,029,069	\$3,140,912	\$2,888,157	563,285	\$10.70
Physician	\$78,025,640	\$43,803,824	\$34,221,816	4,690,582	\$16.63
Program Exception	\$1,253,901	\$651,456	\$602,445	772	\$1,624.22
Medically Fragile Foster Care	\$3,730,020	\$1,937,669	\$1,792,351	25,748	\$144.87
Miscellaneous Providers	\$4,419,572	\$2,036,846	\$2,382,726	681,328	\$6.49
Subtotal Outpatient Providers	\$440,053,396	\$275,732,305	\$164,321,091	16,647,415	\$26.43
Total Fee-For-Service Providers	\$1,007,907,018	\$613,840,242	\$394,066,776		
<u>OTHER PROVIDER PAYMENTS</u>					
FQHC Wraparound/Cost Settlements	\$79,515,814	\$41,318,405	\$38,197,409		
HCPs Coding Changes	\$959,591	\$498,627	\$460,964		
Disproportionate Share Payments (OP "DSH")	\$60,385,938	\$31,378,043	\$29,007,895		
Disproportionate Share Payments (Statewide)	\$77,490,171	\$40,265,830	\$37,224,341		
Disproportionate Share Payments (Philadelphia)	\$142,852,639	\$74,229,803	\$68,622,836		
Supplemental ER Access Payment	\$18,051,386	\$9,379,951	\$8,671,435		
Community Access Fund (CAF) Payments	\$36,590,411	\$18,971,574	\$17,618,837		
Increase to Temple Access to Care Payment (FY1415)	\$10,377,750	\$5,377,750	\$5,000,000		
Temple Access to Care Payment	\$15,236,508	\$7,924,508	\$7,312,000		
Mercy Catholic Access to Care Payment	\$1,651,084	\$858,729	\$792,355		
Med Ed/Passthroughs	\$82,291,599	\$42,760,772	\$39,530,827		
Graduate Medical Education to Train Psychiatrists	\$500,000	\$260,050	\$239,950		
Kensington	\$300,000	\$156,030	\$143,970		
NPHS Augmented Payment	\$9,661,463	\$5,024,927	\$4,636,536		
Lancaster Cleft Palate	\$312,565	\$162,565	\$150,000		
Crozer Chester Medical Center	\$4,144,434	\$2,155,520	\$1,988,914		
UPMC Altoona	\$726,401	\$377,801	\$348,600		
Rehabilitation Adjustment	\$23,618,816	\$12,284,146	\$11,334,670		
MA Dependency Payment	\$26,806,500	\$13,942,061	\$12,864,439		
Medical Education Payment	\$35,233,404	\$18,308,158	\$16,925,246		
Medicaid Stability Payment	\$151,798,564	\$78,950,433	\$72,848,131		
Enhanced Payment	\$24,602,969	\$12,796,004	\$11,806,965		
Inpatient DSH Adjustment	\$6,940,268	\$3,606,337	\$3,333,931		
Sole and Community Hospital DSH	\$58,821,349	\$30,592,984	\$28,228,365		
Medicaid Expansion	\$163,298,846	\$163,298,846	\$0		
Balancing Incentive Program (BIP)	\$0	\$619,235	(\$619,235)		
Obstetric and Neonatal Services	\$3,000,000	\$0	\$3,000,000		
Critical Access Hospitals	\$3,200,000	\$0	\$3,200,000		
HIT - Provider and Hospital Incentives	\$80,000,000	\$80,000,000	\$0		
Total Other Provider Payments	\$1,118,368,470	\$695,499,089	\$422,869,381		

Medical Assistance - Fee-for-Service
Fiscal Year 2016-2017 Governor's Executive Budget
Fiscal Year 2015-2016

	Total	Federal	State	Avg Monthly Eligibles	Avg \$ Per Eligible Per Month
<u>ADMINISTRATIVE/CASH FLOW IMPACTS</u>					
Medicare Part A Premium Payments	\$139,888,439	\$72,689,530	\$67,198,909	29,070	\$401.01
Medicare Part B Buy-In	\$469,329,312	\$243,875,244	\$225,454,068	332,847	\$117.50
Medicare Part B Buy-In - Special MA Eligibility Provisions	\$40,294,768	\$40,294,768	\$0		
HIPP Premium Payments	\$44,337,246	\$23,038,741	\$21,298,505		
Expenditures Transferred to MA for Workers with Disabilities	(\$13,902,777)	(\$7,188,556)	(\$6,714,221)		
Claim of Federal Funds for recipients in IMDs	\$0	\$11,007,471	(\$11,007,471)		
Project Access - Department of Education Administrative MOU					
- Subgrant reimbursement for LEA's of costs	\$23,986,066	\$23,986,066	\$0		
- Operational expense to PDE for admin costs and contractor billing	\$2,266,000	\$2,266,000	\$0		
- Medical Assistance Expenditure Adjustment (Project Access/PDE)	\$0	\$28,861,459	(\$28,861,459)		
-Medicaid Cost Settlement (Fiscal Year 2014-2015)	\$13,968,039	\$13,968,039	\$0		
Select Plan for Women Family Planning Council Grants	\$1,500,000	\$0	\$1,500,000		
Act 152/D & A Treatment Services (Grant & Subsidies Item)	\$13,254,000	\$0	\$13,254,000		
Act 22 Inmate Reimbursement (Corrections MOU)	(\$10,387,679)	\$0	(\$10,387,679)		
Rollback of Expenditures to Fiscal Year 2014-2015	(\$81,959,932)	(\$42,627,361)	(\$39,332,571)		
Total Administrative Cash/Flow Impacts	\$642,573,482	\$410,171,401	\$232,402,081		
<u>OPERATING</u>					
Claim Validation and Recoupment	\$750,000	\$375,000	\$375,000		
Claims Processing and PROMISE Contract Costs	\$10,316,464	\$7,776,117	\$2,540,347		
MMIS Reprocurement	\$87,799	\$79,019	\$8,780		
TruCare License Fees	\$193,163	\$144,872	\$48,291		
Clinical Consultant	\$17,775,466	\$12,236,411	\$5,539,055		
Health Information Technology (State Funds Only)	\$2,404,460	\$0	\$2,404,460		
InterQual Criteria	\$626,642	\$313,321	\$313,321		
Legal Support/Rate Setting	\$600,000	\$300,000	\$300,000		
Medicaid Information Technology Architecture (MITA)	\$57,000	\$51,300	\$5,700		
Medical Review Team/SSI/Disability Advocacy Program (DAP)	\$1,849,900	\$924,950	\$924,950		
Pennsylvania Automated Cost Reporting System (PACRS)	\$67,000	\$33,500	\$33,500		
Revenue Maximization	\$1,433,962	\$0	\$1,433,962		
Program, Policy and Resource Review and Maximization (P2R2M)	\$659,443	\$0	\$659,443		
Medicare Eligibility Identification	\$1,000,000	\$500,000	\$500,000		
Preferred Drug List	\$1,787,496	\$893,748	\$893,748		
TPL Data Exchange	\$2,000,000	\$1,000,000	\$1,000,000		
Health Policy Research Grants	\$2,000,000	\$1,000,000	\$1,000,000		
Enrollment Revalidation Support	\$450,000	\$225,000	\$225,000		
Independent Examination Cost	\$266,000	\$133,000	\$133,000		
Total Operating	\$44,324,795	\$25,986,238	\$18,338,557		
<u>MANDATED FEDERAL/OTHER REQUIREMENTS</u>					
Refunds	(\$18,298,815)	(\$9,508,522)	(\$8,790,293)		
Third Party Liability Recoveries	(\$62,563,338)	(\$32,509,475)	(\$30,053,863)		
Provider Recoveries / Provider Refunds	(\$18,575,909)	(\$9,652,507)	(\$8,923,402)		
Pharmaceutical Company Rebates	(\$36,873,043)	(\$19,159,675)	(\$17,713,368)		
Total Mandated Federal/Other Requirements	(\$136,311,105)	(\$70,830,179)	(\$65,480,926)		
<u>FISCAL YEAR 2015-2016 INITIATIVES/PRRS</u>					
Initiative--Human Services Funding Restoration	\$491,000	\$0	\$491,000		
Subtotal Fiscal Year 2015-2016 Initiatives/PRRs	\$491,000	\$0	\$491,000		
Uncommitted	\$387,237,209	\$387,237,209	\$0		
FY 2015-2016 Cash Requirement	\$3,064,590,869	\$2,061,904,000	\$1,002,686,869		
Statewide Hospital Assessment	\$469,517,159	\$0	\$469,517,159		
Hospital Assessment (Philadelphia)	\$140,251,710	\$0	\$140,251,710		
Total FY 2015-2016 Program Requirement	\$2,454,822,000	\$2,061,904,000	\$392,918,000		
Medical Assistance Federal		\$1,981,904,000			
Act 10-A of 2015		\$1,981,904,000	\$428,035,000		
Surplus/(Deficit)		\$0	\$35,117,000		
ARRA HIT Federal		\$80,000,000			
Act 10-A of 2015		\$80,000,000			
Surplus/(Deficit)		\$0			

Medical Assistance - Fee-for-Service
Fiscal Year 2016-2017 Governor's Executive Budget
Fiscal Year 2016-2017

PROVIDER TYPE	Total	Federal	State	Claims	Cost Per Claim
<u>INPATIENT PROVIDERS</u>					
Acute Care Hospital	\$432,037,843	\$223,110,237	\$208,927,606	114,006	\$3,789.61
Private Psychiatric Hospital	\$16,614,190	\$2,073,764	\$14,540,426	3,851	\$4,313.78
Inpatient Facility, Medical Rehab Hospital	\$5,541,794	\$2,863,997	\$2,677,797	869	\$6,379.36
Residential Treatment Facility (JCAHO Certified)	\$2,887,205	\$1,495,374	\$1,391,831	568	\$5,084.40
Inpatient Medical Rehab Unit	\$4,843,201	\$2,493,576	\$2,349,625	663	\$7,299.55
Inpatient Drug & Alcohol Hospital	\$140,195	\$72,671	\$67,524	68	\$2,060.75
Private Psychiatric Unit	\$15,528,732	\$8,029,533	\$7,499,199	4,128	\$3,761.71
Drug & Alcohol Rehab Unit	\$88,920	\$46,093	\$42,827	38	\$2,311.48
Subtotal Inpatient Providers	\$477,682,080	\$240,185,245	\$237,496,835	124,192	\$3,846.32
<u>OUTPATIENT PROVIDERS</u>					
Prescription Drugs	\$101,884,658	\$52,812,635	\$49,072,023	2,665,009	\$38.23
Public Schools	\$101,282,487	\$101,282,487	\$0	3,810,483	\$26.58
Inpatient Facility	\$34,699,107	\$18,097,353	\$16,601,754	2,017,167	\$17.20
Ambulatory Surgical Center	\$1,750,481	\$922,168	\$828,313	24,985	\$70.06
Home Health	\$16,778,120	\$8,679,663	\$8,098,457	43,512	\$385.60
Hospice	\$6,748,375	\$3,475,366	\$3,273,009	10,331	\$653.22
Clinic	\$19,440,360	\$10,214,853	\$9,225,507	292,505	\$66.46
Mental Health/Substance Abuse	\$3,066,391	\$1,592,259	\$1,474,132	31,891	\$96.15
Psychologist	\$1,201,405	\$624,143	\$577,262	18,567	\$64.71
Pharmacy Non-Drug	\$7,594,906	\$3,936,422	\$3,658,484	198,297	\$38.30
DME/Medical Supplies	\$42,412,333	\$21,970,757	\$20,441,576	1,240,363	\$34.19
Transportation	\$6,059,262	\$3,145,167	\$2,914,095	66,013	\$91.79
Dentist	\$27,549,283	\$14,290,536	\$13,258,747	514,539	\$53.54
Laboratory	\$3,031,465	\$1,624,432	\$1,407,033	239,518	\$12.66
Renal Dialysis Center	\$5,759,971	\$2,954,885	\$2,805,086	563,464	\$10.22
Physician	\$88,143,769	\$45,068,066	\$43,075,703	4,787,042	\$18.41
Program Exception	\$1,353,457	\$701,216	\$652,241	821	\$1,648.55
Medically Fragile Foster Care	\$4,028,174	\$2,086,931	\$1,941,243	30,374	\$132.62
Miscellaneous Providers	\$4,757,395	\$2,157,425	\$2,599,970	676,269	\$7.03
Subtotal Outpatient Providers	\$477,541,399	\$295,636,764	\$181,904,635	17,231,151	\$27.71
Total Fee-For-Service Providers	\$955,223,479	\$535,822,009	\$419,401,470		
<u>OTHER PROVIDER PAYMENTS</u>					
FQHC Wraparound/Cost Settlements	\$81,106,130	\$42,043,390	\$39,062,740		
HCPs Coding Changes	\$934,640	\$484,494	\$450,146		
Disproportionate Share Payments (OP "DSH")	\$60,385,938	\$31,302,561	\$29,083,377		
Disproportionate Share Payments (Statewide)	\$77,490,171	\$40,168,967	\$37,321,204		
Disproportionate Share Payments (Philadelphia)	\$142,852,639	\$74,051,237	\$68,801,402		
Supplemental ER Access Payment	\$18,051,386	\$9,357,387	\$8,693,999		
Community Access Fund (CAF) Payments	\$36,590,411	\$18,971,574	\$17,618,837		
Temple Access to Care Payment	\$15,163,832	\$7,851,832	\$7,312,000		
Mercy Catholic Access to Care Payment	\$1,643,208	\$850,853	\$792,355		
Med Ed/Passthroughs	\$82,291,599	\$42,657,908	\$39,633,691		
Graduate Medical Education to Train Psychiatrists	\$500,000	\$258,900	\$241,100		
Kensington	\$300,000	\$155,340	\$144,660		
NPBS Augmented Payment	\$13,161,463	\$6,815,006	\$6,346,457		
Lancaster Cleft Palate	\$311,074	\$161,074	\$150,000		
Crozer Chester Medical Center	\$4,124,666	\$2,135,752	\$1,988,914		
UPMC Altoona	\$722,937	\$374,337	\$348,600		
Rehabilitation Adjustment	\$23,618,816	\$12,229,823	\$11,388,993		
MA Dependency Payment	\$26,806,500	\$13,880,406	\$12,926,094		
Medical Education Payment	\$35,233,404	\$18,264,116	\$16,969,288		
Medicaid Stability Payment	\$151,798,564	\$78,601,296	\$73,197,268		
Enhanced Payment	\$24,602,969	\$12,739,417	\$11,863,552		
Inpatient DSH Adjustment	\$6,940,268	\$3,597,662	\$3,342,606		
Sole and Community Hospital DSH	\$58,821,349	\$30,457,695	\$28,363,654		
Observation Payment	\$16,402,360	\$10,284,280	\$6,118,080		
Medicaid Expansion	\$364,076,853	\$359,061,039	\$5,015,814		
Obstetric and Neonatal Services	\$3,000,000	\$0	\$3,000,000		
Critical Access Hospitals	\$3,200,000	\$0	\$3,200,000		
HIT - Provider and Hospital Incentives	\$80,000,000	\$80,000,000	\$0		
Total Other Provider Payments	\$1,330,131,177	\$896,756,346	\$433,374,831		

**Medical Assistance - Fee-for-Service
Fiscal Year 2016-2017 Governor's Executive Budget
Fiscal Year 2016-2017**

	Total	Federal	State	Avg Monthly Eligibles	Avg \$ Per Eligible Per Month
<u>ADMINISTRATIVE/CASH FLOW IMPACTS</u>					
Medicare Part A Premium Payments	\$144,018,578	\$74,655,630	\$69,362,948	29,488	\$407 00
Medicare Part B Buy-In	\$518,891,055	\$268,980,151	\$249,910,904	338,098	\$127 89
Medicare Part B Buy-In - Special MA Eligibility Provisions	\$43,994,714	\$43,994,714	\$0		
HIPP Premium Payments	\$48,842,124	\$25,318,536	\$23,523,588		
Expenditures Transferred to MA for Workers with Disabilities	(\$13,357,577)	(\$6,923,995)	(\$6,433,582)		
Claim of Federal Funds for recipients in IMDs	\$0	\$11,127,709	(\$11,127,709)		
Project Access - Department of Education Administrative MOU					
- Subgrant reimbursement for LEA's of costs	\$23,986,066	\$23,986,066	\$0		
- Operational expense to PDE for admin. costs and contractor billing	\$2,266,000	\$2,266,000	\$0		
- Medical Assistance Expenditure Adjustment (Project Access/PDE)	\$0	\$28,861,459	(\$28,861,459)		
-Medicaid Cost Settlement (Fiscal Year 2015-2016)	\$13,968,039	\$13,968,039	\$0		
Select Plan for Women Family Planning Council Grants	\$1,500,000	\$0	\$1,500,000		
Act 152/D & A Treatment Services (Grant & Subsidies Item)	\$13,254,000	\$0	\$13,254,000		
Act 22 Inmate Reimbursement (Corrections MOU)	(\$10,387,679)	\$0	(\$10,387,679)		
Total Administrative Cash/Flow Impacts	\$786,975,320	\$486,234,309	\$300,741,011		
<u>OPERATING</u>					
Claim Validation and Recoupment	\$750,000	\$375,000	\$375,000		
Claims Processing and PROMISe Contract Costs	\$10,316,464	\$7,776,117	\$2,540,347		
MMIS Reprocedurement	\$87,799	\$79,019	\$8,780		
TruCare License Fees	\$193,163	\$144,872	\$48,291		
Clinical Consultant	\$17,525,466	\$12,111,411	\$5,414,055		
Health Information Technology (State Funds Only)	\$2,404,460	\$0	\$2,404,460		
InterQual Criteria	\$626,642	\$313,321	\$313,321		
Legal Support/Rate Setting	\$600,000	\$300,000	\$300,000		
Medicaid Information Technology Architecture (MITA)	\$57,000	\$51,300	\$5,700		
Medical Review Team/SSI/Disability Advocacy Program (DAP)	\$1,849,900	\$924,950	\$924,950		
Pennsylvania Automated Cost Reporting System (PACRS)	\$67,000	\$33,500	\$33,500		
Revenue Maximization	\$1,433,962	\$0	\$1,433,962		
Program, Policy and Resource Review and Maximization (P2R2M)	\$659,443	\$0	\$659,443		
Medicare Eligibility Identification	\$1,000,000	\$500,000	\$500,000		
Preferred Drug List	\$1,787,496	\$893,748	\$893,748		
Provider Prior Authorization Portal (Clear Coverage)	\$250,000	\$125,000	\$125,000		
TPL Data Exchange	\$2,000,000	\$1,000,000	\$1,000,000		
Health Policy Research Grants	\$2,000,000	\$1,000,000	\$1,000,000		
Enrollment Revalidation Support	\$450,000	\$225,000	\$225,000		
Independent Examination Cost	\$266,000	\$133,000	\$133,000		
Total Operating	\$44,324,795	\$25,986,238	\$18,338,557		
<u>MANDATED FEDERAL/OTHER REQUIREMENTS</u>					
Refunds	(\$18,374,268)	(\$9,524,761)	(\$8,849,507)		
Third Party Liability Recoveries	(\$62,563,338)	(\$32,431,270)	(\$30,132,068)		
Provider Recoveries / Provider Refunds	(\$18,575,909)	(\$9,629,287)	(\$8,946,622)		
Pharmaceutical Company Rebates	(\$37,915,092)	(\$19,653,558)	(\$18,261,534)		
Total Mandated Federal/Other Requirements	(\$137,428,607)	(\$71,238,876)	(\$66,189,731)		
<u>FISCAL YEAR 2015-2016 INITIATIVES/PRRs</u>					
Initiative--Human Services Funding Restoration	\$491,000	\$0	\$491,000		
Subtotal Fiscal Year 2015-2016 Initiatives/PRRs	\$491,000	\$0	\$491,000		
<u>FISCAL YEAR 2016-2017 INITIATIVES/PRRs</u>					
Initiative--Human Services Funding Restoration	\$491,000	\$0	\$491,000		
Subtotal Fiscal Year 2016-2017 Initiatives/PRRs	\$491,000	\$0	\$491,000		
FY 2016-2017 Cash Requirement	\$2,980,208,164	\$1,873,560,026	\$1,106,648,138		
Statewide Hospital Assessment	\$476,424,143	\$0	\$476,424,143		
Hospital Assessment (Philadelphia)	\$140,251,710	\$0	\$140,251,710		
Total FY 2016-2017 Program Requirement	\$2,363,532,311	\$1,873,560,026	\$489,972,285		
Medical Assistance Federal		\$1,793,560,026			
ARRA HIT Federal		\$80,000,000			

MEDICAL ASSISTANCE – FEE-FOR-SERVICE

PROGRAM STATEMENT

This appropriation funds all services provided to Medical Assistance (MA) recipients, including primary health care, preventive services, and essential care in an inpatient and outpatient setting when the recipient or service is not covered in Managed Care. The MA program covers a wide array of service providers including physicians, acute care hospitals, pharmacies, dentists, psychiatric and rehabilitation units of acute care hospitals, outpatient departments/clinics, private psychiatric hospitals, rehabilitation hospitals, residential treatment facilities, certified registered nurse practitioners, certified nurse midwives, independent medical clinics, federally qualified health centers, rural health clinics, drug and alcohol, psychiatric and family planning clinics, home health agencies and medical and equipment suppliers. Currently, there are 230 private inpatient hospitals and 72 certified residential treatment facilities in-state that participate in the MA program. There are over 90,000 individual providers enrolled in MA.

CHILDREN'S HEALTH CARE

Access to comprehensive health care and early intervention services for children has been shown to be effective medically, economically and socially over the long term. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, which supports prevention, early intervention and treatment, is available to all MA recipients under the age of 21. Following the Omnibus Budget Reconciliation Act of 1989, the EPSDT provisions of the Federal Medicaid statute and associated regulations have required all states to provide MA eligible persons under 21 years of age scheduled, periodic preventive screenings including vision, dental and hearing screens, as well as all medically necessary health care services, even if the benefits are not specifically identified as covered under the State's Medicaid State Plan.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW

Through its Prior Authorization and Utilization Review (UR) processes, the Department reviews the medical necessity and compensability of advanced radiology diagnostic services, home health, durable medical equipment, select pharmacy and dental services, shift nursing, hospital admissions and continued stays of MA recipients in acute care general hospitals, specialty hospitals and units, short procedure units, ambulatory surgical centers and residential treatment facilities for children and adolescents under the age of 21. Admissions must be certified through the UR program in order to be eligible for payment. Payments are denied if care requested is inappropriate, unnecessary or non-compensable. In addition to the money saved through admission denials, significant costs are avoided by the sentinel effect of this utilization review program.

INPATIENT HOSPITAL RETROSPECTIVE REVIEW PROCESS

The Bureau of Program Integrity (BPI) is responsible for detecting, deterring and correcting provider noncompliance and potential fraud and abuse by providers of MA services. BPI applies administrative sanctions and refers cases of potential fraud to the appropriate enforcement agency. This responsibility includes evaluating services rendered via paid claims history reviews, sampling reviews of medical and fiscal records, and on-site visits to facilities to interview staff regarding medical record and billing practices.

PHARMACY PROGRAM MANAGEMENT

By the early 2000's, MA program expenditures for pharmacy services had risen faster than any other single service expenditure. Costs related to prescription drugs comprised an average of 25 percent of total MA expenditures. The Department responded to this unprecedented escalation in costs by implementing the following program changes in payment and utilization management that resulted in significant cost savings without compromising access, while actually enhancing quality:

- Established a Pharmacy Division in the Bureau of Fee-for-Service (FFS) programs centralizing responsibility for pharmacy program development and operations
- Updated the pricing methodology for pharmacy claims
- Appointed a Pharmacy and Therapeutics Committee
- Revamped the structure of the Drug Utilization Review Board
- Developed a Preferred Drug List
- Collected supplemental rebates
- Collected market share rebates for diabetic supplies
- Maximized Federal rebate collection
- Required clinical prior authorization for consumer health and safety
- Established quantity limits and dose optimization, and limits on early refills
- Implemented a DHS pharmacy call center
- Automated prior authorization
- Implemented the first State Medicaid Specialty Pharmacy Drug Program in the nation
- Re-designed the Retrospective Drug Utilization Review program
- Implemented the Managed Care Organization Federal Drug Rebates

With the expansion of HealthChoices (the physical health mandatory managed care program) to all 67 counties, the Pharmacy Division will focus on administrative oversight of pharmacy services in managed care to maximize Federal drug rebates and ensure access to quality pharmacy services. In FFS, the focus will continue on maintaining access to quality pharmacy services.

ACUTE CARE GENERAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM/STATEWIDE QUALITY CARE ASSESSMENT

Within the FFS program, the Department pays for inpatient hospital services provided by acute care general hospitals using a prospective payment system utilizing All Patients Refined Diagnosis Related Group (APR-DRG) software. The calculation of hospital-specific APR-DRG base rates is based upon a statewide average cost which is adjusted to account for a hospital's regional labor costs, teaching status, capital, and MA patient levels. The prospective payment rate for each recipient discharged from the hospital is established by multiplying the relative value of the APR-DRG into which the patient has been classified by the hospital-specific payment rate. Special payment provisions for transfers, readmissions, high-cost outliers, low-cost outliers and services in non-distinct part psychiatric and drug and alcohol units may also apply.

The Department received CMS approval of the State Plan Amendments which authorized the Statewide Quality Care Assessment for inpatient hospitals. The revenue that is generated from the Statewide Quality Care Assessment, along with the related Federal matching funds, has enabled the Department to update and improve its inpatient acute care hospital reimbursement system. Since Fiscal Year 2011-2012, the assessment percentage has been 3.22 percent of an eligible hospital's net inpatient revenue. The Statewide Quality Care Assessment has been reauthorized for three years beginning July 1, 2015. The assessment percentage for Fiscal Year 2015-2016 is 3.71%.

PHILADELPHIA HOSPITAL ASSESSMENT

The Philadelphia Hospital Assessment is a local healthcare related provider assessment that is imposed by the City of Philadelphia on general acute care hospitals located within the City of Philadelphia. This assessment was initially authorized by CMS beginning January 1, 2009; it was subsequently reauthorized through June 30, 2016. An additional reauthorization would be needed to continue the assessment into Fiscal Year 2016 - 2017. The assessment rate is 3.45 percent of a hospital's net inpatient revenue for high-volume Medicaid hospitals and 3.93 percent for non-high volume Medicaid hospitals. A portion of the revenue from the assessment is used to fund payments designed to ensure access to emergency and outpatient services for MA recipients in the City of Philadelphia. The funds generated from the assessment are used by the Commonwealth to assist in funding the Medicaid program.

DISPROPORTIONATE SHARE

For acute care general hospitals, rehabilitation facilities and psychiatric hospitals, eligibility for disproportionate share payments is based on the minimum Federal requirements. Three additional State-defined eligibility provisions for general acute care hospitals encompass a rural sole community hospital method, a volume method and a high MA for the county method. Hospitals are ranked based on their individual Medicaid utilization. There is a separate ranking for rural hospitals. Each qualifying hospital receives a pro-rated share of an agreed upon aggregate amount based on the hospital's weighted disproportionate share percentage applied to the hospital's projected MA revenue. The disproportionate share payment calculation takes into consideration both the FFS and managed care utilization incurred by the facility. A similar ranking and payment calculation process is followed for rehabilitation and psychiatric providers. Federal matching funds are available for this program.

PROVIDER ENROLLMENT AND SCREENING

The FFS Program enrolls and manages a network of over 90,000 individual providers and 230 hospitals. The number of providers is steadily increasing. In recent years, many Federal mandates have emerged that are provider-enrollment centric in nature. Most of the mandates incur additional enrollment actions, checks and indicators. In 2010, the Provider Enrollment and Screening Requirements of the Affordable Care Act imposed full database checks for provider board members, collection of an application fee, revalidation/re-enrollment/re-application of all provider service locations, site visits, enrollment of all ordering, referring and prescribing providers, and more. Many of these requirements required system changes that were implemented in Fiscal Year 2015-2016.

PREVENTING FRAUD AND ABUSE

The Department is committed to protecting the integrity of the MA Program from abuse and waste, ensuring that recipients receive quality medical services and that those recipients do not abuse their medical benefits.

BPI identifies and investigates fraud, abuse and wasteful practices conducted against the MA Program. Among other things, BPI reviews pharmacy services, inpatient/outpatient behavioral health services, physical health services (e.g., physicians, chiropractors, dentists, home health, hospice, durable medical equipment) and inpatient/outpatient hospital services. Cases of suspected provider fraud are referred to the Office of Attorney General's Medicaid Fraud Control Section and cases of suspected recipient fraud are referred to the Pennsylvania Office of Inspector General or the Attorney General's Drug Diversion Unit. The Recipient Restriction/Centralized Lock-In Program is also managed by BPI. Under this program, recipients who are identified as overusing or misusing MA are restricted to obtaining services from a single provider of the recipient's choice.

THIRD PARTY LIABILITY

As a condition of receiving MA benefits, recipients are required to allow the Department to seek payment from available third party healthcare resources on their behalf. All other third party resources must be used before MA dollars are spent. These resources, such as health and casualty insurance and Medicare, are an important means of keeping MA costs as low as possible. Approximately 43 percent of recipients have third party resources that can be used to cover at least some of their health care costs. Over 26 percent have commercial insurance and over 17 percent have Medicare coverage.

FISCAL YEAR 2016-2017 INITIATIVE – HUMAN SERVICES FUNDING RESTORATION

The Fiscal Year 2016-2017 “Human Services Funding Restoration” initiative will restore an additional one-third of the 10 percent reduction initially made to county programs during Fiscal Year 2012-2013 when the Human Services Block Grant was established. This represents the second year in the effort to fully restore the 10 percent cut over a three-year period. The Governor’s Executive Budget for Fiscal Year 2016-2017 includes a total of \$0.491 million in State funds in the Medical Assistance - Fee-for-Services appropriation.