I. Thank you for invitation. I always appreicate the opportunity to talk to those of you whose life's work is dedecated to helping those in need.

II. I was asked to make a few introductory remarks and then open up to questions. So let me start with the most obvious.

III. The Gov's proposed budget

A. Cost shift
1. the way to resolve your difficulties financially is to pass them off to someone or someother entity to worry about.
2. just about anything you can look at is subjected to this cost shift process
3. education
4. local government needs (break up of DCA)
5. closing of the health centers (which we have beaten back so far.)
6. the elimination of the MNO and reevaluation of the chroniclly needy perhaps the cruelest proposal of all.
   a. 283,000 adults without children (working poor for the most part)
      (1) shift to hospitals and other ins. payers
      (2) restored and recommitted to HHS Com.
      (3) increase uninsured by 35%
   b. 24,000 chronically needy due to medical condition keeps them from working
      (1) revaluate their condition
         (a) who pays?
         (b) who pays if new applicant
      (2) possibility to experiencing the same horror show that the Reagen Admin. inflicted on the SSI people in the early 80's.
      (3) did provide $33.7 million for counties to pick up additional costs, will it be enough?
   c.

House of Representatives

COMMONWEALTH OF PENNSYLVANIA
HARRISBURG
April 24, 1996

MEMO

TO: Representative Thomas J. Tangretti
Greensburg District Office

FROM: Kate Conrey, Research Analyst (717-783-1702)
Legislative Research

SUBJECT: Westmoreland Health and Welfare Council's Legislative Committee

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As per your request, I have provided background materials of various health and welfare topics. The following information is provided:

I. Governor's budget as it pertains to MH/MR services and the fiscal implications for counties. I have highlighted information about Medical Assistance and managed care in the proposed budget. (Research Memo for Representative Surra.)

II. Case-Mix Payment System
(Research Memo prepared by Jen Kiralfy (ph: 7-2759) for Representative Veon.)

III. MH, MR and D/A Impact on State Budget
(Research Memo and Survey Response for Representative Mayernik.)

IV. Early Interventions Services Funding Cuts
(Research Memo for several members of Democratic Caucus.)

V. Homeless Issues
(Research Memo for Representative Buxton.)

I. MH/MR Services, Managed Care, and Medical Assistance in Governor's Budget

According to Beth Balaban, the Governor's Budget makes a significant change in Medical Assistance funding for those who are listed as Chronically Needy individuals. These individuals were certified by health care providers as not being able to work because of a health condition. Under the new budget, some of these individuals will loose their medical benefits.

Currently, there are 88,000 people who are chronically needy. DPW estimates 24,000 people will loose their benefits. Of this amount, approximately 6,000 to 10,000 people will still need mental health, drug and alcohol treatment, so the counties will receive $33.7 million to treat and serve this population. The department believes that the counties have the resources and ability to serve this population. This $33.7 million is necessary. If these individuals do not receive treatment, they will have to be institutionalized, costing the Commonwealth too much money and not being cost efficient.

Also of importance in this year's budget is the funding for HMOs for HealthChoices in Southeastern Pennsylvania. Historically, HMOs were allotted x amount of dollars per person on assistance. According to this budget, funding will be broken down into two parts or there will be a "carve out" of these dollars: a certain portion will go toward physical health and a certain portion will goes towards behavioral health. The counties will be given more authority to choose which HMO will serve behavioral health.

Background

The Department of Public Welfare's proposed 1996-97 budget differs from those of the past because of uncertainty in administration of federal welfare reform and how block granting will be implemented by the counties. According to the administration, DPW's budget proposal was guided by one basic principle: **To find better ways of serving our most vulnerable citizens with limited resources.**

Uncertainty in Federal Reform

- Pennsylvania could loose from $.5 to $1.5 billion under proposed federal Medicaid caps
- Federal Medicaid matching rates vary from 53% to 60%
- Each 1% = $70 million in state funds
- Without legislation it remains at 53%
- Federal impasse means no relief from Medicaid rules
- Work requirements and supports such as day care remain uncertain

People No Longer Eligible for Medicaid Under the Proposed Budget

- 24,000 Individuals receiving "Chronically Needy" General Assistance benefits who may no longer be considered unemployable due to better defined standards and second medical opinions.

- 133,000 Able-bodied adults without children, except pregnant women, refugees, elderly, and individuals with a potential disability.

HealthChoices 1996

The Department intends to implement managed care to more than 438,000 MA recipients (nearly 30% of the state's total MA population) in southeastern Pennsylvania. Under HealthChoices, recipients will benefit from managed care in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties.

Recipients will have the freedom to chose a number of Health Maintenance Organizations (HMOs) and Primary Care Practitioners to receive their health care. The Department will contract with an independent Benefits Consultant to assist enrolling recipients.

Recipients will be phased-in beginning November 1, 996 with AFDC and Health Beginnings eligibles. General Assistance (GA), Supplemental Security Income (SSI), and Healthy Horizons eligibles will be phased in beginning July 1, 1997.

The Department intends to expand its use of mandatory managed care for the MA population statewide. The Department is examining several models of managed care, including the use of HMOs and Primary Care Case Management to address the needs of Pennsylvania's diverse MA populations.

Pennsylvania's Managed Behavioral Health Care Initiative - HealthChoices

- Mental health and drug and alcohol services in the HealthChoices area will be provided through separate capitated managed care contracts. Recipients with more serious needs will be guaranteed care.
- Counties that can demonstrate a capacity to meet the Department's standards and criteria will be offered the "right of refusal" to enter into a full-risk capitation contract.
- Counties that wish to contract with the Commonwealth will submit a proposal and implementation plan for review by the Department.
- In areas where counties are unable to meet Department standards or choose not to participate, the Department will enter into a competitive bid process for a direct contract with a private managed care organization.

Mental Health Programs
FY 1996-97 Budget Initiatives

- Implement Capitated Managed Care for Behavioral Health
- Provide $33.7 Million to counties to provide services to former General Assistance/Medically Needy only Medicaid recipients
  Funding to be differentiated by Mental Health, Drug & Alcohol and Act 152 funded services.
- Expand Community Hospital Integration Projects Program (CHIPP)
  Minimum of 170 people discharged via new CHIPP
  Funding commitment of at least $5 million
  Counties selected for CHIPP expansion will be based on:
    Counties/hospitals without current CHIPPS
    Continuation toward hospital rightsizing
    Part of the HealthChoices service area

Mental Retardation Programs

- Preserve Early Intervention - 1,068 additional children
  - -Withdraw from Part H of IDEA
    - *increasing program flexibility by removing federal requirements
    - *enabling the Commonwealth to establish fiscal controls
    - *allowing the program to generate third party revenues
  - -Restructure Act 212 to guarantee basic services to about 9,300 children
  - -Per capita costs capped at $5,400 to ensure service for every child
  - -Modify categories of at-risk children to reflect current research
- Expand the Medicaid Waiver to serve the waiting list
  - -County programs can identify existing state funds to earn federal funds
  - -Funds will be targeted to serve approximately 1,646 on county waiting lists
- Continue Commitment to Community Placements - Western, Embreeville and other state centers

Rightsizing State Institutions
FY 1996-97 Cost Reductions

- Personnel -- $6.6 million (MH) and $2 million (MR)
  Staff reductions in both MH and MR programs; 235 in MH primarily by furlough; and 100 in MR through attrition and furloughs.
- Operating Accounts -- $3.2 million (MH) and $3 million (MR)
  A reduction in the use of contract consultants and an increase in operating efficiencies.
- Fixed Assets - $433,000
- Mental Health Community Placements -- 170 Patients via CHIPPS
- Mental Retardation Community Placement
  48 Individuals from Western Center
  46 Individuals from Embreeville Center
  65 Individuals from other state centers

Impact on County and Community Programs
New Funding

Behavioral Health	$33.7 Million - (former GA Medically Needy Recipients)
Expand MR Waiver for Waiting List	$24 Million (Federal)
Increase Adoptions	$1 Million
Statewide Homeless Assistance	$.23 Million
Expand Attendant Care	$1 Million
Increase Domestic Violence and Rape Crisis Funds	$.4 Million

II. Case Mix Payment System

Background and History

The PA Case-Mix System is a regulated reimbursement plan set up to implement payment policies for nursing facility services under the Medical Assistance (MA) Program. Controlled by DPW, Case-Mix is intended to promote the economic and efficient operation of nursing facilities and also clarify existing policy to conform with Federal laws and regulations to PA's approved Title XIX Medicaid State Plan.

According to DPW, the Case-Mix regulations were designed to level the playing field for nursing homes. Previously, there were two payment levels and categories for nursing homes - intermediate or skilled care. These levels allowed for skilled care facilities to receive more money based on the type of care provided, regardless of the actual need of the patient. **Consequently, many facilities were reimbursed at skilled care levels while accepting low maintenance patients and receiving for more money than actually necessary.**

With the development of the case-mix regulations, however, the reimbursement calculations were changed to formulas that take in account the need or acuity of care of the individuals. In other words, the sicker the patient the higher the rate. Initially, these changes were well received and perceived as being fair. Unfortunately, following a recent restructuring of the system, nursing facilities are in an uproar about case-mix.

Under the new system, a neutralizing step was added, which averages private pay patients with medical assistance patients and calculates a facility-wide ratio. In turn, the calculated ratios of each facility are placed in an appropriate peer grouping. These peer groupings, which includes 44 different levels, have become the center of much debate. That is, many facilities say they are being unfairly classified and are not being reimbursed fairly. In fact, according to Bob Kopsack, under this neutralizing practice, the homes serving the sickest patients are the ultimate losers because they are being classified with other facilities that may not provide the same type of services.

In addition, opponents of the case-mix system say the system is flawed because of the way the case-mix ratios are calculated. In order to calculate these ratios, figures are taken from cost reports that facilities are required to file with DPW. While facilities are required to annually submit these reports, only audited reports are used to calculate the case-mix rate. Unfortunately, however, some facilities' reports have not been audited for two or more years. Therefore, the calculated rates are not accurate and do not truly reflect the current needs of the nursing facilities.

On September 22, 1995, by a vote of 4-1, IRRC approved DPW new regulations related to case-mix. These regulations, scheduled to be implemented January 1, 1996, have evoked a steady stream of opposition. Most notably, these regulations have resulted in cuts in Medicaid reimbursements while holding nursing homes to an inflation rate of below 4% per year.

Current Status

Currently, following the announcement of the IRRC decision and the release of the rates for 1995, nursing homes across the Commonwealth are claiming shortfalls in their budgets. As a result, nursing facilities are responding with massive layoffs. Moreover, in anticipation of further cuts, nursing facilities are strongly considering turning away patients that either require extensive care

that could be potentially costly or that do not require an amount of care that is significant enough to receive an appropriate reimbursement from Medicaid. Moreover, according to the facilities, in order to deal with the shortfalls, private pay patients will see an increase in charges and, in effect, will be subsidizing the MA patients.

As of March 8, 1996, the Case-Mix situation is in flux. According to Bob Kopsack, a nursing home administrator in Beaver County (Rochester Nursing Home), nursing home administrators have met with Governor Ridge to discuss their plight and to seek possible solutions to the problem. Evidently, the Governor expressed some concern for the situation and was seemingly shocked that the Case-Mix system was becoming so burdensome. Most importantly, he assured the administrators that some steps would be taken to ensure cost reports are audited on a more timely basis and rates are determined to better reflect the economic environment. To date, the Governor has not been in contact with the administrators, however, an official with DPW has offered to convene a meeting with those involved and negotiate a resolution by July.

Clearly, while its original intent was well received and much anticipated, the Case-Mix system has been the center of much debate and controversy. The nursing facilities are urgently calling for reforms to the system. They are requesting some attention be paid to their plight from the Governor, DPW, and the General Assembly. So far, as you can see, because of the complexity of the issue and the difficulty involved in repealing IRRC decisions and changing DPW regulations, very little has actually been done to resolve this situation.

Legislative Action Called For by Nursing Facilities

1. Guarantee that rates be calculated using current data not out dated audited reports.
2. Drop the case-mix neutralizing.
3. Revise the profit cap formula.
4. Reform the peer grouping practices.
5. Legislate a fairer way to reimburse facilities.

Current Legislative Efforts

- Two pieces of legislation were drafted addressing the issue of guaranteeing that rates be calculated using current data.
    a) rates shall be calculated using filed cost reports
    b) rates shall be calculated using audited cost reports unless these reports are more than 12 months old then use the filed cost reports.
- Consultation on going with Bob Kopsack in regards to developing language to deal with removing neutralizing, revising the profit cap formula, and reforming peer group practices.
- Representative Dermody has introduced legislation that addresses the issue of Commonwealth reimbursements to public nursing home facilities. (House Bill 1044) This legislation, however, to my estimation, does not address the same issues that are of concern to Mr. Kopsack. Instead, House Bill 1044 relates to interim annual payments made by the Commonwealth to county institutions.

Conclusions

Clearly, the controversy surrounding Pennsylvania's Case-Mix regulations is serious and requires immediate attention. Unfortunately, however, as you well know, the issue is extremely complex and complicated. Because the situation basically involves regulations passed down by DPW, legislative remedies are difficult, but not impossible, to pursue. As you know, the flaws in the system did not develop overnight and surely will not be remedied overnight. Most importantly, considering the political environment and the budget restraints indicative of this Administration, Case-Mix will not, in my opinion, be a priority.

III. MH, MR and D/A Impact on State Budget

Background

The federal government's funding for welfare programs has yet to be determined. Federal Medicaid (known as Medical Assistance in Pennsylvania) matching rates vary from 53% to 60% for Pennsylvania. Each 1% equals $70 million in state funds.

Governor Ridge has assumed in his budget that the federal government matching rate for Medical Assistance (MA) programs will be 57%, or the federal government will pay 57 cents and Pennsylvania will pay 43 cents for each MA dollar. Currently, the federal matching rate is 53 cents and is scheduled to decrease, effective October 1st, to 52.85 cents. The House Democrats questioned this assumption. The administration admitted that there is no guarantee the matching rate will go up and does not have a contingency plan if it does.

States will be given permission to define who is disabled for purposes of providing medical assistance. Coverage will be guaranteed for those under 6 and pregnant women who live at 133% of the federal poverty guideline, but disability status for all others is up for grabs. This will impact MH, MR, D/A populations. The notion is that these people can get service elsewhere.

This year's budget provides funding for HMOs for HealthChoices in Southeastern Pennsylvania. Historically, HMOs were allotted x amount of dollars per person on assistance. This budget provides funding in two parts or a "carve out" of dollars: a certain portion will go toward physical health and a certain portion will go towards behavioral health. The counties will be given more authority to choose which HMO will serve behavioral health.

Recipients will have the freedom to chose a number of Health Maintenance Organizations (HMOs) and Primary Care Practitioners to receive their health care. The Department intends to contract with an independent Benefits Consultant to assist enrolling recipients. The Department is not certain on the logistics of this consultant. In the past, HMOs had used deceptive practices to entice enrollees; for example, a free toaster when joining a HMO.

Applicability of HealthChoices for MH, MR and D/A Services

- Mental health and drug and alcohol services in the HealthChoices area will be provided through separate capitated managed care contracts. Recipients with more serious needs will be guaranteed care.
- Counties that can demonstrate a capacity to meet the Department's standards and criteria will be offered the "right of refusal" to enter into a full-risk capitation contract.
- Counties that wish to contract with the Commonwealth will submit a proposal and implementation plan for review by the Department.
- In areas where counties are unable to meet Department standards or choose not to participate, the Department will enter into a competitive bid process for a direct contract with a private managed care organization.
- The Department intends to expand its use of mandatory managed care for the MA population statewide. The Department is examining several models of managed care, including the use of HMOs and Primary Care Case Management to address the needs of Pennsylvania's diverse MA populations. Ultimately, HealthChoices of Southeastern Pennsylvania will serve as a prototype as it is implemented statewide.

HMOs and Mental Health Counseling Issue

HB1861 and SB1129 which would create the Mental Health Professionals Act licensing family, marriage, therapists, pastoral counselors, etc. are of some importance. Both bills are in their respective Professional Licensure Committees. HB1861 is actively being worked on. A major point of contention is the "scope of practice" that HB1861 would permit to licensed mental health professionals. Few of these counselors have the knowledge to actually diagnose biologically based mental illnesses. Many have had no exposure to the Diagnostic and Statistical Manual (DSM), which describes and compares the symptoms of mental illnesses. Psychologists, Psychiatrists, the Medical Society, and the Alliance for the Mentally Ill all have reservations about licensing these counselors as "Mental Health Professionals."

Another point of contention is that HMOs have been denying payment to "unlicensed practitioners." This could be avoided if an amendment allowed licensing to protect the titles of marriage counselors, therapists, etc. who would work as part of a team headed by a psychologist or psychiatrist.

State Hospitals Closure Issue

Closing large state hospitals and treatment centers may be a good idea but only if really adequate and really accessible replacement services are available at the community level - without waiting lists. The Governor wants to privatize these services which means that bids will be looked at not only for treatment content but for the cost. Potential providers will try to design their programs so as to promise services that fit the majority of cases but also that give the biggest bang for the buck. Specialized treatments, in depth diagnoses and case management cost more than one-size-fits-all approaches to mental health care management.

(Response to survey for community MH, MR, and D/A providers for Representative Mayernik)

1. What is your position on State funding going directly to Community Mental Health Centers?
I support direct funding to community mental health funding. I believe that by eliminating intermediary sources, the funding dollars are spent more effectively and efficiently by community mental health centers who are in the best position to provide accessible and quality services.

3. In reviewing the Governors Budget, can you predict and summarize what impact it may have on MH, MR, D/A Services?
Governor Ridge has proposed to eliminate General Assistance Medically Needy Only Medical Assistance category to approximately 283,000 Pennsylvanians, effective immediately, increasing the number of uninsured adults by 35% and costing $410 million. The Department of Public Welfare has identified approximately 34, 000 (the House Democrats believe this figure is a significant underestimation) with serious mental illness or substance abuse problems.

If these proposed cuts are enacted our streets, our malls, our neighborhoods may resemble a Dickens novel where only platitudes, indifference and incarceration are offered to counter suffering and anguish.

Do you think this funding is adequate?
I believe all adult Pennsylvanians must have access to needed health care services. Until alternatives are developed, we must have assurances that the loss of these benefits does not eliminate the level of care that community MH, MR, D/A provide.

I realize that the Governor has allocated an additional $34 million for county programs to provide an array of mental health and substance abuse services for the projected affected 34,000 individuals. However, I question this decision since this population needs case management, psychiatric care, outpatient services, partial hospitalization and medications which are all Medical Assistance funded services. A county allocation cannot adequately replace Medical Assistance funding and will ultimately jeopardize these essential services.

If not, can you sponsor or support legislation for additional fiscal support for these services?
Recently, the House of Representatives considered SB1441 which would have eliminated the Commonwealth's liability in providing these services. SB1441 was amended by Representative John Taylor which reinstated these health benefits. The bill was subsequently recommitted to the House Health and Human Services Committee for further study. I voted in favor of both of these measures. I intend to work with my colleagues in the House Appropriations Committee in seeing that these Medical Assistance services are maintained.

4. How do you see managed health care impacting on people with mental illness, mental retardation and on individuals with drug/alcohol problems?
The Department of Public Welfare is splitting behavioral health services from medical or physical health services in the managed care system in HealthChoices managed care program for Southeastern Pennsylvania. I understand that the Department intends to expand its use of mandatory managed care for the MA population statewide. I would certainly hope that several models of managed care, including the use of HMOs and Primary Care Case Management to address the needs of Pennsylvania's diverse MA populations would be considered.

(Response to community MH, MR, D/A providers for Representative Mayernik cont'd.)

I realize that public managed care for physical health care needs through primary health care practitioners, Health Maintenance Organizations, Health Insuring Organizations, and Public Health Clinics may be the best and appropriate trend for Medical Assistance recipients. However, specialized services for MH, MR, and D/A must be managed through a mechanism that best meets the needs of the local community. I fully realize that persons with mental disabilities and addictive diseases, as well as individuals with long term needs (i.e. persons with HIV /or AIDS) must be assured coverage. I support a managed care system for MH, MR, and D/A if appropriate and timely treatment is met.

What legislation can you introduce or support to address managed care for individuals with low or middle income?
Representative Allen Kukovich has introduced HB1701 which would provide for a Health Insurance Consumer Bill of Rights. This bill would prohibit any insurer, nonprofit hospital plan, professional health service corporation or managed care from requiring a person to obtain evidence of health or genetic status as a condition of enrollment, declining an enrollee based on health or genetic status or history, and imposing a pre-existing condition exclusion period or waiting period. It is my understanding that Representative Kukovich had intended to incorporate this bill as an amendment into SB1441. Nonetheless, I believe this measure is a positive step in representing the health interests of low and middle income individuals and families.

What can be done to ensure that the persistent and seriously mentally ill, and mentally retarded individuals will receive adequate care?
Of course, providing adequate funding and support for MH, MR, and D/A services will greatly enhance services. The House Democrats have historically fought for these dollars and will continue to support an increase in these funds. Additionally, the House Democrats will continue to oppose General Assistance Medically Needy Only Medical Assistance cuts.

I understand that community providers representing MH, MR, and D/A services need separate contracting for behavior health managed care services. I would certainly work with N.S.W. Community to realize this goal and to assure that children, adolescents, and adults receive essential services by a reputable managed care provider.

IV. Early Intervention Services Funding Cuts

Background

In 1990, the Legislature unanimously passed HB1861, Early Intervention Services System Law (Act 212 of 1990) which guaranteed early developmental services to infants through age three to children with disabilities. The program is currently administered by DPW and local agencies through a combination of state, federal and local funds. Under Act 212 Pennsylvania opted into federal funds through Part H to receive funding for this program.

The Administration intends to withdraw from Part H of the Individuals with Disabilities Education Act. Because of this decision, Pennsylvania will forgo $11.3 million in federal funds and the state would no longer be required to comply with federal rules that prohibit states from establishing their own guidelines. Consequently, Pennsylvania will have to cap its payments to all counties on a calculated statewide average cost and children would no longer be guaranteed the range of early intervention services that are currently available. These services include physical therapy, family training, special instruction, assistive technology and audiology services to infants, toddlers and children to age three.

This program is loosely interpreted and according to the Administration, Pennsylvania currently pays too much into the program where the federal government could be paying more. The Administration proposes to change Act 212 and withdraw from Part H in which Pennsylvania would loose $11.3 million in federal funding.

The Administration made this decision without contacting providers, parents and state officials. At the recent budget hearings the Administration could not provide basic answers to questions regarding the implementation of this "redesigned" program. Questions like the benefits package, grievance procedures and the inclusion of a parents advisory council of this new program could not be provided.

Representatives O'Brien and Cowell will soon be introducing a resolution requesting that the Governor reconsider this decision. **Please note that I have drafted numerous letters for various members of the Caucus on this issue.** Numerous parents of these special children have been in contact with their State Representative regarding the Administration's decision to withdraw from federal Part H funding. Nancy Thaler, Deputy Secretary of Mental Retardation has expressed fiscal concerns about the implementation of Act 212. However, many providers and parents believe that the program is not out of control. Certain counties (Philadelphia and Allegheny) have higher costs but that does not necessarily mean the program should be eliminated.

V. Homeless Issues

Background

A Homeless Assistance Program exists in the Department of Public Welfare. This program provides temporary shelter to homeless individuals and rental assistance to those in immediate danger of becoming homeless. Shelter may be provided in large mass shelters or in hotels and motels through a voucher system.

Housing Assistance also exists. This is a cash payment to an individual or family to prevent or end homelessness. Housing assistance can include assistance to prevent homelessness by intervening in cases where an eviction is imminent. Housing assistance also moves people out of temporary shelters and into permanent housing. Case management services are provided to assure ongoing coordination with the client which also assists the client in becoming self-sufficient.

Special residences for the mentally ill homeless are being provided in a small number of counties with concentrations of mentally ill homeless individuals. The program provides housing for mentally ill homeless for an indefinite period of time, coupled with supportive services that will enable the client to move to a long-term semi-independent living situation.

The budget calls for new funding of statewide homeless assistance act to $.23 million. The department plans to merge homeless funds into Human Services Development Fund (HSDF). The department notes that this merger will help expand homeless services statewide and provide greater flexibility to local governments.

Pennsylvania Housing Finance Agency

Homeowner's Emergency Mortgage Assistance Program (HEMAP). HEMAP was enacted in 1983 (Act 91) and was designed to protect citizens through no fault of their own, are in danger of losing their homes to foreclosure. Eligible applicants receive assistance in an amount sufficient to bring mortgage payments current and may also receive continuing assistance for up to 36 months. HEMAP payments are loans upon which repayment begins and interest starts to accrue with the recipient is financially able to pay.

Act 91 originally had a three year life with an expiration date of December 23, 1986. The program has been extended twice. First in Act 189 of 1986 which extended it through to December 23, 1989 and then with Act 182 of 1992 which extended the program permanently.

Since its inception in 1972, PHFA has committed financing to 36,472 apartment units and 52,346 single family homes through the sale of over $4 billion of tax-exempt and taxable bonds. It has channeled over $152 million of General Fund monies into the HEMAP Program to save more than 19,500 homes from foreclosure.

General Fund monies for HEMAP are not included in this year's budget. The program will place a greater emphasis on the collection and use of repayments on outstanding loans to maintain the current program. **Senate Wagner has introduced SB1436 PN1809 which appropriates $9 million to the Pennsylvania Housing Finance Agency for HEMAP for FY 1996-1997. This bill has been introduced since the Governor's budget has not funded this program. Status: March 11, 1996 Referred to Senate Appropriations Committee.**

Related issues - Homeless

SB1441 - Amends the Public Welfare Code to deny 270,000 low-income persons from Medical Assistance who have previously qualified due to insuring high medical costs associated with an illness or injury.

The Mental Health Associations in Pennsylvania note that this legislation (without the Taylor amendment) would severely cut off services to those who suffer mental illnesses and who are at risk at becoming homeless. Without care, without medication, our streets, our malls, our neighborhoods may resemble a Dickens novel where only platitudes, indifference and incarceration are offered to counter suffering and anguish.

The University of Pennsylvania's Health System realizes Secretary Houstoun's "let 'em get care in the ER" for what it is. They view this as the ultimate shrug of government's shoulders at the plight of the least of us, and that cutting off access to health care for the medically needy is the crassest form of cost shifting. The costs, while initially borne by hospitals, will be shared out to all of us in higher costs for our own insurance, in increasing scarcity of services overall, and in creation of an institutional violence which, in denying care, assumes that persons desperate for care will not act out in one way or another.

The Governor's use of LIHEAP money only for fuel, not for weatherization, may push more people into homelessness.

HUD is considering cutting back rental assistance for low income households. This a vital program provided by the federal government. People are already on waiting lists to receive assistance. Being on the waiting list is very stressful. This type of stress exacerbates some the people on these waiting lists who may have mental health problems or drug and alcohol problems.

House of Representatives

COMMONWEALTH OF PENNSYLVANIA
HARRISBURG
December 7, 1995

MEMO

TO: Representative Thomas Tangretti
Room 25B, East Wing

FROM: Kate Conrey, Research Analyst
Legislative Research Office

SUBJECT: Health and Welfare Hot Topics

As per your request, I have provided background materials of various health and welfare topics. The following materials are enclosed for review:

Nursing Facility Services; Case-Mix Reimbursement System Regulations
Health and Human Services Committee Regulatory Review Analysis Form
Democratic SubCommittee Chairs letter to Representative Cornell

Drug and Alcohol Detoxification and Rehabilitation Services in Hospitals Regulations

Clinic and Emergency Room Services Regulations
Democratic SubCommittee Chairs letter to Commissioner Comerford

Representative Richardson Long Term Care Memo

HB2 (Act 20 of 1995) Welfare Reform House and Senate Bill Analysis

I realized that your meeting with the Health and Welfare Council of Westmoreland County was canceled. However, if this meeting has been rescheduled and you would like additional research, please feel free to contact me at 3-1702.

Attachments

Nursing Facility Services (Case-Mix Reimbursement System) Regulations
These regulations implement payment policies for nursing facility services under the Medical Assistance (MA) Program. It establishes a case-mix payment system for nursing facilities that serves the need of Pennsylvania's MA nursing facility residents. It is intended to promote the economic and efficient operation of nursing facilities and also clarifies existing policy to conform with federal laws and regulations to Pennsylvania's approved Title XIX Medicaid State Plan.

The Democratic SubCommittee Chairs of Health and Human Services requested Representative Cornell to call the committee to meet and disapprove these regulations. The Democrats opposed this proposal because of concerns of access to nursing facility care. The problem involves several interrelated issues, including the nursing home bed shortage in Philadelphia and Allegheny Counties, the moratorium on new bed construction and the $22,000 per bed cap on capital reimbursement.

The Democrats had opposed this measure because of the Department of Public Welfare's inflationary rate of 3%. The for-profit facilities noted that this amount was too low and that 7% inflationary rate was more reasonable. The regulations were approved with a 3% rate of inflation.

According to Bob Klugiewicz these regulations are designed to level the playing field for nursing homes. Previously, there were two payment levels to nursing homes: (1) interim care and (2) skilled care. The skilled care category allowed a lot of latitude for reimbursement. Nursing homes had been admitting persons on the lower end of care but still had been receiving a high amount of money for these individuals because there were in the skilled care category. Now, the new formula reimburses nursing homes based on the need or acuity of care of the individual. Consequently, the nursing homes who had employed these practices will be receiving less money because low need of these individuals.
These regulations were approved by the IRRC on September 22, 1995.
Eventhough these regulations have been approved, there has still been an outcry by small nursing home operators about the payment provisions of these regulations.

Drug and Alcohol Detoxification and Rehabilitation Services in Hospitals Regulations
These regulations establish payment rates for inpatient hospital care in conformity with Title XIX of the Federal Social Security Act. These regulations authorize coverage for medically necessary inpatient drug and alcohol services when an inpatient setting is medically appropriate. In the past year, the department attempted to promulgate regulations which did not include a regulatory exception. These regulations were disapproved and the department resubmitted regulations which answered numerous comments concerning access and availability of alternative treatment settings.

The department found that many MA patients were being admitted to hospitals for detoxification services that could have been treated provided in a less intensive treatment setting. Also, the department found many MA patients with multiple admissions to inpatient hospitals for detoxification services without the benefit of rehabilitation. The revised regulations limit payment for inpatient hospital admissions for drug and alcohol services to situations in which a complication exists so that an inpatient level of care is medically necessary. Payment would also be made when a nonhospital bed is not available within a 50 mile radius of an inpatient hospital which the patient applies for treatment.
Theses regulations were approved by the IRRC on October 19, 1995.

Clinic and Emergency Room Services Regulations
These regulations are designed to discontinue payment to MA recipients who use hospitals and physicians of the emergency room for non-emergency use. The recipient must declares that he or she does not have access to primary care physician or outpatient clinic for it to be covered. Use of emergency room for non-emergency care has been commonly cited as a contributor to increasing health care costs. During FY 1993-94, approximately 49.8% of all claims from hospitals for emergency room care were coded as non-emergency room visits, costing $10.4 million in state and federal funds.

The Democratic Chairs of the House Health and Human Services Committee urged the IRRC to disapprove the regulation. The letter urged the IRRC to at look at the preamble of the Hospital Association which implies that enrollment in managed care "is prima facie evidence that the patient has access to a primary care provider"... and "if the hospital has an outpatient clinic... the patient would be deemed to have access to primary care whether or not it was possible at the time to refer the patient to that clinic." The same assumption is made whether or not it was possible for the patient to reach or receive care in a timely manner from the managed care gatekeeper. The letter further stated that both of these assumptions were contrary to the department's stated purpose of allowing payment when access to primary care is not available to the individual. These regulations were approved by the IRRC on September 7, 1995.

Long Term Care - Its Importance as a Reform Issue
Representative Richardson circulated a memo which noted the importance of long term care. It noted that most middle income Pennsylvanians are transferring their assets in order to qualify for Medical Assistance and eventually receive Medicaid. Since Medicaid is the only government program that covers the high cost of nursing home care and the cost of private long term care insurance is very expensive, many older middle income people have no other option.

Chairman Richardson proposed Equal Access to Nursing Home legislation which would ensure access to long term care facilities for Medical Assistance recipients in need of such care. The Health and Welfare Committee had held hearings last session in which individuals testified that MA recipients, especially African Americans and other minorities, are unable to get into long term care facilities.

Nursing homes are paid by essentially two sources: privately (usually an individual's private savings or insurance) and Medicaid. Medicare pays up to 100 to 150 days for long term care. In most instances, this coverage is usually used in a hospital stay because of a dehabilitating illness. Medicaid then kicks in to pay for the rest of the stay, or most likely, an individual's care in a nursing home.

(The following interpretation of long term concerns was provided by Bob Klugiewicz, Legislative Liaison for Department of Aging.)
Currently, many senior citizens are realizing that if they spend all their assets or creatively place them into other accounts, Medicaid can cover their expenses, and they or their family members can still use their money. This a common occurrence with many senior citizens who might rationalize that their hard earned money should be enjoyed by them or their family and not the government! There are senior citizens or family members who take full advantage of shuffling their assets. This money shifting is usually done well in advance of an individual's admittance into

a nursing home. Some wealthy individuals have been know to take full advantage of this "system". For example, an individual is accepted into a nursing home and has total savings and assets of $100,000. A few months later, the individual or family member reports to the nursing home that there is no more money (either the senior citizen spent it or set up a account so the nursing home cannot touch it or possibly a family member has control of the funds and spent the money).

HB2 - Welfare Reform (Act 20 of 1995)
Act 20 of 1995 eliminates cash assistance to transitionally needy recipients. It is estimated that 90,000 people are classified as traditionally needy, mostly able-bodied adults without dependent children. This law is expected to save the Commonwealth $26 million annually by eliminating cash benefits available for 60 days in any 24-month period paid to transitionally needy recipients. The individuals who loose these cash benefits remain eligible for medical benefits and food stamps. All able-bodied recipients who can work, but are unable to secure employment, are required to participate in Workfare (formerly known as the Community Work program).

The law now provides mothers receiving welfare to cooperate with the Department of Public Welfare in identifying a child's father. The department is required to recover birth expenses from the fathers or their insurance companies. Also, the law authorizes the department to create a finger-imaging identification program for recipients. Additionally, state and local police will have access to recipients' records.

Legal services, funded with federal money in fiscal year 1995-96, are expanded to include employment termination, unemployment compensation, insurance, health care, discrimination, wage and pension claims, wills and estates taxation, social security, and debtor/creditor issues.

The law amends programs so that people purchasing property with an unsatisfied Department of Public Welfare claim are not liable. It also requires department payments for auto purchase or repair to go jointly to seller/mechanic and the participant.

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CHAIRMAN – SUBCOMMITTEE ON COUNTIES
POLICY

House of Representatives

COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

October 3, 1995

Scott Casper
Director
Legislative Research
609 Main Capitol
Harrisburg, PA 17120

Dear Scott:

I have to speak at a breakfast to the Health and Welfare Council of Westmoreland County on October 19, 1995. If you could have one of your staff gather some information pertaining to Health and Welfare general issues or "hot topics".

As you can see this is of a timely nature and I would appreciate having the information as soon as possible. My secretary will be on vacation so I would appreciate very much if you could call the District office at 412-834-6400 to make arrangements to send the information.

Thank you very much for your cooperation in this matter.

Sincerely yours,

Thomas A. Tangretti

Thomas A. Tangretti
State Representative
57th Legislative District

TAT/csl

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

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HEALTH AND HUMAN SERVICES,
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APPOINTMENTS

PA COUNCIL ON THE ARTS
PA CHILDREN'S TEAM
PA TRAUMA FOUNDATION
NATIONAL CONFERENCE OF STATE
LEGISLATURES — PHILLY '97

September 12, 1995

Rep. Roy W. Cornell, Chairman
House Health & Human Services Committee
Room 45, East Wing Capitol Building
Harrisburg, Pennsylvania 17120

RE: Department of Public Welfare
Office of Medical Assistance
Nursing Facility Services: Case-Mix Reimbursement System
IRRC Regulation No. 14-431

Dear Representative Cornell:

We, the Democratic SubCommittee Chairs of the Health & Human Services Committee on behalf of our members, request that the Committee meet to consider and disapprove the above-referenced regulations.

As you may know, case-mix regulations with various revisions and modifications have been before the Committee a number of times in the past. After an extensive review of this latest incarnation of case-mix and numerous meetings with the Department of Public Welfare, the IRRC staff and the nursing facility associations, we have concluded that very serious questions and concerns as to whether access to needed nursing facility care will be adversely affected by this regulation remain unanswered. The problem involves several interrelated issues, including the nursing home bed shortage in Philadelphia and Allegheny Counties, the moratorium on new bed construction and the $22,000 per bed cap on capital reimbursement.

The following numbers from the Rate Comparison Analysis commissioned by the Department of Public Welfare and the Department of Health's State Health Services Plan projection of nursing bed need and bed numbers clearly illustrate this problem and the interaction between these related issues. First and foremost, of the 15 largest MA nursing home bed providers in Philadelphia, 13 will experience a reduction in reimbursement rates under case-mix. The biggest loser under the case-mix reimbursement system, at a loss of -20.99%, would be Elmira

Jeffries Nursing Home. When Elmira Jeffries filed for bankruptcy last legislative session, the City of Philadelphia, this Committee and the Department of Health intervened to prevent the loss of the facility's much needed nursing beds. Such extraordinary measures to save the facility were necessary due to a shortage of 7,967 nursing home beds in Philadelphia County. This shortage continues in Philadelphia and other areas of the state, including Allegheny County with a shortage of 4,225 beds. The current shortage in Philadelphia, at 7,418, shows little improvement over the last year. Under case-mix, rather then the slight decrease shown over the last year, the bed shortage is likely to increase dramatically.

DPW has acknowledged that over time, the case-mix incentive to favor heavy care patients will result in decreased access for light-care patients. These light-care patients have been certified to be in need of nursing facility care and will continue to be in need of care when no beds are available. Those beds will not be available because, unfortunately, in order to obtain a waiver from the moratorium on new bed construction facilities in areas experiencing bed shortages must demonstrate that the new project will be **financially and economically** feasible. The $22,000 per bed limit capital reimbursement that has been in effect since 1977 would only increase to $26,000 under this regulation despite an acknowledged $39,670 per bed statewide median appraisal. As the cost of construction continues to increase, it has and will continue to be increasingly difficult to nursing facilities to remain economically viable.

The economic viability of these facilities raises yet another question that has not been raised by this Committee in the past, that is whether the Commonwealth could successfully defend this payment system against a Boren Amendment lawsuit. The Boren amendment to the federal Medicaid provisions for reimbursement to hospitals and nursing homes requires that such reimbursements be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." (42 U.S.C. 1396a(a)(13)(A))

The bed shortage/moratorium/bed cap conundrum is not a new one. In fact, as relatively new members of the Committee, many of us did not attend a Public Hearing held by the Committee subsequent to publication of this regulation in proposed form in October 1993. That Public Hearing held in Philadelphia concerned the shortage of nursing home beds and the need for expanded access to community based care. The final report on that hearing, titled **"Creating and Preventing Loss of Nursing Home Beds in the Community"**, found the following barriers which prevent the establishment of Medical Assistance nursing home beds in areas experiencing a bed shortage:

* In 1982 the Department of Public Welfare placed a moratorium on the development of new nursing home beds in Philadelphia. The moratorium unduly restricts the construction of needed new nursing home beds in areas where there is a shortage of beds. And, thereby severely restricting access to needed nursing home care for MA recipients.

* It cost between 42 and 50 thousand dollars a bed to develop a new nursing home bed in Philadelphia while MA will only reimburse up to $22,000 per bed for capital cost leaving an insurmountable gap between cost and reimbursement.

For the reasons stated above, we urge you to hold a House Health and Human Services Committee meeting to sustain a vote disapproving this regulation as it is **not** in the public interest to adopt a nursing facilities reimbursement system which produces little, if any, savings which adversely affecting the provision of health care to the citizens of the Commonwealth.

In closing, we must reiterate our continuing support for health care reforms, particularly in the provision of long term care services, which are beneficial to the citizens of this state, the state's financial health and the health care industry. But, the proposed reimbursement system does not qualify as such.

Sincerely,

cc: Thomas P. Comerford, Chairman IRRC
Feather O. Houstoun, Secretary DPW
Rep. H. William DeWeese, Democratic Leader

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
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APPOINTMENTS

PA COUNCIL ON THE ARTS
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PA TRAUMA FOUNDATION
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LEGISLATURES — PHILLY '97

September 6, 1995

Thomas P. Comerford, Jr., Chairman
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, Pennsylvania 17101

Re: Department of Public Welfare
Office of Medical Assistance
Clinic and Emergency Room Services
IRRC Regulation No. 14-430

Dear Commissioner Comerford:

The Democratic Chairs of the House Health and Human Services Committee, on behalf of our members, ask that the Independent Regulatory Review Commission disapprove the above captioned regulation until the Department revises or modifies the regulation to include several of the changes requested by the Hospital Association of Pennsylvania (HAP), the American College of Emergency Physicians and Community Legal Services (CLS) on behalf of the Pennsylvania Welfare Rights Union. We make this request and support the following changes for the reasons stated below:

1. The Hospital Association points out language in the preamble which implies that enrollment in managed care "is prima facie evidence that the patient has access to a primary care provider"... and, "if the hospital has an outpatient clinic..., the patient would be deemed to have access to primary care, whether or not it was possible at the time to refer the patient to that clinic." And, presumably the same assumption is made whether or not it was possible for the patient to reach or receive care in a timely manner from the managed care gatekeeper. Both of these assumptions are contrary to the Department's stated purpose of allowing payment when access to primary care is not available to the individual.

   HAP further addresses this issue by suggesting that the more appropriate sanction for prevention of improper use of hospital emergency room by a

patient enrolled in a case management program would be against the case manager or the managed care organization for failing to provide 24 hour care or to properly instruct the enrollee on how to access services.

2. Community Legal Services' comments add emphasis to HAP's comments on the unavailability of care to recipients enrolled in managed care. We fully support CLS's position that the regulation must include a provision which allows payment for emergency room visits, whether or not the patient is enrolled in managed care, if the patient has been unable to reach the primary care physician or to arrange for timely care or has been referred by the physician to the hospital.

3. The American College of Emergency Physicians and CLS also point out a problem which is of great concern to us, the symptoms and exhibiting diagnoses for which emergency room treatment will be reimbursed listed in Appendix A does not contain surgical or traumatic symptoms. The list does not contain broken or fractured bones, head injuries, stab wounds, gunshot wounds or internal bleeding other than hemorrhaging and it also excludes coverage for psychiatric emergencies. The list must be updated to include the omitted symptoms and for inclusion of medical conditions which are equivalent in severity to those listed.

These commentaries also point out problems with the Department's failure to allow flexibility in use of the complaint at triage, the physician's coding or the discharge diagnosis in determining whether reimbursement should be made for emergency care. Although CLS and PaACEP differ on which would be more appropriate, both are right in that "patients should not be penalized for going to the emergency room for symptoms that could be serious" or for "not presenting the full story of their problem at the triage stage."

In conclusion, we fully support the comments submitted to the Commission by the interested parties and ask that IRRC Regulation 14-430 be disapproved until the necessary changes are made.

Sincerely,

Rep. Kathy M. Manderino
SubCommittee Chair for Human Services

Rep. David K. Levdansky
SubCommittee Chair for D & A

cc: Feather O. Houstoun, Secretary DPW
Rep. H. William DeWeese, Democratic Leader