COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

APPROPRIATIONS COMMITTEE

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PUBLIC HEARING IN RE: Subcommittee on Health and Human Services

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BEFORE: KATHY MANDERINO, Chairman
Dan Frankel, Member
Sean Ramaley, Member
Jake Wheatley, Member
Matthew Smith, Member

HEARING: Tuesday March 25, 2008
Commencing at 12:58 p.m.

LOCATION: LaRoche College
9000 Babcock Boulevard
Pittsburgh, PA 15237

WITNESSES: Marc Cherna, B. Scott Finnell, Debbie Welch, Shirl Regan, Judy Monahan-Grystar, Audra Palmo, Eileen Simmons, Timothy Ohrum, Dr. Bob Mirsky, Kristy Wright

Reporter: Barbara J. Jones

I N D E X

P R O C E E D I N G S

REPRESENTATIVE MANDERINO:

I'm Representative Kathy Manderino. To my right is Representative Dan Frankel, Representative Sean Ramaley, Representative Jake Wheatley. At the table in front of me, the gentleman who was just speaking is Marc Cherna. We'll give you their titles on the agenda. B. Scott Finnell, Shirl Regan, and at the end of the table Debbie Welch. Now, when everybody talks, she'll know whose name to put where. Thank you.

REPRESENTATIVE FRANKEL:

Thank you. First of all, Marc, I mean, I just wanted to say, you know, it's terrific being able to work with you during the course of years. It's not just always asking for additional funding. It's dealing with tools that you need to do what you can do, sometimes with less, and doing it very creatively, I think. And it's obviously been recognized right here in Allegheny County in terms of the things you've done. But at the end of the day, you know, we still have to deal with the issue of shrunken resources, which I think has been addressed throughout this crowd.

MR. CHERNA:

Right.

REPRESENTATIVE FRANKEL:

When you folks go to talk to the legislators about your issues, those of us here, those of us in Harrisburg, what kind of responses do you get in terms of your individual needs?

MR. CHERNA:

Well, being government is sort of different than being on the private side. So it's really my chief executive who primarily does the discussions in that group, but whenever I do talk to any of you individually, I always get, you know, people understand, people support. And they say they'll do what they can, and sometimes it works out and sometimes it doesn't.

But, you know, someone that's in the business 35 years, I understand the reality is that, you know, there are limited dollars and everybody pushes on you and you have to make tough choices. So I very much understand that. That's why when I come up with things, I try to come up with things that seem doable and not just pie in the sky, you know, give us twice as much money, which we would love to have and people need it, but the reality is they're not going

to raise taxes to do that. So trying to work together, as you pointed out, Dan, you know, that we're testing a partnership so we can actually, you know, improve services within the finite dollars it gets.

MS. REGAN:

I would say very much the same thing. We --- when I go and meet people, I always get a good response and then I'm told there's no money. One of the things that --- and we certainly understand that, but one of the things we're looking at is how can we help explain all of the things that we do not just in Allegheny County but across the state so that our need is seen greater. Like I said, people leave from the shelters. And when I talk about everything else that we do, peoples' eyes open. So we have good response. We were just told there's no money.

I think people still do care about our issues. I think people understand a lot more than they did 25 years ago when I started in this. And one of the things I didn't get a chance to talk about is we also do a lot of systems advocacy, you know, that --- working with the Pittsburgh Police and city council this past summer and the mayor and then just recently with the Steelers. So there's a lot of work

that's going on that you may not always be aware of. But shelters are our most precious program, and those are the ones that are absolutely in dire need. Programs are turning down their heat because they can't afford it. We need an increase. And we're willing to work across the board.

One of the things I forgot to mention is that 1.4 percent increase in state dollars over the last seven years has resulted in $401,000. So this is a really crucial issue for us to be able to keep the lights on.

MS. WELCH:

As a group of professionals, I don't know anybody that makes --- can make something out of nothing. We make glorious creations out of toilet tube rolls. And so as far as that is concerned, I think that we make the best of every resource certainly we get. But I think in the Commonwealth of Pennsylvania to be able to have a standard that whether you live in Allegheny County or you live in Butler County or you live in Philadelphia, there is some accountability for the program that you're providing for young children. It is incredibly important.

It gives families an idea of knowing that

when they sent their child to a four star or a program that is working very hard to develop their star program that their child is going to be safe, their child is going to be taken well care of, and they are absolutely going to have the best basis for their schooling and life experiences.

MS. REGAN:

I'd like to respond to something that Mr. Wheatley said and that has to do with fraud within our nonprofits. I'm sure you must hear about one or two or three where that happens, but what about the other hundreds of hundreds of us that are legitimate, doing good business. I can tell you that we are monitored day and night. We have to have standards that --- to actually be able to accomplish them, we have to have more staff. So I think that's something to take into consideration. There are hundreds and hundreds and hundreds of nonprofits out there that are doing an outstanding job with that penny, and I just want to speak on their behalf.

REPRESENTATIVE WHEATLEY:

Thank you.

MR. CHERNA:

I want to add to that piece. We have 400 agencies under contract. They've always certified

every one of them. We monitor each one. We have 194 funding sources in the department, and they're audited by the state, by the feds. There are people who live in our building all the time auditing, and we always come out with clean audits. So we really can demonstrate that the money is well spent, that the money is not going anywhere and our adamant costs are very low relatively speaking, 34 percent. So all this money is really going to serve the people, and it can be demonstrated. And it's very easy for some folks to posture and say fraud all the time, but prove it, you know. And finding one thing out of all that --- like Shirl said, you know, the millions of people get served and you are going to find something wrong. But, you know, 99.9 percent of the time it's done right and it's done efficiently and people really do make it work. Thank you.

REPRESENTATIVE FRANKEL:

It's clear to me that that --- certainly the level of accountability and efficiency in many years of facing those difficult fiscal challenges and sooner or later there's only so much you can do. You know, we sit on the Appropriations Committee and we listen to our colleagues, in particular, you know, when they talk about individual programs and the

governor's budget that is not cutting too much or not adequately enough. But there's also an issue to close this in. And I think unfortunately all fall under the category of the Department of Public Welfare and ---.

MR. CHERNA:

Changes the name.

REPRESENTATIVE FRANKEL:

And, you know, we hear folks often, as Marc recognized, kind of demonize the entire category as a way of talking about, you know, welfare and the way it was conceived of in the 1960s as cash assistance, which is really very little of what the Department of Public Welfare does today. And when we listen to them talk about the programs and how important they are and we need to direct more funding.

But, you know, it seems to me ultimately that --- that as a group there needs to be a better way to present the case for human services, not just individually for a specific program because when you deal with the governor's budget that starts out at 4.2 percent overall increase --- you know, so that's --- that's the best that we're going to do. And an effort by certainly a segment of our legislator who wants to table our budget to tie it to keeping it below the cost of living. You know, we need to present a

better, more unified presentation to explain what this --- I mean, this is part of that effort to do that. And hopefully we'll have some success, but when you try and segmentize every part of it to go individually for your own piece of it, it loses its affect itself, I think.

Anyway, it's a very difficult thing for us who want to advocate to make sure that you get the resources you need in a very difficult environment. And I congratulate all of you for the great work that you've done, in many cases doing more with less. Thank you.

MR. CHERNA:

It's always you pay now or you pay me much more later. And, you know, to the extent we can show that we do meet their evaluations, their health care evaluations, you know, the latest thing absolutely shows that if you don't provide services now, people end up in the county jail. People end up uninsured, going to the hospitals. People end up in nursing homes. I mean, we're right on that line, but it's that intervention now that will actually save money providing services through families in their homes so children don't have to go to placement and families don't have to be disrupted. I mean, you can

step by step, but there's some of your colleagues that don't really want to hear that. That's a challenge.

MR. FINNELL:

Can I make a comment? One thing about this money that we spend, you know, often times we talk about, you know, how much money is going to human services. But if you recognize that in human services capacity, most of the money that we spend, we spend on staff dollars. And so that money just returns right back into the economy. Half of our budget --- clearly half, if not three quarters of our budget is paying staff who are paying taxes, who are buying gasoline, who are buying groceries and buying homes. Then if you add on that the real mission of what we do, as Marc's just explained, is we're creating workforce because we are helping kids become productive citizens as they move forward as opposed to being a drain later on. It really has a great benefit to the overall economy of any state when we make this kind of investment, and it's not just money that gets spent and wasted.

REPRESENTATIVE MANDERINO:

The panel before us really shows a microcosm of what it is we are doing in this year's human services budget. Debbie, I know you were asked

to talk about Keystone Stars, and Keystone Stars as a little program that is designed to upgrade the training and education of the staff so that it translates into quality is one of the, quote, unquote, winners in the governor's proposed budget with $4.8 million increase. But at least I'm aware, and I'm sure my collages are, too, that in our state budget that pays for child care and child care providers, there's a much bigger issue in terms of reimbursement rate; what you can afford to pay staff, whether you have staff yourself that don't have health care benefits, are getting other public assistance dollars because they are so low paid compared to their education standards. So I don't want to --- since you were here to talk about kind of one of the smaller programs that is being recognized as a good investment, I didn't want to short shift the fact that at least I recognized that in the world of state human services funding and child care there are also some budget deficits. So I just want to acknowledge that.

Shirl, domestic violence, flat funded. And you made the point about flat funding in an era of decreasing federal dollars and increasing costs of living. Basically flat funding means less services.

MS. REGAN:

Less services. Absolutely.

REPRESENTATIVE MANDERINO:

Scott, you talked about MA realignment.

MR. FINNELL:

Yes.

REPRESENTATIVE MANDERINO:

I want to explore that a little bit because MA realignment was --- if I'm remembering correctly, was supposed to be a funding mechanism to help us provide the same services by drawing --- realigning how we were matching money and drawing down more federal dollars. But you basically made the point that MA realignment is losing you money or losing you services, and I need you to make that connection for us, what you mean.

MR. FINNELL:

I can just tell you from my experience because as I've listened to the panelists and recognized that our funding usually comes through the county, I think I'm providing anecdotal evidence to back up everything that Marc has said about us going on.

What happened to us at Pressley Ridge is that when we made the shift to do the MA realignment, it required us to match up with the funding stream to

add doctors and nurses and change the whole modality of that program so that it would line up with the billing codes that were available for the Medicaid money. Now, we ---.

REPRESENTATIVE MANDERINO:

I don't mean to interrupt, but does that mean all of a sudden you had to start providing a higher level of service than you had been providing in order to be eligible for those dollars?

MR. FINNELL:

Yes.

REPRESENTATIVE MANDERINO:

Okay.

MR. FINNELL:

Basically the nomenclature that we used around the organization is that we've become a hospital in the woods. And that was never what our Ohiopyle Therapeutic Wilderness Program was intended to be. It's an experiential program that treats kids in that environment and helps them learn control over their environment and other decisions that they make in their life.

When you shift to a medical model type of a treatment, we were going into a situation where we had to have doctors sign off on every child visit, on

every meal that a child ate and it just really added enormous cost. And our program is in Fayette County, which means that it's not like we have doctors running out our ears down there. So we had to increase expense of finding doctors and psychiatrists and finding nurses, providing 24-hour care.

Then what happens in the referrals that we were getting, we were getting referrals for medically fragile kids. Medically fragile kids don't need to be living in the woods. That's not the program that that program was intended to serve. And so what we've had to do is shift back. And even with being able to draw down the federal dollars with the increased expense of what it cost us to run that program in Fayette County, we couldn't compete with a program that's being run in Allegheny County. They could do it cheaper than we could. So our expenses were normally higher --- or naturally higher because of how far our program is.

REPRESENTATIVE MANDERINO:

If I can ask you, Marc. I'm going to come back because I have another question for Scott, but I want to understand this because you as the county are really the payor to them as the provider.

MR. CHERNA:

Yes.

REPRESENTATIVE MANDERINO:

Now, prior to MA realignment, you obviously recognized that this outbound, outdoor wilderness therapeutic program that they provided met some sort of niche for the children that you had to provide services to.

MR. CHERNA:

Uh-huh (yes).

REPRESENTATIVE MANDERINO:

So did MA realignment mean you were spending more money for the same services, you were targeting different kids and different needs because you were following the money that there was this whole group of kids with higher needs than he could handle that had been being unserved anyway, so you were trying to make a round peg fit a square hole? Tell me what was going on.

MR. CHERNA:

Yeah. And I think it was kind of an unintended consequence. I mean, in fairness to the Department of Public Welfare, I think they really tried to help the counties and the system because we used to get about $250 million in TANF money. Under the federal, that money dried up because it was a

surplus, which was sent down by the last administration. So when this new administration came in, they basically had nothing left, but the money was already allocated. So the county had that $250 million in their budgets. That money went away. So the state tried to be creative in saying well, if we can make our residential programs Medicaid eligible with a residential treatment facility, then we get 50 percent of that money would be federal. We would really reduce this county's share and we'd reduce the state's share in having to come up with that.

So we were very aggressive in trying to convert programs, and some worked better than others. And I think Scott's program is an example of one that, you know, was not anticipated to end up that way. It didn't work frankly to cut through the quick and it --- you know, you need medical necessity and a lot of these children didn't really qualify for medical necessity, and it was just a different type of program. Some residential centers which were not RTF were able to adjust. Many were not and also getting ---. So ultimately the Medicaid realignment did not work very well, and we basically ended up pretty much limited here. You know, a few of our kids are eligible for most parts, but it's not there as much as

it was. A lot of people have converted back like Scott did.

So it was a --- you know, a challenge, you know, in trying to make something work, that didn't work very well. So the state has put money back in the budget, but what it requires is that county match, which I --- what I go back. They also did this STG money to try to minimize that, state transition grant. So when that money's gone, the state transition money gone, the Medicaid realignment didn't work and the bottom line is county government has to come up with this money to generate the match, and they can't do it because they're not going to raise property taxes.

REPRESENTATIVE MANDERINO:

So this year --- I mean, we --- this has been kind of a couple year --- a couple of years of trying other ways to fill these gaps, and each year we end up back at the drawing board because it's not going to work that way, so to speak.

MR. CHERNA:

Right.

REPRESENTATIVE MANDERINO:

So this year we are back at --- I just want to understand from a budget point of view. We

are back at a drawing board where the options are going to be plug the hole for the counties again with some --- something similar to TANF transition funds or literally push down $45, $50 million without assuming any inflation on the counties that they're not paying for now.

MR. CHERNA:

That they can do.

REPRESENTATIVE MANDERINO:

And then the counties then are going to have to make --- if that is what ends up happening, the counties are going to have to make a decision between raising county budgets or cutting services in human services the county provides.

MR. CHERNA:

Yes.

REPRESENTATIVE MANDERINO:

Now, on the cutting human services that county provides point, how much of what the counties are doing --- let's just talk about Allegheny County, your experience. How much of what Allegheny County is doing --- and I know we don't like --- as human service providers, we don't like to think of anything as discretionary. But from a policy point of view, there are mandated services and then there are not

mandated services.

MR. CHERNA:

Right.

REPRESENTATIVE MANDERINO:

So how much of what you're doing is not a state mandated service?

MR. CHERNA:

Well, it's mandated when the judge is saying you must do it. So all of the in-home prevention type programs, the things that don't reach the judicial piece, you can say are not absolutely mandated. However, if you don't provide in-home services, you don't provide prevention, then the floodgates open, which is where we were, you know, 12 years ago here. We reduced our placements by, you know, 1,200 kids, almost 35 percent, because we did in home services and all that.

So it ends up saving us money. But in the short term if you --- if you reduce or eliminate those programs, then you're not helping the family, so ultimately children are going to get hurt. Deaths will go up and children will need placement and there's no money and the courts will order it. Then the counties will have to come up with the extra money because they're given a court order. So penny wise,

it's kind of foolish to do that. And just to add to this piece, the Federal Title III money we have gotten probably $50 million less than the state because they are squeezing so hard, because all of our money is going to Iraq and Afghanistan and everything else. So everybody around the country is really losing their federal dollars which was reimbursement. So that just exacerbates the problem that we have.

REPRESENTATIVE MANDERINO:

I think to the extent that you can put price tags on this, you have to because otherwise it's easy to talk about the problem and then --- and pretend at the same time that the cuts don't mean anything. Allegheny County's human services budget, what percent of it is what you're calling preventative?

MR. CHERNA:

Well, from treating prevention in home services, about 38 percent of our children and youth budget.

REPRESENTATIVE MANDERINO:

So 38 percent is not court mandated?

MR. CHERNA:

Right. Well, the courts --- let me take that back because the courts may mandate some in home

services, but a fair amount is not because it doesn't get to the court system because we're providing services.

REPRESENTATIVE MANDERINO:

So if the county doesn't get the money, that's the first place they're going to look to cut back?

MR. CHERNA:

Well, we can do that or we reduce staff. You know, we do things like that and then we get higher caseloads which then puts kids at risk. I mean, I hesitate, and I know politically you're better off taking the programs that will get the most attention and say this is what we're going to cut first and do that, I really hesitate to ever scare consumers by doing that. Ultimately people get hurt. We can see what we can do to reduce --- you know, minimize that damage which we've always done, although it's not the politically correct thing to say especially at this kind of hearing, but I can't --- I got to tell the truth.

REPRESENTATIVE MANDERINO:

One more question and then I'll just ask for some follow-up information. Scott, one of the points that you made during your oral remarks was that

the government dollars, state, county, federal, the public dollars that you were getting to provide for mandated services don't cover your costs, so that you are increasingly doing private fundraising as a nonprofit in order to make sure that mandated government services are being provided.

MR. FINNELL:

Correct.

REPRESENTATIVE MANDERINO:

Can you put a dollar figure on that for me, a percentage of that, a trend on that? I think that would be helpful.

MR. FINNELL:

I can give you exact dollar amounts, and just --- this is just for Pennsylvania. I said part of the way that we cover that is we actually get paid in other states for what we do, and that helps us provide services here. But during our fiscal year 2007, which is July 1 to June 30 fiscal year, so it ended --- it ended last June --- or it ended last June. We lost about $1,058,000 on 10 to 12 programs every year.

REPRESENTATIVE MANDERINO:

Right. And you gave us that figure. I don't know if $1,058,000 for your particular budget is

one percent, ten percent.

MR. FINNELL:

I'm sorry. For Pennsylvania services, we would have about $30 million. So that's what ---.

REPRESENTATIVE MANDERINO:

Okay. So you're coming up short ---

MR. FINNEL:

About three percent.

REPRESENTATIVE MANDERINO:

--- about three percent on the program. Finally, just for further --- I was very interested, Marc, by your comment about --- we've been trying to change the how we're pulling money in formula.

MR. CHERNA:

Uh-huh (yes).

REPRESENTATIVE MANDERINO:

But we have a lot of how we're pushing out money formula that are really old, and it seems like we haven't sat down and tried to match those up in a way that makes sense. I hear from --- some counties were using their TANF transition for matches for certain things. Some counties were using the TANF transition for prevention and after school programs. Some counties were using their TANF transition exclusively for juvenile justice because the match was

so bad on juvenile justices compared to some other things, that they were using that to fill the gap.

But, you know, I --- I don't know that we could explore it here because I don't know that we would have the depth of understanding without a little bit of a briefer. I would love to have something in writing that suggests how we look --- where you were trying to go, how we look at this whole thing in a more holistic way. And I don't know if those discussions have started with the department yet or not. But at least from the legislative point of view, I think it would really help us to start understanding that a little better.

MR. CHERNA:

I've had discussions with the highest level at the Department of Public Welfare, but ultimately it comes back to it's a legislative function. It's in the legislature, it's in the law about the percentages. And I really do think, you know, that it's worth taking the time --- you know, and I know you can't do it right now, but to look for next year what makes sense and what could be somewhat neutral in terms of looking, because in 20 years the practice has changed and incentives need to change so counties will do the right thing. And that's a huge

move to keep families home, to keep kids in their homes and provide services to keep them safe.

So I mean, with --- you know, Scott does a lot of different things and he's our provider for residential and all of that, but he also does in home services and he knows he has to move in that kind of direction. Can we provide incentives? You know, that is the state of the argument nationally to do that to keep kids safe in their own homes. Casey Family Programs, which is the largest foundation in the country dealing with this, had a goal of reducing placements by 50 percent nationwide. And there's a lot of movement. We need to change our financial piece to incentivize that piece. We can do it without costing a lot of money, but it's worth to have that off line, you know, before you have in the budget process we're ready next year. It requires new legislation to do that, and I'd be glad to assist in any way I can because the federal is also around about a $45 million amount.

REPRESENTATIVE MANDERINO:

I thank you. I thank all of our panelists. In the interest of keeping on schedule because we got a little bit late start, I want to end panel one here. Thank you very much for your

testimony. And I think somebody who's coming up on panel two can grab one other chair. I think we're going to be one chair short. We have six. Everyone's here from panel two, Lisa? Panel two, if you want to make your way up, Judy Monahan-Grystar, Audra Palmo, Eileen Simmons, Timothy Ohrum, Dr. Bob Mirsky and Kristy Wright. I need six chairs, and I have five up here. Excellent. Okay. Now, we have six.

You can sit in whichever order, but we'll start this way and just like we did with panel one, let everyone make their five-minute remark and leave time for questions. Okay. I think we'll do the same thing and start right down here, and I just would remind you to make sure that you introduce yourself so that --- before you start your remarks so that the stenographer can put your name with your remarks when she starts her recording. Thank you.

MS. MONAHAN-GRYSTAR:

Good afternoon. I'm testifying today on behalf of the Conference of Allegheny County Providers. My name is Judy Monahan-Grystar, and I'm the Executive Director for Turtle Creek Valley Mental Health/Mental Retardation Services, Inc.

Our organization is a member agency of the Conference of Allegheny County Providers and

that's short for CAP. The Conference of Allegheny County Providers or Allegheny Providers is a member organization representing approximately 42 mental health/mental retardation and drug and alcohol service providers who employ 14,300 staff and provide services to over 129,000 individuals and families annually who are residents of Allegheny County.

REPRESENTATIVE MANDERINO:

Judy, I'm sorry. I'm going to be rude, too, because I noticed you came in late. Each presenter has five minutes. I would just remind you. So to the extent that you have written testimony that is more than five minutes, I just would ask you to make sure that you don't not get to your most poignant point because I will, if it takes too long, have to ask you to let the next person speak.

MS. MONAHAN-GRYSTER:

I'll try to get through this quickly. The system --- our system of care offers comprehensive continuum of supports and services which include adult and child inpatient and outpatient services, rehabilitation services, day training programs, residential services, employment services, peer run services, prevention services in the communities and in the schools and case management services.

The people we serve have significant psychiatric, developmental and drug and alcohol abuse and addiction challenges in addition to being poor. In spite of these challenges, individuals served through the system are determined to improve their lives and participate in the community. The MH/MR/D&A system provides support and services to assist in their successes. The service system supports the individual family and community at large and employs thousands of people in real jobs who provide quality services and who support the local economy. The service provided often prevent individuals and families from ending up in systems which costs the taxpayers more, i.e. hospital care, jails, juvenile justice.

We constantly hear talk in the legislature of the need to create stable, well-paying jobs. The 42 agencies that are represented through the Conference of Allegheny Providers employ 14,300 staff whose salaries are dependent on the level of funding from you the legislature. Many of these staff members work two or three jobs in the system to support their families and their paychecks are used to support the economy. Why did the governor support an economic stimulus package for all Pennsylvanians and

neglect to include COLA in this year's budget?

Because of misguided priorities, once again the provider community must stand before you to inform the House Appropriations Committee as to how lack of cost of living increase in the budget will impact the delivery of MH/MR and D&A services in Allegheny County.

Let me begin by saying that year after year staff from our provider organizations, individuals and families through our agency write letters, visit representatives, write to the governor providing justification for a cost of living increase. Some years we've been fortunate to receive a two percent increase, which may or may not be passed along by the counties to provider systems. For many years, there was no cost of living provided in the budget, and recently in 2004 and 2005, we received significant decreases in funding. Under Healthchoices, which was implemented in 1998, providers have had minimal increases in some of our fee for service programs such as outpatient and case management services.

The reduction in funding over time compounded by the lack of significant cost of living adjustments and increasing demand for services has resulted in an overburden system of care.

Significantly high staff turnover rates and recruitment and retention issues plague the system. Inability to recruit and retain qualified staff has an immediate economic impact on the access to services. Two years ago, the provider community including consumers and family members and many of you pushed for a permanent solution for providing a cost of living adjustment through HB 1813, which was passed with support from the majority of our state senators and representatives voting to support the legislation. Unfortunately, the governor did not support and vetoed this legislation promising to find another way to provide annual cost of living increase. The failure of our government to provide cost of living adjustments in pace with inflation essentially acts to melt or reduce the effectiveness of the delivery system.

Last year, the system received a three percent increase and that really was received on the mental retardation side. We did not receive three percent on the MH side in Allegheny County and received very little in D&A. But this has --- this increase had no major impact on the provider's capacity to meet the needs of the residents of Allegheny County served through the system and

recruitment and retain trained professional staff. This year's state budget is again a slap in the face to our staff, our agency and the families and individuals we serve.

I am here again today as our organizations have done in the past to provide justification for our request for COLA. I think the justification is pretty straightforward. The current rate of inflation has had a significant impact on our agency budgets. Many of the in-home and community services our staff provides require the use of automobiles. As you know, the increase of gas prices alone is a budget buster for these services. A recent editorial in the Post Gazette dated February 2nd quotes the following, the U.S. rate of inflation in 2006 was 2.5 percent, 2007 it was 4.1 up to 64 percent. Another article states that the employer benefits in 2006 have increased significantly $18,489 in 2005 to $21,527 in 2006. Okay.

Another article dated February 20 provides detail on price increases in the Pittsburgh area. Retail prices are up. I think we all know this. Medical cost. Everything's up. But we're not sure if we're in a recession at this point, but we'll find out.

The Allegheny County Nonprofit Providers have seen significant increases in employee benefits, in particular health insurance, with rate increases each year with ranges from nine to 15 percent. Approximately ten percent of the provider's budget is spent on health insurance. A decent benefit package is needed in order to recruit and retain staff.

As I mentioned earlier, recruiting and retaining professional staff is a major challenge for our industry. The salaries of our professional staff including doctors, nurses, psychologists, social workers and other licensed professionals has increased 20 to 30 percent. For example, our cost for an MD is approximately --- our unit cost for medical service is $250 to $270 per hour, and we are reimbursed at $135 to $150. Every time the doctor sees the patient, the provider will lose money. Because of current market forces, we either pay what the physician requests or we will not have the amount of psychiatric time available to meet the needs of the people we serve.

The current workforce crisis in the industry has made it difficult to even recruit high school graduates, which we are willing to train. I'm referring to direct care positions within our residential and day services. Our competitors are the

Targets and the Wal-Marts who may offer the same pay, $9 to $10 an hour, but whose jobs are not as difficult as caring for an individual with mental or developmental challenges.

We need to stop shifting the burden of an under funded system onto the backs of our employees. Employees who have dedicated their lives to people we serve now are beginning to leave the industry and new recruits who are committed to providing quality services are becoming scarce.

I urge you to include cost of living in the budget for this year and work with the provider community to ensure ongoing adjustments in future budgets through the support of HB2160 sponsored by Representative George Kenney. This bill would provide a yearly COLA that would begin to stabilize the system through a reliable source of funding to ensure the community based human service system remains available to those in need. The system has functioned for over 40 years and has proven to be an efficient and effective alternative to state institutionalization. We continue to close state hospitals and residents return to their communities with the promise that funds will follow and services will be available. Do not break that promise by excluding cost of living

increases in the budget, which technically is a funding reduction. Work with the provider community to find a solution to adequately fund the system, which will require more than an annual COLA to adjust for the many years of funding reductions. Ongoing funding must keep pace with inflation. Our most vulnerable citizens demand nothing less. Our hardworking and committed staff demands nothing less. Please do not let them down. Thank you for the opportunity.

MS. PALMO:

Hi. My name is Audra Palmo. I'm the administrator at Jefferson Hills Manor. I have been a licensed nursing home administrator in Pennsylvania since 2006, have worked in the long-term care industry in other capacities for the past eight years.

Our facility is owned by Guardian Elder Care. I'm here not only representing Guardian Elder Care, but also the Pennsylvania Health Care Association, of which we are a member. Guardian Elder Care is a long-term care company which has 17 nursing facilities across the State of Pennsylvania. We have over 1,200 beds. Jefferson Hills Manor, the facility where I am the administrator, is currently licensed for 83 beds and right now 58 percent of our population

is funded by the Medicaid program.

The reason that we're here today is regarding, of course, the governor's proposed budget. Governor Rendell, when he introduced his budget, when he proposed it, 2008/2009, before a joint session of the general assembly, he said, if you think the widow of a World War II veteran in a nursing home is not entitled to medical assistance, you are sorely mistaken. And if you don't, then by no means can you justify the attacks on our medical assistance increases.

He's absolutely right. But what the governor says and what his budget proposes are two entirely different things. The spending plan outlined by the governor contains no medical assistance rate increase for nursing home care.

When it comes to deciding how to fund the vast long-term care costs of increasing older Pennsylvania, Pennsylvania has a lot more at stake than other states within how our demographics play out. Right now, two million of our 12 million Pennsylvania residents are age 65 or older and by 2020 more than 25 percent of the population or some three million Pennsylvanians will fall into that demographic. It's a 50 percent increase in that age

group in more than a decade. And this poses significant funding and quality of care challenges for families, caregivers and state agencies whose charge it is to safeguard elderly and others.

In Pennsylvania, two out of three nursing home residents are paid for by the Medicaid system. In 2007, it was reported by a national accounting firm that the short comings of what we get paid at the facilities based on what we're reimbursed is facilities are losing on average $12 per resident a day per resident, so about $4,300 per resident per year that we're losing.

There are few other health care providers like nursing homes who are so dependent on state and federal government for the services they provide. Medicaid and Medicare generate nearly 80 percent of our facility's revenues. Private resource and long-term care insurances make up the balance. By contrast, private insurances alone account for 42 percent of hospital revenues.

Nursing home costs have increased 27 percent between 2001 and 2005. During that same period, Medicare's reimbursements only increased 18 percent. The average nursing home provider cannot continue to absorb the un-reimbursed costs to take

care of medical assistance residents long term. With over half of the residents at Jefferson Hills Manor being paid for by Medicaid, we are no different than the majority of facilities across the state.

In 2007, it is estimated that my building itself lost $10 --- $10.75 per day per Medicaid resident. Extrapolated over the 12 months, Jefferson Hills Manor lost $150,000.

We all realize that Pennsylvania is not alone in having a difficult budget year, but nursing homes have done their part to help the state during fiscal times. Two years ago, nursing homes in an effort to help the administration during tough fiscal times agreed to terms of lesser reimbursement than the system would have otherwise paid with the understanding that when the sun sets on June 30th, 2008 the state would again cover the full cost of care for medical assistance nursing home residents.

Specifically, medical assistance paid nearly $290 million less than it owed for the care of medical assistance residents living in nursing homes in the past three budget cycles. Nursing facilities have fulfilled our end of this promise. Unfortunately, the governor's budget has not upheld its side of the understanding.

Because of the reality of Medicaid funding, many nursing homes are dedicating more and more beds to short-term Medicaid rehabilitation residents because the reimbursements for Medicare are greater. If this trend continues and facilities continue to increase their proportion of Medicare replacing Medicaid, those individuals who are Medicaid eligible on day one could face a serious access to care issue in many parts of the state.

Nursing home residents will continue to receive high quality care, but make no mistake the deficit in medical assistance payments are going to clearly and adversely affect their quality of life. Activities allow residents to enjoy the same things that the rest of us enjoy such as music, picnics, movies and outings are going to be reduced because there's not going to be the money to fund them. Nursing homes will continue to be forced to delay capital improvements and beatification projects that would provide residents with a more home-like atmosphere.

While I have spoken exclusively on nursing homes and the budget's impact at this point, it's important to talk a little bit about the expansion of home and community based services and

their relation to nursing home funding.

I believe in a broad continuum of care that enables people to age in the most appropriate placement. Because of that belief, I want to comment that the governor's budget wants to expand home and community care for low income seniors and disabled residents who aren't sick enough to need a nursing home or transition from a facility back into the community. We have dedicated staff in our nursing home to work closely with local area agencies on aging to do just that.

I started out in long-term care as a medical social worker, and I worked very closely with many an area agency on aging. I can state that without question the programs that they offer, they can't compare to what we can do in a nursing facility. Area agency on aging programs such as the waiver program, they give care at home that's typically about 40 hours a week whereas we do 24 hours a day, seven days per week.

Families of people who are truly nursing home eligible are expected to make up those other hours. It's not always a realistic approach to adequately and safely care for people in their homes. Often area agency on aging providers of these services

can't meet the staffing needed for those in the community. And sometimes when there's call offs, people are left at home by themselves without any care at all.

I've also spoken with area agency on aging employers during discharge planning that have accepted people into their program who aren't even appropriate for nursing home care, and they just take them sometimes because they are concerned that they're going to lose their funding if they don't have their slots full for their waive programs.

Based on the data from the DPW, since the 2002/2003 fiscal year, the annual number of nursing home residents on Medicaid has remained relatively constant, around $80,000. Over the same period, however, the number of home and community based beneficiaries has more than doubled from 17,964 users to projected 36,787 users. Some argue that without these expanded home community programs these 27,000 individuals would be in nursing homes, but that's not true.

The acuity or sickness level of individuals being added to home and community based service programs don't rise to the level of the care those need in nursing homes. What the Medicaid Home

and Community Based Program really has done is expand long-term eligibility requirements to people who don't really --- don't really meet the requirements of being in a nursing home.

If you accurately and fairly examine our Commonwealth's medical assistance nursing home spending by comparing the costs to a number of people served with these dollars, a different picture emerges. Pennsylvania spends only five percent higher than the national average, which makes sense since the cost of living and the cost of health care are higher in Pennsylvania than the national average. At a time when our population is aging rapidly, at a time when millions of baby boomers are starting to retire and seek services, at a time when there is clear need for greater investment in long-term care, the governor's budget does not do enough to account for these drastic demographic changes.

Failing to fulfill a commitment to restore adequate funding for nursing home care is nothing less than a broken promise to the Commonwealth's frail elderly and disabled who are the most vulnerable among us.

MR. OHRUM:

My name is Tim Ohrum. I'm legislative

director for Hospital Association of Pennsylvania. You probably know that as HAP. With me here today is Eileen Simmons, who is the chief financial officer with Magee-Womens Hospital here in Pittsburgh.

My remarks today will largely focus on the following, the importance of the state's Medicaid program and the impact of the state budget on that --- on those hospitals.

Pennsylvania's Medicaid program, also known as the medical assistance program, provides services to 7 --- about one in seven Pennsylvanians. Approximately 60 percent of those Pennsylvanians are low-income families and children. Twenty-one (21) percent of those are disabled, 13 percent are elderly and six percent are chronically ill adults. In Pennsylvania, Medicaid finances the care for 65 percent of all the people who are in nursing homes. In Pennsylvania, the disabled comprise 34 percent of the Medicaid recipients, but account for more than 70 percent of all Medicaid spending.

Medicaid funds one out of every three births in Pennsylvania and is the most important source of financing for the cost associated with premature infants. Medicaid hospitals' payments relative to the cost of Pennsylvania has been

substantially below the national average with the comparison to other states, whereas Pennsylvania ranks fourth highest nationally in the total Medicaid spending and sixth highest per enrollee expenditures. It ranks 30th nationally for Medicaid hospital spending.

Pennsylvania hospitals are underpaid for Medicaid services receiving about 85 cents on a dollar for inpatient care and about 54 cents on the dollar for outpatient care. That number has not largely changed in the nine years that I have been with HAP.

The greatest share of medical assistance funding is health care for the elderly and persons with disabilities, as I mentioned earlier. This is reflecting their intensive use of acute care and long-term care services. Although the elderly and disabled represent only about one third of all recipients, they account for two thirds of the cost associated with medical assistance. By contrast, low-income families represent the majority of MA recipients, but they account for less than one fourth of all MA funding.

In early February, the governor introduced his $28.3 billion budget. Items of major significance to hospitals include the medical

assistance budget, the proposal to cover all Pennsylvanians and the extension of Mcare abatement. All of which were inextricably linked in the state budget and in many ways it's caused HAP to try to wrap our arms around an advocacy effort on all those points.

The medical assistance budget includes important changes and several payment reduction proposals that will affect hospitals, and my testimony outlines what those cuts are and gives some details and some in-depth testimony.

However, in the effort to save some time, I would just go to the summary page of my testimony. Medical assistance plays such an important role in serving the health care needs of so many Pennsylvanians. It is our recommendation that the following changes in the proposed state budget be adopted. Items not in the proposed budget that are essential include funding for obstetrical and neonatal care at the amount of $15 million, restore hospital supplemental payments for burn centers, which there are six throughout the Commonwealth of Pennsylvania at $5 million, and change payment policy for critical access hospitals who are those hospitals in the rural of the rural communities in Pennsylvania. There are

13 of them, and essentially by the very definition of them cannot make up the losses from medical assistance that I spoke of earlier on volumes. And so we're asking that we change the payment policy, which would cost $5 million.

Items in the proposed state budget that HAP supports is raising the limit on physician inpatient hospital fees, which would cost $2 million. Currently, those fees are $1,000 per patient, and we would propose as the governor has done to increase that to $1,250. And modernize and improve the payment system for hospitals under medical assistance to $10 million.

Items in the proposed budget that HAP opposes, a hospital tax for Philadelphia and Allegheny County and a change in the readmission policy for medical assistance patients. So currently it is at 14 days, and the governor has suggested that it should go to 11 days.

On behalf of the Pennsylvania hospitals, I thank you for the opportunity to provide this testimony to you today. I'll turn to Eileen Simmons from Magee.

MS. SIMMONS:

Good afternoon. Madam Chairman, members

of the House Appropriations Committee, I want --- as I've been introduced by Tim. I would like to thank you for this opportunity to talk to you today about Magee-Womens Hospital and the services we provide to the MA population and the financial implications of providing those services.

Magee-Womens Hospital is a 278-bed hospital specializing in the care of women and infants. Our specialties include obstetrics and gynecology focusing on high-risk neonatal care in addition to women's cancers. We have a large --- we also have a large general medicine presence and outpatient product line that we focus on health patient related illnesses.

Today I'd like to primarily talk about our programs that impact women specifically addressing the services we provide to the medical assistance population. Medical assistance volume at Magee equates to about 30 percent of our total volume. If you look specifically at the OBGYN population, our younger ones 40 percent are medical assistance recipients. Currently, our loss overall in taking care of medical assistance patients approximates $5 million on an annual basis.

Last year, I wanted to speak to this

committee regarding the importance of a new state funding for OB neonatal disproportion share costs totals, and I would like to specifically thank Representative Manderino's response from the legislation.

You know, a good deal of the funding has come in very useful. We have been able to utilize that funding to enhance and expand our program. Specifically at Magee, we currently have under construction two additional labor suites that that money is utilized to fund bringing our total number of labor suites to 22. In addition, we are also planning in --- in the planning stages of a new patient care unit to accommodate increased volume.

Obstetric services are the lost unit for many hospitals given the high cost of medical liability insurance related to the program and also reimbursement from payers for the services provided. As you are well aware, numerous hospitals across the state have closed or reduced their programs over the last several years. Locally, that includes Saint Francis, McKeesport Hospital, Shadyside, Alle-Kiski, Mon Valley and most recently Mercy Jeannette will be closing its obstetrical program and consolidating.

Given our volume of admission, obviously

Magee is not at risk of closing its program. However, we are dramatically impacted by the closing of those other hospitals and there are strains put on Magee by those closures. We are frequently now running at full capacity. We are seeing much more acutely ill women with increased complications. We are aware they may not be getting the care in their communities, the prenatal care that is necessary because programs have closed.

We are also seeing a substantial increase in drug addicted mothers. The costs of being a safety net hospital are numerous. As mentioned, we are increasing physical capacity. We have also increased staffing as well as specialized programs to deal with the psychosocial needs of our patients. It's critical that the OB money be renewed and extended in next year's budget to enable the appropriate care of these patients to continue.

Even given the financial strain, Magee has continued to invest in the care of these patients. Just some of the things we've done over the last several years to reinvest in the program, we've opened a new 63 bed state-of-the-art NICU. We've increased our onsite position coverage as well in OB triage to provide the best care possible for patients seeking

our care.

I would just like to spend a couple minutes on services we provide to drug addicted mothers because that has been an area where we have seen substantial growth. And really the philosophy at Magee is we want to get to these patients as early as we can and get them in a conversion program. We've also established programs with Western Psychiatric to basically make sure we're dealing with these patients and their needs as early as we can to enable a healthy pregnancy and also a healthy baby.

In addition, we are obviously out there in communities as well. In many of the communities that you serve, we have outpatient clinics in Wilkinsburg, Mount Oliver, Monroeville, Clairton and Bethlehem Haven sites. And these clinics are also operated at a loss of over $1 million a year. These are just some of the services that we provide to the MA population at a great expense to the organization. It is part of our mission. The OB funding is critical to Magee-Womens Hospital and to other facilities across the state.

In addition to the planned cuts being restored, we would --- we would encourage additional funding for the OB services and ask that you consider

that in the budget negotiations that they go on. I think we're touching a lot of lives in a very positive manner. Thank you for your time.

DR. MIRSKY:

Thank you, Madam Chair and good afternoon. My name is Dr. Bob Mirsky. I'm a family physician and vice president and chief medical officer of Gateway Health Plan headquartered here in Pittsburgh.

On behalf of Gateway and its nearly 500 employees, I would like to thank you, the Health and Human Services Subcommittee of the House Appropriation Committee, for providing this forum to articulate our position regarding some of the proposals presented in the governor's 2008/2009 budget by the Department of Public Welfare.

In the interest of respecting the subcommittee's request for brevity with our opening remarks, allow me to state for the record that Gateway concurs with much of the testimony provided by my colleagues and their respective organizations represented on this panel and I will not repeat their points.

Gateway is the eighth largest Medicaid Physical Health Managed Care Organization in the

county and the second largest Medicaid Physical Health-MCO in the Commonwealth with total enrollment exceeding 243,000 Pennsylvanians within a service area covering 39 counties. Gateway along with the Commonwealth's other PH-MCOs is collectively responsible for managing the medical care for 1.1 million Pennsylvanians who constitute 62 percent of the Commonwealth's Medicaid population. Needless to say, we are a critical component of Pennsylvania's overall Medicaid physical health strategy, and destabilization of this medical delivery system would be catastrophic for PH-MCO plan members and medical providers and Pennsylvania taxpayers.

A little bit about quality. U.S. News and World Report and the National Committee for Quality Assurance, NCQA, recently released its third report on health plans. Gateway is ranked number 12 among 196 Medicaid plans nationwide. It is the top ranked Medicaid plan in Pennsylvania. We have maintained an excellent rating from NCQA since it was originally offered.

Results like these require commitment and investment. They're achieved by engaging individual, the family, the community as well as the physicians and providers. We use a holistic approach called

prospective care management or PCM that identifies the multifaceted needs of each member beyond the strictly medical to tailor an individualized treatment plan. We emphasize collaboration with the physician and provider community using care management protocols to optimize health outcomes, enhance quality of life and lower the overall cost and annual increase in cost of medical care. Our health care model has helped build a medical delivery system that mobilizes the necessary resources to deploy proactive, holistic, state-of-the-art approach to patient care.

Additionally, we identified populations with one or more chronic conditions and assure they get the needed care. I'm sure you're well aware that there is a 50 percent quality gap across chronic conditions in the United States. The conditions on which we all focus have significant opportunity for improvement and reflect known racial and ethnic disparities, mainly diabetes, cardiovascular disease and asthma. What all these conditions have in common is that --- is that prescription medications are integral to their identification and their management. In fact, success in their management is frequently measured by patient use of these medications.

We cannot tease out medical management

from the overall care of a patient. Imagine a health plan trying to coordinate care for a member without being able to integrate medication into the care plan. Imagine a physician caring for a patient having to discuss the patient with two separate organizations, one for the medications and another for all other aspects of care. Imagine the added complexity and barriers to effective care when there are so many other obstacles to overcome for this needy population. And finally, imagine being a patient trying to navigate an increasingly fragmented health care system. Carving out pharmacy is clearly not consistent with the integration contemplated in the governor's prescription for Pennsylvania.

Let us discuss some other aspects of the proposed budget. Those that impact needed revenue to provide the care management services I've described. In the governor's budget, the department is proposing to change contract payment terms pertaining to the monthly capitation plans to the Physical Health-MCOs effective 1/1/09. If this proposal is implemented, the PH-MCOs will not receive their January 2009 capitation revenue until February of that year. The result is a permanent one-month loss of state provided revenue for the PH-MCOs with Gateway's share being

approximately $35 million. Additionally, the PH-MCOs will only --- will receive only 11 capitation payments for the fiscal year 2007/2008. In the state funds alone, this is a loss of state provided revenue exceeding $300 million for the PH-MCO medical delivery system. To Gateway, this contractual change is a denial of $70 million in state provided revenue.

I emphasize state provided revenue compared to a bank provided loan in order for us to appropriately serve your constituents. The department has informed the PH-MCOs that they will pay lost interest to the PH-MCOs relevant to this contractual change. Determination of the lost interest will be at the department's discretion. We will all need to identify and secure the necessary funding to fill this gap in state revenue streams and attempt to explain how we would ever pay it back.

The department contends this proposal is an effort to more closely align the contract payment terms with the PH-MCOs to the contract payment terms they have with their participating medical providers. How will retrospective payments to the PH-MCOs align payment terms when the PH-MCOs are contractually required to pay 90 percent of their clean claims within 14 days of receipt? Gateway has always

committed itself to this compliance standard. In fact, we pay our claims within 12 days of receipt and have never been sanctioned for late payment of claim since Gateway's first member being effective nearly 15 years ago in July of 1993.

The department recently informed all the PH-MCOs they can still be held accountable in meeting prompt payment requirements when paying medical providers for rendered services. The department is using the balanced budget act to compel the PH-MCOs to continue prompt payments to medical providers.

Gateway and the Commonwealth's other Physical Health-MCOs have saved Pennsylvania billions of dollars in medical costs as documented by the Lewin Group, developed far better accessibility to medical providers for Pennsylvania's most vulnerable citizens, collaboratively worked with the physician and provider community to implement innovative approaches to patient care and served as a model for other states to programmatically integrate their own Medicaid initiatives. We continuously improve and move in the direction of better outcomes and greater efficiencies for the Commonwealth.

The state has put forth a damaging proposal to delay our payments. Paying bills as you

go is the way we all expect the state to run its business affairs. Asking MCOs to borrow money to pay the bills is anathema to state fiscal responsibility. DPW is asking MCOs to spend money that DPW did not provide. As you agreed last year, we are asking the department --- we are asking that the department's delayed payment proposal and pharmacy carve out be rejected by the Appropriations Committee. Thank you once again for this opportunity.

MS. WRIGHT:

Good afternoon. My name is Kristy Wright, and I'm the chief executive officer of the Visiting Nurses Association of Western Pennsylvania, which cares for more than a 1,000 patients every day in their homes, providing medical, person and end of life care. I'm also the past president of the Pennsylvania Homecare Association, which represents more than 300 health care and hospice agencies across the state.

On any given week in Pennsylvania, homecare professionals care for more than 170,000 Pennsylvanians in their house. We drive more than 210 million miles each year bringing that valuable care.

Consumers receiving in-home care range from newborns with special medical needs, toddlers

with development disabilities, young and middle aged adults with terminal illness and, of course, the greatest consumers of our care are elderly.

I commend the committee today for holding this hearing to stimulate further discussion around the long-term care funding crisis, the challenges the state is facing with regard to the long-term care budget and how to best invest those funds. I also will try not to repeat what my colleagues have brought to the table as I share many of their concerns.

Surveys show that 90 percent of Pennsylvanians want to receive long-term care in their own home. As a health care provider and a registered nurse, I appreciate that fact because that's exactly where I would want to be and I'm sure that's exactly where you would want to be, surrounded by your family and friends. However, I do realize that staying at home is not the right choice for everybody.

So let me be perfectly clear today. I'm not here to talk about the pros and cons of whether a patient could be cared for in their home or whether they should be in a nursing home. What I'm here to support is the development of a network of all of the care options, giving individuals the choice and the support that helps them remain as independent as

possible in the care setting where they can best be served.

To make this a reality, we must strengthen the home and community infrastructure. The governor and other state officials have consistently talked about rebalancing the long-term care system so that consumers have options, and I couldn't agree more. To accomplish this, the administration has focused their efforts on transitioning individuals out of nursing homes as well as earmarking funds to help nursing homes redesign themselves to provide more home and community based services, and yet, no funds have been allocated to support the existing homecare provider network.

Actually, Pennsylvania continues to rank at the bottom of the nation's list for funding its current home and community based system. As a matter of fact and with all due respect to my fellow panel members, this panel did not initially even include a member from the homecare industry, and the Pennsylvania Homecare Association had to push very hard to even get us included today.

Furthermore, home health providers like the VNA where I work have had only one Medicaid reimbursement increase in 16 years, only one, and that

is no COLA any of this years and only one increase. The last increase brought us up to from $67 to $77 a visit for nursing and for therapy and brought us up to $40 a visit for home health aides. Yet, the actual cost, as you all know, of providing those services has continued to rise over those 16 years, and now for us, and we are a relatively low cost provider, across the state it's $118 a visit. That represents a $41 loss with every visit that we make. That's a 35 percent loss, so we are only being reimbursed two thirds of what it actually costs to provide that care.

Interestingly, I attended a meeting a few months ago, and we were questioning why we have had to go so long without increases. And a state official told me the reason why we have not gotten an increase as the homecare industry is because we don't have enough lobbyists and our fellow providers do. I'm always bewildered in state officials say that they want more people to remain in their home as they age, yet we have not done anything to strengthen the existing homecare network.

I'm here to tell you that as a provider I don't know how much longer we can provide the level of services that we provide and sustain that level of loss. As my colleagues have mentioned and you all

know, we are being cut across the board not just at the state level, but the federal, too.

As an example, I realize that everyone has been hit hard by the rising gasoline prices, and I won't go into that. But I want to give you a little bit of a perspective in what that means to home and community based care, which actually travels to the homes. Our organization alone travels over 100 million --- or a million miles a year, and we spent $393,000 in gas reimbursement alone in 2007. That was an increase of $100,000 over the previous year.

So what we're asking for and what I am asking for, as one of the frontline providers, is to assist us with these increasing costs and to assist us because we have not had an increase for so long. We are specifically asking that we have a $23 increase in nursing and therapy visits, which would take it to $100 a visit, still recognizing that that does not cover our costs, and a $10 increase to $50 a visit for home health aide. This would be an estimated cost to the state of about $10 million.

And I'll skip right to the end. The first step is to acknowledge that the impact of the rising costs has a direct impact on the care that we can provide, and the second step is to recognize that

there really is no place like home. Thank you.

REPRESENTATIVE MANDERINO:

Thank you. At the beginning of the panel, we were joined by Representative Matt Smith from Allegheny County. I just didn't get a chance since the first speaker had already started to speak to acknowledge that Matt had joined us. And before I ask my colleagues if they have any questions, just two comments.

I want to correct something, Ms. Wright, that you said, not that you were at fault per se, but neither were any of the other panelists. Who is on this panel was not their choice. Who is on this panel was our choice. We reached out to groups. We also then tried to balance and limit. So to the extent that there were folks that wanted a chance to testify that may have not gotten it or folks that were asked to be limited, that was purely my decision because, as you can see, I knew that if we went on all afternoon in the end, nobody would be sitting here listening to your testimony but me. And having said that, while you all were probably thinking I was being rude as I gave you each your five-minute warning, just so we know, I think the dialogue is very important and members need to understand this.

And, Kristy, you came in the shortest at seven minutes. Somebody else came in at eight minutes, and everyone else came in at nine or ten minutes. So we always think that we're only talking a little bit and we talk a lot. And now, I've taken three minutes to make this point. Let me pass the mike down and ask Representative Smith if he wants to start with any questions or discussions.

REPRESENTATIVE SMITH:

Just thank you very much, Madam Chair. And, Mr. Ohrum, in your testimony I'm reading that Medicaid hospital payments relative to cost in Pennsylvania have been substantially below the national average than that of comparison states. Can you go into a little bit of detail as to why that is and what we can do as a Commonwealth to move forward and try to close that gap?

MR. OHRUM:

Historically, the medical assistance program in Pennsylvania has paid hospitals for caring for patients about 87 cents on a dollar for inpatient and about 55 cents on a dollar for outpatient. And so that has not increased in, I think, about 12 or 13 years. And so we're seeing that the number of medical assistance patients increases, and yet, the amount of

money that's allocated in the state budget has remained the same so it drives that number down.

And so really the only way to really get at it is to increase the medical assistance budget in total. That's not largely been successful as a whole. So we have to go after supplemental payments, for example, the OB neonatal funding, burn center funding, critical access hospital funding. And so you target dollars in the state budget to go to those facilities to help with the services and to keep those specific doors open.

REPRESENTATIVE SMITH:

Thank you.

REPRESENTATIVE FRANKEL:

Thanks for being here today. Madam Chairwoman, thank you very much. Get back to the issue of ultimately looking at the problem. And many of you talked about the governor's proposed budget which is inadequate, but I think you need to understand, obviously I think many of you do, the environment that he proposes that increase in, which as I said before, we effectively created a precedence last year in the budget that says we need to be increasing the rate of spending at or less than the so-called cost of living.

Yeah, I think to a large extent the public does not understand the things that you are telling us because it is so complex. I mean, for instance, you know, Tim, when you talk about two thirds of the Medicaid medical assistance budget dealing with providing services to the elderly, that doesn't get through. I mean, the elderly happen to be probably the most effective advocacy group around on many issues and we do a great job in other areas particularly for the elderly, whether it's prescription drug program, rent, property tax rebates, things that other states don't do.

But we need to be doing some type of way to communicate these things so that we're not --- that we as legislators who want to provide and make up the difference specifically when the federal government has cut back on resources every single year. We want to be able to provide the backbone to do this. And 4.2 percent, which is the governor's increase, we're not --- you know, when he set the bar up there, we're not going to get there. That's as good as we're going to do, so we're --- we get back to this issue every year and we're dealing with many of you which we see in our offices every --- you know, multiple times between now and the end of June or mid-July or who

knows how long we'll go to try and restore or mitigate the cuts that you're seeing.

And, you know, what is the nature of the public policy initiative that is presented by my colleagues? And I think they were all invited to be here today, but I would like to have a dialogue with these add ons. But the major public policy initiative presented by my colleagues on the other side of the aisle is a reduction in the personal income tax break. And I don't hear ultimately, you know, much reaction to that. Again, we're trying to deal with your specific issues and, you know, they overlap in many ways. But it's kind of like, you know, divide and conquer as opposed to trying to present to the public a comprehensive idea. And we're probably as responsible as anybody in terms of what's at stake here and what we have done or not done in a trend that we're headed in. If we rise to the budget, we keep this --- give legitimacy to the idea that keeping the rate of growth of spending --- the state spending at the rate of inflation. If that's going to be the basis for everybody from here on out, we've got a real problem and this is just the beginning of it.

And, you know --- and Representative Manderino wanted to really use this as an opportunity

to talk about some of this, to get that out and get the public --- to help educate the public, but we need your help as well. And again, it's not just dealing with your own piece of that pie, but in trying to collaborate amongst all of yourselves and trying to educate the public at what's at stake here because this is not legitimate. And we say it, and we get accused of dealing, you know, partisan environment.

But we genuinely --- you know, sure are there things that you needed to do over the years to adjust your services to economize, streamline, yes. And I think in many cases you've done that much, but I think there is more to do. But that doesn't compensate the environment that we're in with the federal government continuing to cut and cut and cut, and we continue to deal with an environment where --- that not only are we not looking at trying to raise revenues particularly where we're looking at a recession that is not even accounted for in the terms of the governor's revenue estimates for this year's budget, because this is --- I think when we get down to January, we see a very different environment than what was painted for us when he made his speech in February.

So I think we need to all be working

closely together to create --- to educate the public and work particularly among those of you who are most at risk here, especially your clients and patients. You need to understand the dynamics so that we can make the case more effectively and use it to bolster our colleagues to do the right thing ultimately, so I didn't mean to make a lecture. It's a little frustrating for us.

REPREESNTATIVE MANDERINO:

Thank you all again for your testimony. And I have some specific questions, but before I get to the questions, let's just put some numbers on what these six folks talked about.

A COLA for all of the human services providers at just two percent, $180 million. Pharmacy carve out that you think would be detrimental to peoples' health, $117 million. The delay in payment of one month to our managed care organizations, I want to ask you about this later, but you came up with a figure of $300 million. $10 million for --- more for home visiting --- home provided services. $33 million is the COLA just for nursing homes this year if it's just at two percent, but you're telling us that your industry is under funded and subsidizing those necessary services by approximately $100 million a

year. That's the price you gave us when you said 290 over the last three years. Tim, you didn't even put a price tag on your under funding of what you called the percent reimbursement on Medicare, but I have to think that is hundreds of millions of dollars, not tens of millions of dollars.

My point is these are all --- if we add them all up, probably bring us well over a billion dollars of very necessary human services, quote, unquote, welfare spending in Pennsylvania. And that is kind of the context, I think, that Representative Frankel was trying to put on what it is that we are trying to balance. I do have some specific questions.

Ms. Wright, let me start with you because you put a price tag of about $10 million to get what you call reimbursement rates up to kind of a cost on some of the major services that you give. One of the things that I had a discussion with Secretary Richman (phonetic) about when she was before us is --- and I don't know if this fits in. I'm trying to understand if I'm talking about two price tags or one price tag all together. For example, I see this because I represent two councils, and one --- Philadelphia is very urban and Montgomery County mostly suburban. And I could see just for their visiting nurses a huge

disparity in what each is reimbursed for by their Area Agency on Aging. With Montgomery County being able to pay $25 an hour and Philadelphia County being able to pay $15 an hour in the same labor market, looking for the same nurses.

And the secretary talked to us about how --- I think it's CMS, a federal agency that kind of oversees all this. And basically, telling our state you have 54 different systems going. You need one statewide system. Bring it all together. Okay. My question is, does $10 million let us bring it all together, or is this --- if you know, or is this just a price tag assuming the current system stays status quo what it would cost to bring certain reimbursement rates up based on how we're spending today?

MS. WRIGHT:

The system is very complicated, and there are different types of services paid at different rates. There are waiver services. There are home health services, and there are often services which don't even fall into this because they're lottery funded. So some of them are --- they come through the home health services, will come through either directly paid or depending on where you are in the state through a managed care organization. The waiver

services come from the department, DPW, and is filtered through the Department of Aging down to the 15 different AAAs in each county who then get to take those moneys and determine how and what they pay their providers in that county.

So we're talking about just sort of overall in the aggregate because it is impossible at this point to just figure all that out separately because there are so many different systems and so many sources of money. We can get you --- the Pennsylvania Homecare Association has the specifics of how that was calculated and I'll make sure you get that.

REPRESENTATIVE MANDERINO:

Great. Great. That would be very helpful. Dr. Mirsky, I understand that --- we had this discussion two budget seasons now, carve out versus non-carve out. DPW's saying they'll get much --- they'll save $117 million because of what they can get in terms of rebates from the pharmaceutical companies versus what you can. But let's just put that dollar figure aside. I know that the Managed Care Association in the past don't that DPW's number of $117 million in savings is a real number. And if you have anything you want to give us in writing about

that, we probably have it from past years, I'm interested.

But I don't either --- this is the first time I'm hearing a price tag of $300 million put on what I'll call the extra one-month float issue, you know, the delayed payment issue. How'd you come up with that --- with that number and is the department actually anticipating $300 million savings from that, or are you saying that's what you're estimating it's going to cost each organization kind of aggregate? I'm just lost on this number in trying to understand it.

DR. MIRSKY:

I can't speak for DPW, but it basically is 11 payments instead of 12 for the year. So it's one twelfth of the overall reimbursement to the managed care organizations. That amounts to $300 million. We only get 11 payments instead of 12.

REPRESENTATIVE MANDERINO:

Mr. Ohrum, am I saying that right? I'm very --- I don't want to say skeptical. That's probably too strong, but I'm very confused every time I hear a discussion about Medicare under funding --- or Medicaid under funding, excuse me, because it seems to me everybody under funds. And it seems to me when

I hear complaints about people who have a private insurance market policy on the private market and they're in an HMO, hospitals will say, well, the HMO is only reimbursing us at 75 percent and Medicaid is only reimbursing us at 85 percent and Medicare --- I don't know what a real number is. And I'm not meaning to be difficult, but when you say to me our state Medicaid system is --- basically is under funding by 15 percent or 15 cents on the dollar, compared to what? Compared to actual cost? Compared to what private insurers are doing? Like, help me understand what these numbers mean because if we're going to back --- back into the system and figure out how we fix them, if I go back to a policymaker and they're saying, well, that's not a real number because of this. I'm trying to understand what that number's based on.

MR. OHRUM:

And Eileen may be able to offer some insights on this, too. But I think it's --- let me just start quite broadly. There's three different sources of money. One would be your commercial pay. One is Medicare, federal. One is Medicaid, state. The commercial pay is typically the best payer, and they probably pay slightly over the cost of care.

Medicare would be the second best payer, and they're probably in the mid 90 percent range for providing the cost of care. Pennsylvania's medical assistance program, Medicaid, is the worst of the three payers. And so typically what hospitals, health care providers, in general will do is cost shift. So while they lose money on this portion of patients, the revenues that come in, say, from the commercial audience they can shift over to help cover the costs for the Medicaid population and the Medicare population. So that is broadly answering your question.

So now we can get --- we can drill further down into that if you'd like to. I think it's pretty helpful to have a CFO here for that.

MS. SIMMONS:

What Tim says is absolutely true. And the reality is if you look at --- we need to bring our margins down and see ---. Our costs are the same regardless if you're a medical assistance recipient or you're a commercial recipient. You can --- whatever service you come in for, our costs are basically the same. And the reality is because we can negotiate with the commercial payer, we can capitalize on that, on the specialty service we provide, on the fact that

they want to include us in their plan. So we basically come in and --- have a better negotiating scene, and we know we have to make up the costs on government payers because, quite frankly, the expectation isn't that we're going to go from 85 cents on a dollar to 95 cents on a dollar. The reality is we got into the prospective of the 85 cents on a dollar because over the years we haven't keep up with inflation. So some of the same things that you're hearing from all the panel members, we continually get further and further behind. Even if we get a three or a four percent bump, it's still not coming close to what we've lost over the years.

REPRESENTATIVE MANDERINO:

When you look at reimbursement rates for, let's just us this as an example, CHIP and Adult Basic, are you putting them in that commercial column, or are you putting them in that Medicaid column in terms of the reimbursement rates?

MS. SIMMONS:

Medicaid.

REPRESENTATIVE MANDERINO:

You're putting them in the MA column?

MS. SIMMONS:

Yes. They're not considered commercial.

Your Highmark ---.

REPRESENTATIVE MANDERINO:

So even though they're being provided by commercial insurers, your reimbursement rate for a CHIP kid who's from Highmark is different than your reimbursement for a Highmark kid, you know, a ---

MS. SIMMONS:

A private insurer.

REPRESENTATIVE MANDERINO:

--- commercial insurer.

MS. SIMMONS:

Yes, yes.

REPRESENTATIVE MANDERINO:

Okay.

MR. OHRUM:

That was the reason why we target some of our payment fixes to save the critical access hospitals, the OB hospitals because we recognize where you're coming from. It kind of gets to the heart of what Representative Frankel was saying. We know that you can't fund us at what it costs to care for a medical assistance patient. It would be ridiculous for us to sit here and say give us $100 million to fix that problem. So you look at where the weakest link is in the chain and the items that I listed, OB,

critical access, Medicaid redesign, et cetera, those are the areas where it's the weakest link. And so we try to target those dollars there trying to make it at least reasonable to try to address some funding shortages.

REPRESENTATIVE MANDERINO:

Okay. Thank you very much. We did --- and I'll just do one --- this panel is leaving, and I thank you very much for your testimony. We had only one person sign up for what we called the public testimony or the public forum at the end, and that's Nancy Murray from Achieva. Last chance if there was anybody else. This is --- you don't need written testimony. You get two and half minutes, three minutes. And I really am going to give you the wind up signal for three minutes. If there is anybody else who wants to make a brief comment, please come up and join Nancy at the table at this time. You are more than welcome to. Nancy, I think it's just you.

MS. MURRAY:

Okay. Thank you. I would like to offer comments on House Bill ---.

REPRESENTATIVE MANDERINO:

State your name again for --- and your organization for the stenographer.

MS. MURRAY:

Nancy Murray from Achieva. I would like to offer comments on House Bill 361 and begin by thanking both Representative Frankel and Representative Manderino for cosponsoring that piece of legislation.

Currently, in the State of Pennsylvania if a child is abused, neglected, abandoned or exploited, there are protections through the Children and Youth and family system. If an adult over the age of 60 is abandoned, neglected, abused or exploited, there are protections through the older adult protective services system. Right now in the state, the people between the ages of 18 and 59, people who lack the capacity to protect themselves, there are no such protections. And Pennsylvania's one of only six states in the entire country that does not have this system in place. Each year in every legislative district there are people with cognitive, mental or physical disabilities who are abused, neglected and abandoned by their so-called caregivers.

This afternoon we've heard about programs that need millions of dollars from the legislature to continue to operate. I have some figures for you. To implement House Bill 361 and to finally put in place

protections for some of our most vulnerable citizens in the Commonwealth, only $500,000 is needed to get this program off the ground. So I ask for your help today to move House Bill 361 out of the Appropriations Committee onto the House floor for a full vote and to put that $500,000 in the governor's budget. Thank you very much.

REPRESENTATIVE MANDERINO:

Thank you very much for your testimony. And just so you don't think that you were getting off cheap, you are correct that the first year implementation is a half a million dollars, but fully implemented it's a $6.8 million new spending program. So I think we also are --- recognize both the need and the cost issue. So I thank you all very much. I thank the members for turning out, and I thank particularly everyone in the audience and those that took the time to prepare and deliver testimony to us. It is very helpful. We will take this back. We have now both a recorded audio and paper version of your testimony, and it will be shared with the rest of the committee members.

Thank you very much. And if there aren't any closing comments from my colleagues, this Subcommittee of the Health and Human Services is now

adjourned.

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HEARING CONCLUDED AT 2:35 P.M.

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