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TESTIMONY

Presented to
THE HOUSE HUMAN SERVICES COMMITTEE

by
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Good morning, Chairman DiGirolamo, Chairman Cruz and members of the Human Services Committee.

I am Shirley Walker, President and CEO of PAR. PAR is the only statewide provider association whose mission is solely to provide services to people with autism and to people with intellectual disability. Our members provide the full range of services and supports from residential services to in-home services, from day services to employment. We provide services to tens of thousands of individuals in Pennsylvania who have an intellectual disability or autism.

I welcome this opportunity to appear before the committee. PAR strongly supports the request for funding that is needed to enable individuals on the waiting list and their families to have the services they truly need.

I am here today to add some facts for your consideration that have not yet been mentioned in this hearing and I do not believe are well understood.

But first, I want to acknowledge and express PAR's sincere appreciation to DHS Secretary Ted Dallas and Deputy Secretary Nancy Thaler for the time and attention that they have devoted during the past year to not merely listening to the concerns we have expressed to them regarding the punishing and irrational payment policies that were enacted prior to their coming to

DHS, but also for being willing to consider potential short-term and long-term remedial actions. But as willing as Secretary Dallas and Deputy Secretary Thaler may be to consider changes in DHS policy, they are severely constrained by the persistent lack of sufficient funding available to DHS to support these services. Only you can help them with funding constraints.

As the statewide association whose focus is on working to insure that our members who provide these services can continue to provide the services that our waiting list families are seeking, we come to you to make you aware of mis-perceptions that we believe have contributed to our current state.

In 2011 policies were imposed by DHS -- ONLY on providers of services to people with disabilities, not on any other Medicaid service providers. Why was that?

What happened in 2011, however, is only the exacerbation of the disparity that has impacted the services for people with intellectual disability or autism over many years.

The chart before you graphically and sadly depicts the wide and glaring disparity in rate increases for intellectual disability and autism service providers versus the routine annual funding of rate increases that has been appropriated to other Medical Assistance providers like hospitals, nursing homes, and MCOs.

To better understand the chart before you, please note that there is a difference between funding increases that are needed to address increased utilization of services, and funding that is needed for rate increases.

This chart depicts funding that has been made available by the legislature for rate increases over the years -- fat-lined in comparison to other Medicaid providers.

Funding for increased utilization is the funding that is needed to support people who are receiving services. As they grow older or perhaps a medical problem occurs that causes the need for additional support, it clearly takes more funding to support them. That requires funding that is referred to as increased utilization.

Funding for increased utilization also is the funding that is used to get people off the waiting list into services.

On the other hand, funding for rate increases is what is required to pay the workforce that provides services. The wages for this valued work needs to be at a level that the worker can support his or her own family without having to have a second job or needing a hand-up in government funded food assistance for their families.

Rate increases have fallen so far behind that we now have over 3500 vacancies that are being so-called "filled" by temp agencies or regular staff on overtime. Both are bad options.

The Office of Developmental Programs noted recently that 85% of the dollars we receive in rates are spent on staffing. That is telling. So when there aren't sufficient dollars for rate increases you can easily see who gets it in the neck: it is the individual receiving services. Because if direct support professionals are forced to leave their jobs as soon as they find a better paying job so that they can support their own family, the individual being supported gets turned over to another and another and another person to support them.

Dis-continuity does not result in a quality service. It takes a direct support professional considerable time and experience with an individual to understand how to provide the best support for that individual.

The disparity in funding for rate increases that you see in the chart is creating the crisis that is stemming from not being able to adequately pay our workforce which means our workforce has to leave when they can find better paying jobs.

We have been asking a lot of people why this disparity exists. We were surprised with responses that we have been receiving.

For example, we were told that other medical assistance programs are mandatory and services for people with intellectual disability are optional and that is the reason for the disparity. But that is not accurate.

Intellectual Disability services are covered services under the 1966 Mental Health and Intellectual Disability Act passed by the Pennsylvania general assembly in its good wisdom and signed into law.

Intellectual Disability and Autism services are subject to the same funding requirements under federal law as are, for example, hospitals and nursing homes. But, they are not treated the same when it comes time to consider rate increases! Why is that?

Payments for ID/A services, as with payments to hospitals, MCOs and nursing homes, must be consistent with efficiency, economy and quality care and be sufficient to assure the availability of providers competent to provide quality care. These rules apply to all medical assistance providers. So why is there a disparity?

And, unlike MCOs, hospitals, and nursing homes, Medical Assistance essentially is the sole payor for intellectual disability services. We don't have any 3rd party pay available for intellectual disability services.

Further, unlike nursing homes and hospitals, ID/A providers receive no disproportionate share payments even though nearly every person with intellectual disability served by our members is 100% Medical Assistance eligible. So why don't services to people with disabilities get disproportionate share payments?

We also note on the chart the annual supplemental disproportionate share payments made to hospitals who have a much smaller percentage of persons they support who are on medical assistance than we have. The financial assistance to help them with their Medicaid population is a large number! Why don't providers of services to people with disability who are 100% medical assistance eligible get disproportionate share payments.

In addition to these disparities, we are subject to numerous regressive payment policies that are impacting the availability and quality of home and community based services. I will give you 3 examples of rules that no other medical assistance provider type is subject to:

1. Community-based service providers, unlike every other Medical Assistance provider of services, cannot retain any earnings. If a provider experiences any savings in a fiscal year to try to be more prepared for emergencies or even to build a small capital base for extenuating circumstances such as a budget impasse, it is taken from them, dollar for dollar, in the future rates. Why is that?
2. If an individual being served in a residential program is away with his/her family on weekends or for a vacation, under current payment policies and procedures, a provider may not be reimbursed for the costs that it must continue to incur to maintain the residential program. We can't lay off staff or shut off the electricity or quit paying the mortgage. If an individual has to return unexpectedly from a planned trip with family we would have to be staffed and ready. Our

costs remain yet the fiscal policies that remain in place will not reimburse those required costs.

If an individual is away from their residence, their home, for any reason outside the control of a provider, why is a provider penalized? We are a single payor system. So how does a provider ever deal with that loss in revenue?

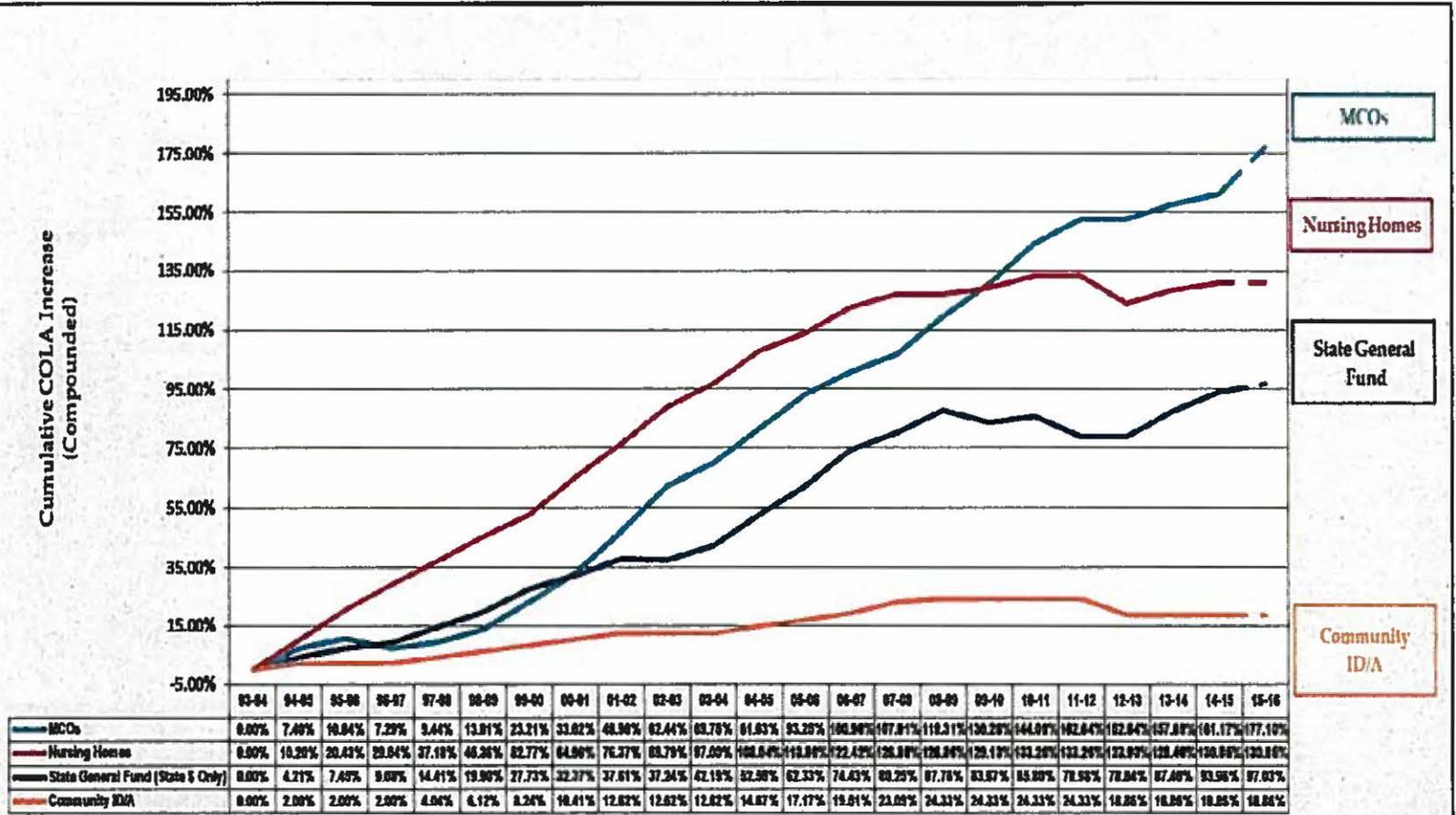
3. For residential services, the allowable costs reported by providers to DHS are typically two years old when used for rate setting purposes with no adjustment to account for basic cost of living increases like utilities, not to mention increases in healthcare costs or for mandated wage increases. Why is this? Why are these providers treated differently?

We are cognizant of the stresses, strains and demands on the budget. We ask that as you confront the budget, that you prioritize the waiting list and a rate increase for intellectual disability and autism services that is sufficient to start closing the gap that the chart shows. Rate increases that directly impact the workforce that supports people with disabilities should be valued at least in the same way as rate increases for other Medicaid providers.

We want to work together with you on solutions and are currently working with members of the House Intellectual Disability and Autism caucus on legislation to address the funding and rate setting issues. When the legislation becomes a reality, we ask for your active support. The legislation is being written to help close the gap through a thoughtful, planful correction of the long-standing disparity.

Thank you for your consideration of my testimony. Please use me as a resource for any questions you may have now and in the future.

ID/A Rate Increases for Community Services Lag Well Behind the Increases Received by Other Major Medicaid Providers in Pennsylvania



Source: Governor's Executive Budget

Note: In FY 15-16, approximately 96.0% of MA Hospital inpatient and Outpatient Revenue is through Managed Care. An additional \$767,103,000 is paid to hospitals in Disproportionate Share Hospital (DSH) and Supplemental Payments.