Citizens for Choice in Health Care

Safeguarding excellence — Opposing government control

CCHC Testimony for the Pennsylvania House State Government Committee
November 18, 1997
Rep. Paul Clymer (R) Chair

Mr. Chairman and Members of the Committee:
My name is Twila Brase. I am a registered nurse by profession, and president of Citizens for Choice in Health Care - CCHC. Rep. Rohrer has asked me to testify on House Bill 975. I would like to begin by giving you information on our organization. CCHC, based in St. Paul, MN is a non-profit membership organization which incorporated early in 1995. We support individual choice in health care decisions, and medical privacy.

CCHC was founded out of the realization that in 1992 a major piece of state health care reform legislation had been enacted with very little public knowledge or consent. After extensive research, it became clear that the rapid and little publicized passage of the legislation was a result of the promise of funding and technical assistance from the Robert Wood Johnson Foundation-RWJ.

Included in this legislation were: statewide limits on health care spending, penalties on physicians who exceeded their revenue limits, creation of at least 13 new committees and commissions, division of the state into regions headed by regional coordinating boards, an anti-trust exception allowing mass mergers, the threat of strict state-mandated fee schedules for physicians who stayed outside HMOs, extensive data collection by the Health Department, a new 2% tax, authorization for denial of health care services for any care not considered medically necessary or cost-effective, and finally, a mandate that HMOs be non-profit, and placed under regulation of the Health Department with lower reserve limits than other insurance companies.

Had the public realized the full extent of the law I just briefly outlined, I am sure they would have resisted to the degree they have just resisted the state's desire to publicly subsidize a new baseball stadium. It was defeated only 5 days ago after two special sessions and endless media coverage. However, the health care reform law, unlike the stadium, had only one month of press coverage instead of ten. The difference was the offer and promise of private funding for the initiative.

To give you a little history, in 1991, a task force studying health care in Minnesota recommended transitioning out of an employer-based system to a publicly funded system with unified financing and a means of budgeting total health care expenditures. They also recommended the expansion and creation of managed care organizations throughout Minnesota.

In the spring of 1991, the Health Care Access Act was introduced and included price controls and expansion of HMOs based on these recommendations. It was passed by the legislature, but vetoed by the Governor as "too expensive."

In the fall of 1991, seven legislators, who called themselves the Gang of Seven, met behind closed doors to figure out how to pass health care reform legislation. No other legislators were allowed to see drafts of their proposals or their bill until it was introduced. At the very same time, the Robert Wood Johnson Foundation put out a Call for Proposals for a new grant program called: State Initiatives in Health Care Financing Reform. Its purpose was to "help states...develop... significant health care financing and delivery changes."

On February 28, 1992 the Minnesota State Health Department sent a grant application,along with letters requesting grant approval from Governor Carlson and others, to the Alpha Center, the grant approval arm of RWJ. It is presumed that receipt of the grant was assured because only nine days later the Gang of Seven, along with Governor Carlson, held a news conference announcing a new

health care reform initiative named HealthRight, later renamed the MinnesotaCare Act.

The first press coverage of what is still considered "the most sweeping health care reform law in the nation" occurred March 10, 1992. Both House and Senate passed it one month later, on April 10th. It was signed into law on April 23rd. Those who were at the Capitol at that time tell me that there was four similar bills going through the committees at the same time, allowing little public scrutiny and rapid passage. In addition, legislators were given only a three page synopsis of the bill, and told by the Governor not to oppose it.

The reason this bill passed, with a projected annual cost of $ 252M, is because there was a promise of start-up funding—a $891,591 RWJ Grant that was later received by the Minnesota Department of Health—and enactment of a hidden 2% gross revenues health care services tax to begin 1993. Hospitals, clinics and health care professionals were responsible for collection of the tax, but they were not allowed to itemize it on patient bills. This was set up to be the continual funding source after depletion of the grant.

Because the Governor had the initial funding for the legislation, there were no new general taxes to consider. Therefore, the full ramifications stayed out of the public eye. Accept for physicians, chiropractors, and dentists, the public took little notice. The 2% tax was portrayed as a tax on hospitals and doctors, and doctors were assured that tax revenue would be used only for care of the enrollees in the MinnesotaCare subsidy program—an expansion of Medicaid—and that they would be reimbursed in full for care to this limited population. However, in 1995 only 42% ($56M) of the tax revenue went for direct patient care, of the remainder $7M went to health care reform efforts and $27M went into the general fund for Medicaid. In your packet is a list of items funded by the tax.

In the case of our baseball stadium, the public decided against it because the public was notified that they would have to pay the price in taxes. With notification, they became actively opposed. However, in the health care reform law, they were not notified and the tax mechanism was hidden.

Because of the law, the public has paid an enormous price in medical privacy and access to health care. Local clinics and hospitals have closed; doctors—notably specialists—have left the state, HMOs using access to health records, create patient profiles on all enrollees; three major tax-exempt managed care organizations control the market; 60% of the insurance companies have discontinued coverage in Minnesota; a new Office of Technology seeks to create a state-mandated MNCard with the capability of medical record placement; subsidized health coverage has expanded into the middle class; $6.6 million was given to our Academic Health Center to redesign all health care curriculum to emphasize managed care principles; and in 1998, because of little competition, most health insurance premiums will rise 25-45%, with some reported as high as 500%.

As I go around the state giving presentations and holding town meetings to talk about the law, the people of Minnesota are increasingly dissatisfied with the present health care system, but unaware that it is a result of state legislation enacted through private funding.

The Robert Wood Johnson Foundation continues to fund state programs to consolidate health care, increase government involvement in health care decisions, and intrude on patient privacy. Let me draw your attention to a few more recent grants Minnesota has received from RWJ. In 1995, RWJ gave the Minnesota Department of Human Services $1.2M to integrate Medicaid and Medicare funding for the elderly. In 1997 RWJ gave $100,000 to the Health Data Institute to increase electronic transmission of medical data ["look into ways to use the Internet to transmit everything from insurance claims to health plan enrollment data to patient's medical records" (MN Physician, October 1997)], $20,000 to fund a forum to increase collaboration between state and federal health departments and the medical profession, and $500,000 to place people with disabilities into managed care.

Without this funding, the legislature would not have been able to pass legislation that continues to restrict health care choices and intrude on patient privacy.

I would like to cite two additional examples of public policy influence by RWJ:

First, in December of 1993, Senator Linda Berglin, chief author of our health care reform law, became an Alpha Center trustee. As you remember the Alpha Center is the funding arm of RWJ. In April of 1997, Senator Nancy Kassenbaum-Baker, author of the federal Kennedy Kassenbaum bill, became an Alpha Center Trustee as well. The Kennedy-Kassenbaum bill contained language from the 1994 Minnesota Administrative Simplification Act, which was part of our health care reform law. This may be an example of how RWJ rewards legislators who pass RWJ-approved or assisted legislation.

Second, RWJ offers Health Policy Fellowships for people *"to contribute to U.S. health policy development through active involvement in the policy-making process." Program elements include meetings with "White House advisors...top administrators of federal agencies, congressional committee staff members and "sessions with senators, representatives, and other experts on the national political and governmental process."* I quote: *"Fellows help develop legislative proposals, arrange hearings, brief legislators for committee sessions and floor debates, and participate with staff in House and Senate conferences...These assignments are supplemented throughout the year by seminars and group discussions on developing health policy..."* (Institute of Medicine, Office of Health Policy Programs and Fellowships)

Citizens for Choice in Health Care thanks Rep. Rohrer for his leadership in exposing the attempts of private organizations to change public policy without the permission of the public. No private organization should be able to legislate without being elected. No private organization should be allowed to use their tax-exempt status to accumulate funds used to later buy legislative action. And no private organization should be allowed to make demands from any legislature or state agency in exchange for funding of legislation or programs.

Few citizens know that private foundations buy legislative action through grants to state agencies. And fewer citizens have the resources required to file lawsuits against state or federal government agencies which accept these funds in exchange for the individual freedom and privacy of their citizens. Pennsylvania citizens can be thankful that Rep. Rohrer is introducing a bill preventing this egregious circumvention of the legislative process. **CCHC supports House Bill 975 with two exceptions:**

First: Page 4, line 24: I would suggest "shall conduct a public hearing if the initiative fits any of the considerations under F (1,2,3, or 4).

Second: Page 5, lines 15-23: It should be noted that the Attorney General cannot always be considered the final protector of privacy rights. Legislators should hold that responsibility and accountability. In Minnesota, the Attorney General agreed to Child Support Obligor language that allows all financial institutions to send to the Department of Human Services, identifying information on all people holding accounts within their institutions, as long as the department agrees to destroy the information of those who owe no child support. There is no enforcement and no mechanism to assure that the social security numbers of all Minnesotans will not be copied or used by department staff. I would reconsider the wording of this section. No citizen should give over the protection of their private data to a government agency which may decide cost considerations and convenience supersede privacy concerns. In addition, I was told by one staffer at the Attorney General's office, "We represent the state. We are the law firm of the state. We do not sue the state." That being the case, the Attorney General in Pennsylvania may hold the interests of the state bureaucracy above the interests of Pennsylvania citizens. Thank you.

Institute of Medicine

Office of Health Policy Programs and Fellowships

RWJ Health Policy Fellowships: Program Description and Purpose

Program Purpose

The Robert Wood Johnson Health Policy Fellowships Program is designed to develop the capacity of outstanding mid-ca health professionals in academic and community-based settings to assume leadership roles in health policy and managem This career development program provides opportunities for mid-career professionals to gain an understanding of the heal policy process and to contribute to the formulation of new policies and programs. This program is seeking individuals w

* have the capacity and leadership skills to contribute to U.S. health policy development through active involv in the policy-making process;

* bring a fresh and informed perspective to the important and perplexing questions facing health policy makers today; and

* have the skills and commitment to translate lessons learned at the national level to affect positive change in t health care enterprise at the state and local level.

The program, initiated in 1973, is funded by The Robert Wood Johnson Foundation and conducted by the Institute of Me (IOM) of the National Academy of Sciences. Six Fellows participate each year in a one-year program of orientation and full-time work experience in the nation's capitol. Fellows are selected from: (1) academic faculties in medicine, dentistry, biomedical sciences, nursing, public health, health services administration, the allied health professions, economics, and social sciences; and (2) related organized, community-based providers and institutions in the health care system, such as h maintenance organizations.

Program Description

The September-to-August program begins with an eight-week orientation period arranged by the IOM. Fellows meet witl White House advisers, including officials of the Office of Management and Budget; top administrators of agencies respon for health activities; congressional committee staff members; and representatives of health interest groups. All of these g influence and help formulate national health policy. Also included in this period are seminars on health economics, the congressional budget process, and the politics and process of federal decisionmaking.

In subsequent weeks the Health Policy Fellows join with the American Political Science Association (APSA) Congressi Fellows for sessions with senators, representatives, and other experts on the national political and governmental process. During this period, Fellows contact congressional offices that have an active interest in health issues and, in consultatior the program director, negotiate their working assignments. Assignments in the executive branch are also possible.

The work assignments begin in December and end in August. During these assignments, Fellows help develop legislativ proposals, arrange hearings, brief legislators for committee sessions and floor debates, and participate with staff in House Senate conferences. They take part in all areas of the policy process, not as onlookers, but as full-time, working particip

These assignments are supplemented throughout the year by seminars and group discussions on developing health policy, on the general policy and governmental process.

Health Policy Fellows are also invited to attend forums and meetings of the IOM and the National Academy of Sciences, well as the many cultural and social functions they schedule.

As part of the Fellowship year, each Fellow is asked to prepare a formal presentation on a policy-oriented research issue i which s/he has become involved. Each Fellow is also required to submit an evaluation report on the program at the end c Fellowship year.

The Robert Wood Johnson Foundation *Special Report*

STATE HEALTH CARE REFORM

Looking Back Toward the Future

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A RELUCTANT PUBLIC HALTED COMPREHENSIVE REFORM EFFORTS
INCREMENTAL REFORM MORE POLITICALLY PALATABLE
MANAGING THE POLICY PROCESS REQUIRES GOOD USE OF OUT-OF-SESSION SEASONS
REFORM MEANS CHANGES TO STATE ADMINISTRATIVE STRUCTURES
FUTURE PROSPECTS FOR STATE HEALTH REFORM

RWJF HOME

TESTIMONY BEFORE
PENNSYLVANIA HOUSE STATE
GOVERNMENT COMMITTEE CONCERNING HB 975

I would like to thank the Committee for scheduling hearings on this important issue, and for inviting the Commonwealth Foundation to offer testimony. The Foundation has long advocated a more open government, one which transacts its business in a way which solicits public opinion, invites public participation, and provides for the public's welfare. To that end, we have called for reforms to the budgetary process which expands public involvement; campaign finance reform which increases public accountability; and lobbying reform which establishes public disclosure. It is well accepted that the public should know if private parties financially benefit from public decisions, or if private parties are lobbying for public action. HB 975 extends this principle to private foundations and demands that the public also be made aware of their attempts to influence public decisions. It is about time.

Other witnesses have addressed the general need for this legislation more completely than I can. Accordingly, I shall limit my testimony to two areas. First, I will offer some suggestions regarding the bill's language in the spirit of improvement. Second, the Commonwealth Foundation's research has uncovered at least three places where the Robert Wood Johnson Foundation is currently -- as we speak -- influencing Pennsylvania health policy without legislative oversight. We call on this committee to immediately investigate these ongoing practices to determine if they are in the public interest as determined by the people's representatives.

Section 219.1(c) contain very strong language, language so strong that it may permit current practices to continue unabated. I refer to the language which only prohibits the acceptance of funds without statutory authorization if an agency is required to operate, modify or adopt a program, project or initiative. It is easy to imagine contract language after passage of this bill which only requires a government agency to study a program, or one which does not mention a specific program but which all parties involved understand will result in the proposal or adoption of any program. If the object of this bill is to ensure that no private entity cause the expenditure of public moneys for pet projects, this language should be altered to prohibit acceptance of any funds from a private entity without legislative authority.

If the intent of this bill is merely to give the public the opportunity to comment on proposed private entity donations, then attention must be focused on the contents of the IRRC report mandated under Section 219.1(e). While the majority and minority chairs automatically receive a copy of any proposed private entity contract or agreement, the IRRC report is not required to attach such a copy to its report. The minimal requirements of the IRRC report as currently envisioned in the bill could be satisfied without providing a detailed description of the proposed funding initiative; the project description need only include the identity of the private entity and the proposed amount, not the purpose behind the funding. The public deserves to know this information; the legislature must know it.

The bill's language must be tightened up so that its provision will not be circumvented merely by paying staff costs without a formal understanding of creation of a project or program. While program-related money is subject to the structures of Sections (c) and (e), payment of employee costs is subject only to the provisions of Section 219.1(k). This provision does not bar receipt of funds intended to pay for state employee compensation without legislative authorization and it does not require IRRC or any other commission to review such arrangements. It merely requires the identity of the funding entity and funded employees to be published in the Pa. Bulletin and transmitted to the majority and minority Appropriations Chairs, along with a description of the purpose behind the subsidy. Since the description is not subject to outside evaluation, one could easily imagine the following entry in the Bulletin. Jane Doe, Department of Health, Robert Wood Johnson Foundation, administrative assistance. What has the public learned? Nothing. What prevents that employee from then developing new projects, programs or initiatives with the active connivance of the Foundation and the executive agency? Nothing. This language should be strengthened to avoid inadvertently creating an end-run of the provisions of subsections (c) and (e).

Introduction of this bill and the publication of Rep. Rohrer's committee's report caused the Commonwealth Foundation to closely scrutinize this year's budget to determine if the practices complained of are still occurring. Unfortunately, we found that they are. We found the following three instances where the Robert Wood Johnson Foundation is currently giving money to Pa. executive agencies for the following budget line items:

- General Government Operations, Department of Health, $205,000 (p. E20.3 of 97-98 Gov. Executive Budget);
- Primary Health Care Practitioner, Department of Health , $55,000 (p. E20.4); and
- Community Mental Retardation Services, Department of Public Welfare, $133,000 (p. E33.6)

While listed in the Executive Budget, these items do not require legislative approval in the final budget bill because they are technically augmentations, not appropriations.

What do these expenditures pay for? Staff? If so, what are these staff doing? Programs? Then what are these programs. It is unfortunate that the public is not aware of these activities. It is unacceptable if you, our elected representatives, are not.

The public policy will always attract interest from private groups, both self-interested and public-spirited. In a democracy, the activities and influence such groups have should be open to public debate and scrutiny. With regards to the Robert Wood Johnson Foundation, it appears that the public was denied knowledge of their past activities and are being shielded from their current activities. It is high time that the Legislature reassert its constitutional authority over public expenditures via laws and investigation. I am glad this committee is continuing this process.

Summary by Fund and Appropriation

(Dollar Amounts in Thousands)

	1995-96 ACTUAL	1996-97 AVAILABLE	1997-98 BUDGET
GENERAL FUND:			
General Government:			
General Government Operations	$ 16,839 a	$ 18,828 b	$ 18,954
(F)WIC Administration and Operation	6,801	8,212	9,658
(F)Categorical Grant Administration	691	1,245	0
(F)SSA (XVI) D & A Referral/Monitoring	15	0	0
(F)Health Assessment	423	481	484
(F)PHHSBG - Administration and Operation	1,494	2,113	3,356
(F)SABG - Administration and Operation	3,474	4,275 c	4,688
(F)MCHSBG - Administration and Operation	11,586	11,851	12,645
(F)Early Childhood Immunization Program	100	0	0
(F)Center for Disease Control Conferences	2	63	63
(F)Pediatric Prehospital Emergency Care	244	400	400
(F)TB - Administration and Operation	0	0	495
(F)Lead - Administration and Operation	0	0	650
(F)AIDS Health Education Administration and Operation	0	0	2,014
(F)Community Migrant Health	153	262	262
(F)Tobacco Control	310	355	355
(F)Breast and Cervical Cancer Administration and Operation	0	0	695
(F)HIV Care Administration and Operation	0	0	616
(A)Data Center Services	3,108	2,764	2,909
(A)Departmental Services	27	23	23
(A)Early Childhood Immunization - Bulk Purchase	61	0	0
(A)Robert Wood Johnson Foundation Grant	0	0	205
Subtotal	$ 45,328	$ 50,872	$ 58,472
Organ Donation	**120**	**140**	**120**
Transfer to Organ Donation Awareness Fund	**300**	**0**	**0**
Diabetes Programs	**457**	**461**	**461**
(F)PHHSBG - Diabetes	504	844	0
(F)Diabetes Control	241	280	280
Subtotal	$ 1,202	$ 1,585	$ 741
Quality Assurance	**7,099** d	**7,400**	**7,387**
(F)Medicare - Health Service Agency Certification	5,392	4,791	5,280
(F)Medicaid Certification	5,105	5,010	5,423
(F)Medicaid Civil Rights	126	0	0
(A)Publication Fees	10	10	10
Subtotal	$ 17,732	$ 17,211	$ 18,100
Vital Statistics	**5,642**	**5,261**	**5,404**
(F)Cooperative Health Statistics	1,305	2,442	2,452
(A)Reimbursement for Microfilming	54	60	70
(A)Vital-Chek Surcharge	0	0	75
Subtotal	$ 7,001	$ 7,763	$ 8,001
State Laboratory	**3,150**	**3,027**	**3,088**
(F)Clinical Laboratory Improvement	622	800	710
(F)Epidemiology and Laboratory Surveillance and Response	0	250	250
(F)Emerging Infections Program	0	363 e	484
(A)Blood Lead Testing	13	10	10
(A)Blood Lead Specimen Testing	29	43	43
(A)Erythrocyte Protoporphyrin Testing	8	9	9
(A)Reproduction and Search Fees	0	1	1
(A)Alcohol Proficiency Testing	65	63	63
(A)Drug Abuse Proficiency	107	104	104
(A)Licensure for Clinical Laboratories	370	375	375

Summary by Fund and Appropriation

	(Dollar Amounts in Thousands) 1995-96 ACTUAL	1996-97 AVAILABLE	1997-98 BUDGET
(A)Low Volume Proficiency Testing	33	18	18
(A)Training Course Fees	0	1	1
Subtotal	$ 4,397	$ 5,064	$ 5,156
State Health Care Centers	**15,678**	**16,099**	**16,015**
(F)Indo-Chinese Refugees	42	60	60
(F)Disease Control Immunization	4,775	13,674	12,489
(F)Chronic Disease Prevention and Control	49	160	160
(F)PHHSBG - Block Program Services	5,222	7,959	7,198
(F)Medical Assistance - SHCC	0	2	0
(A)Early Periodic Screening, Diagnosis, Treatment	0	1	1
(A)Medical Assistance - SHCC	0	1	1
(A)Departmental Services	16	21	21
Subtotal	$ 25,782	$ 37,977	$ 35,945
Vietnam Veterans Health Initiative Commission	**168**	**0**	**0**
Coal Workers Pneumoconiosis Services Share med.	**199**	**200**	**200**
(F)Black Lung Clinic	610	650	751
Subtotal	$ 809	$ 850	$ 951
VD Screening and Treatment	**1,131**	**1,108**	**1,108**
(F)Survey and Follow-Up - Venereal Diseases	2,081	2,174	2,447
Subtotal	$ 3,212	$ 3,282	$ 3,555
Subtotal - State Funds	$ 50,783	$ 52,524	$ 52,737
Subtotal - Federal Funds	51,367	68,716	74,365
Subtotal - Augmentations	3,901	3,504	3,939
Total - General Government	$ 106,051	$ 124,744	$ 131,041
Grants and Subsidies:			
Primary Health Care Practitioner	**$ 4,819f**	**$ 3,931g**	**3,088**
(F)Loan Repayment Program	146	237	215
(A)Robert Wood Johnson Foundation Grant	193	292	55
Subtotal	$ 5,158	$ 4,460	$ 3,358
Cancer Programs	**2,711h**	**2,520i**	**2,595**
(F)Data-Based Intervention Research	46	0	0
(F)Breast and Cervical Cancer Program	2,070	3,807	2,580
Subtotal	$ 4,827	$ 6,327	$ 5,175
AIDS Programs	**5,910j**	**6,328k**	**6,328**
(F)AIDS Health Education	4,833	5,235l	4,735
(F)HIV Care	6,283	7,304m	12,640
(F)Housing Opportunities for People with AIDS	1,894	948n	2,000
Subtotal	$ 18,920	$ 19,815	$ 25,703
Arthritis and Lupus Research	**196**	**0**	**0**
Regional Cancer Institutes	**1,100**	**1,350**	**1,350**
School District Health Services	**38,452**	**39,065o**	**39,279**
Local Health Departments	**26,466**	**27,268**	**26,247**
Local Health - Environmental	**7,309**	**7,309**	**7,294**
WIC - State Supplement	**3,744**	**3,000**	**0**
Maternal and Child Health	**1,803**	**2,100**	**3,150**
(F)Women, Infants and Children (WIC)	137,684	151,500	156,093
(F)MCH Lead Poisoning Prevention and Abatement	1,246	3,822	4,332
(F)MCHSBG - Program Services	18,947	15,012	15,364
(F)Genetics	0	50	0

Summary by Fund and Appropriation

(Dollar Amounts in Thousands)

	1995-96 ACTUAL	1996-97 AVAILABLE	1997-98 BUDGET
(R)January 1996 Storm Disaster - Individual & Family Assistance	8,000	0	0
(R)Jan. 1996 Storm Disaster - Individual & Family Supplemental	5,000	0	0
Subtotal	$ 1,230,117	$ 1,134,858	$ 1,019,933
Supplemental Grants - Aged, Blind and Disabled	**130,231**	**118,139**	**118,864**
(A)Intergovernmental Transfer	24,913	26,985	26,985
Subtotal	$ 155,144	$ 145,124	$ 145,849
Medical Assistance - Outpatient	**792,293**	**779,693**p	**573,550**
(F)Medical Assistance - Outpatient	871,546	879,619q	735,173
(F)Disease Control Immunization	200	478	478
Subtotal	$ 1,664,039	$ 1,659,790	$ 1,309,201
Expanded Medical Services for Women	**4,060**	**4,060**	**4,141**
AIDS Special Pharmaceutical Services	**5,060**	**5,722**	**6,294**
(F)Ryan White	0	1,600	4,732
Subtotal	$ 5,060	$ 7,322	$ 11,026
Behavioral Health Services	**0**	**52,500**	**65,900**
(A)Intergovernmental Transfer	0	12,107	12,107
Subtotal	$ 0	$ 64,607	$ 78,007
Medical Assistance - Inpatient	**452,180**	**393,426**r	**281,176**
(F)Medical Assistance - Inpatient	920,374	637,820s	465,766
Subtotal	$ 1,372,554	$ 1,031,246	$ 746,942
Medical Assistance - Capitation	**661,031**	**626,094**t	**736,383**
(F)Medical Assistance - Capitation	523,304	607,376u	806,020
Subtotal	$ 1,184,335	$ 1,233,470	$ 1,542,403
Medical Assistance - Capitation - Behavioral Health	**0**	**0**	**292,915**
(F)Medical Assistance - Capitation - Behavioral Health	0	0	211,691
Subtotal	$ 0	$ 0	$ 504,606
Long-Term Care Facilities	**648,496**v	**606,403**w	**671,771**
(F)Medical Assistance - Long-Term Care	1,156,053x	1,528,749y	1,621,769
(A)Intergovernmental Transfer	304,731	723,130	713,518
Subtotal	$ 2,109,280	$ 2,858,282	$ 3,007,058
Medical Assistance - Transportation	**18,555**	**18,560**	**18,931**
(F)Medical Assistance - Transportation	14,987	16,545	16,545
Subtotal	$ 33,542	$ 35,105	$ 35,476
Intermediate Care Facilities - Mentally Retarded	**110,932**z	**107,382**aa	**113,693**
(F)Medical Assistance - ICF/MR	130,513	130,563	129,546
Subtotal	$ 241,445	$ 237,945	$ 243,239
Community Mental Retardation Services	**413,401**	**432,662**	**465,033**
(F)Medical Assistance - Community MR Services	174,800	214,210	265,186
(F)SSBG - Community MR Services	15,331	17,124	15,318
(A)Robert Wood Johnson	0	100	133
Subtotal	$ 603,532	$ 664,096	$ 745,670
Emergency Mental Retardation Services	**1,000**	**0**	**0**
Pennhurst Dispersal	**2,819**	**2,819**	**2,819**
Early Intervention	**35,088**	**42,578**	**46,962**
(F)SSBG - Early Intervention	2,406	2,687	2,404
(F)Medical Assistance - Early Intervention	6,776	7,363	7,722