



**Senate Public Health & Welfare Committee
Past Payment practices of the Office of Developmental Programs**

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Good morning Chairwoman Vance, Chairwoman Kitchen, Vice-Chairman Mensch, and members of the Senate Public Health and Welfare Committee. My name is Tim Costa and I am pleased to come before this committee with John Cox to provide you an update on the Office of Developmental Programs (ODP) two years in to the Prospective Payment System, or PPS. We are continuing the top to bottom financial review and a review and inventory of all operations and programs Secretary Alexander mentioned to you in his confirmation hearing. Secretary Alexander has made it his top priority to ensure that DPW is a financially responsible steward to the taxpayers and that those in need receive the right services, at the right time and in the right setting. As Secretary Alexander promised during his confirmation hearing, we are thoroughly reviewing the Department's fiscal situation. As this review has proceeded, the severity of that situation has become clearer to us recently and we would like to detail for this committee the serious challenges facing ODP, the progress we have made, and the promising opportunities in front of us. ODP's services to individuals with intellectual disabilities has altered significantly since inception – moving from delivery in state facilities to a system primarily offering a wide array of services in the Community; and one administered by Counties to a State-wide program as of 2009. The systems, regulations, policies and practices to support this management transition required by the Centers for Medicare and Medicaid Services (CMS) have struggled to keep up with all of these changes while providing needed programmatic reforms.

Introduction and Background

As you know, the state manages a system to provide benefits for persons with intellectual disabilities. It is the right thing to do and we are committed to ensuring the program can provide assistance to families in need now and well into the future. The current system, a statewide system, was set up with few rules and no regulations that offered caregivers clear service definitions and other direction to ensure fair, efficient and effective business practices. The prior County-managed program provided fiscal controls that did not carry over to the state-run system. As a result, the state has paid for many things beyond what the Federal government will match for reimbursement and an environment had developed that allows waste and excess to stymie some of the good being done by the system and presents many challenges in the program's finances. Despite these challenges, we believe these there are great opportunities for the future of ODP.

The payment system now in place is known as the Prospective Payment System, or PPS, which provides reimbursement to the providers for the approved services they perform. PPS consists of PROMISE, Pennsylvania's Medicaid Management Information System, in which providers enter their requests for reimbursement, and the Home and Community Services Information System, or HCSIS, which acts as a central repository of the individual service plans that detail what services have been approved for each individual recipient in what amounts. This new payment system that ODP has only recently developed is intended to provide a level of fiscal control as well as a fiscal awareness at the state level. Fiscal control had previously been handled by the counties and ODP is only now developing the capability. My hope is that our testimony today will help you as legislators to understand better the challenges we face and the opportunities we have to work together to address them.

All of us want the same thing – to provide quality services for those in need through a sustainable, successful program with clear and fair rules of the road for families and providers to follow. Lack of clear rules carries a real price. With almost 16,000 persons with intellectual disabilities on the waiting list hoping to enroll into the system and get the services they need, the need for reform is urgent.

In addition, Pennsylvanians rightly expect the state to live within its means and to be a better fiscal steward of their tax dollars. ODP's responsibility is to live within the State Fiscal Year 11-12 appropriation. Later this year, after consultation with stakeholders, we will release new regulations. These regulations will be the first to be implemented for the system since it became centrally managed by the state government more than two years ago. These regulations will provide fair and reasonable guidelines for families and providers, ensure the program's integrity and ability to deliver quality, necessary services to those in need, and assure taxpayers that their money is being spent wisely and carefully.

Under the Prospective Payment System, DPW operates two Waiver programs approved by the Centers for Medicare and Medicaid Services, also known as CMS, for individuals with intellectual disabilities: the Consolidated Waiver and the Person/Family Directed Support Waiver. These waivers, collectively known as the ID Waiver Program, provide home and community based services for persons with intellectual disabilities and are administered statewide by ODP. Previously, the ID Waiver Program were managed for over twenty-five years by a federal-state-county partnership. The Federal government lays out the general program parameters and the state provides the program design, covers the balance of the funding, and defines the services providers can offer. If the services qualify, the Federal government, through Medicaid funding, matches the state funding for those services. This matching totals over half of the funds in the program. In the past, the counties administered the program, including the establishment of provider rates, at the local level as part of the county community-based service system established under the Mental Health and Mental Retardation Act of 1966.

Individuals seek to enter the ID Waiver Program by visiting their county office, where they are screened for eligibility. If they are determined to be eligible, an assessment is done to determine their needs and the seriousness and urgency of their situation. Based on this assessment, they are placed on the waiting list, which is organized based on the priority of needs of each individual. Those individuals with the most urgent and serious needs are ranked at the top of the list. As slots become available in the ID Waiver Program, individuals are admitted into one of them based on their ranking on the waiting list. Once admitted, an individual service plan, or ISP, is developed for the individual recipient and updated each year. That ISP is not currently tied to the assessment of needs done earlier in the enrollment process.

CMS requires that the programs be managed on a consistent statewide basis. A person receiving services in one part of the state should be able to access the same services in a similar manner in any other part of the state. Because there were 48 county-based programs administering the services and negotiating provider rates at the local level, DPW could not meet this requirement in the old system. As a condition of continued federal approval of the ID Waiver Program, in State Fiscal Year 04-05, CMS required Pennsylvania to change the way the ID Waiver Programs were administered and required Pennsylvania to develop a statewide rate-setting methodology.

Effective July 1, 2009, the Department started a two year transition to the new Prospective Payment System. PPS is currently a cost-based system which utilizes cost report information submitted by providers to establish rates. Currently under the PPS, ODP calculates provider-specific rates on an annual basis. Rates are calculated from data collected in a standardized cost report. Only those cost reports that are submitted and approved in this process are used to develop rates.

In order to set rates for providers under the PPS as it currently exists, providers are required to submit a cost report to DPW outlining the costs they have incurred over the past year. If a provider chooses to not submit a cost report and/or the cost report does not successfully pass the review process, providers are assigned the lowest rate for each service they provide. Without reliable cost reports, DPW cannot set an accurate rate for providers; nor can the PPS function successfully, compounding these rate problems. In the first year of the transition, ODP had little in the way of cost information, leading to some of the fiscal challenges we face today.

As ODP completes the transition from the county-based system to the statewide system, we will move towards a uniform statewide rate system based on a market-driven approach rather than the current cost-based system. Such a move is critically important to ensure that providers are the state's partner in controlling costs, and that they operate on a level playing field with one another in delivering services.

A successful transition is especially critical within the Consolidated Waiver (referenced above), under which most of the ODP services are provided. The Consolidated Waiver constitutes the vast majority of payments to Waiver providers – \$1.64 billion of the \$1.8 billion current fiscal year total appropriation. As such, the majority of our focus in

today's testimony will be on this Waiver. If it is necessary to ensure DPW remains within budget, the Department can apply a rate adjustment factor to individual provider rates to bring their expenditures in line with available appropriated funds. In the past, the rate adjustment factor has not been utilized by the Department to the extent that it could be to avoid requiring a supplemental appropriation. In the last fiscal year, for example, instead of having a large enough RAF, the Department shifted accounting methods and paid bills from the last fiscal year in the current fiscal year. Though that decision addressed the fiscal gap of the moment, it did so at the expense of our current fiscal situation, and by ignoring the problem made it worse.

With the shift from a county-based payment system to centralized payments through Treasury, the supporting information systems were changed in a number of ways. Under the county system, counties were responsible for meeting a person's needs and managing to their allocation. In the new statewide system, the counties no longer play the same role in managing an allocation and their ability to view and manage service costs in the HCSIS case management system was removed.

Another important change was that in response to requirements from CMS, rates would be set at the state level, using consistent standardized cost reports. In addition, CMS asked that we narrow the range of our rates over a period of time. There are currently 17,000 individual rates in the system. The reality is, thus far we have just transitioned from a county-based system with individual provider rates to a statewide system with individual provider rates. The transition to a small number of more uniform rates must continue not only to satisfy CMS requirements but to provide a more level playing field for providers and to ensure a more fair, equitable and predictable system.

Forensic Review of ODP's Finances

As Secretary Alexander specified during his confirmation hearing, we set out to perform an in depth review of the financial situation at ODP and provide solutions to address any problems. As part of this process, DPW engaged Alvarez and Marsal, an independent professional services firm, to perform forensic analysis working in conjunction with ODP's actuarial consultant, Mercer Health and Benefits. Thanks to their help in this process, which is still ongoing, we know much about our fiscal reality that we did not know several months ago. It has already had a positive impact on ODP and will bear more fruit in the upcoming months and years to find common-sense and cost-effective ways to allow Pennsylvania to sustain a social-services system for those that truly need it.

The scope of the financial forensic review includes the following:

- **Budget Management** : The team developed a more robust budget and forecasting process based upon actual trends and used this information to drive an improved operational decision making process. Until this review began to help us improve these capabilities in the past few months, there was no tool to manage the information available to ODP about service costs and our fiscal

situation during a given fiscal year. We were flooded with data, but starving for information. Now we have such a tool and, going forward, we can and will hold managers accountable for bottom-line results, something that has been sorely lacking throughout ODP.

- Current Fiscal Situation: The team identified short term budget needs and potential short fall requirements
- Cost Containment: The team identified specific areas for immediate opportunities for cost savings
 - Revenue reconciliation, including a detailed review of the process of revenue target development
 - Use allowance
 - Medical leave and vacancy policies
 - Supplemental habilitation and individualized staffing
 - Residential occupancy mix

The team is also working on longer term initiatives to both improve program quality and fiscal controls based upon a revised strategic vision of the program. The department is also conducting an operational review of various ODP processes, policies and procedures to identify opportunities to enhance quality, improve efficiency, and strengthen fiscal controls.

With this review underway, ODP is gaining a stronger understanding of its fiscal situation. As I mentioned at the beginning of this testimony, we have recently become aware, well into the Administration, that the severity of that situation is considerably worse than we initially understood earlier this year.

The Fiscal Challenges

The past decade has seen significant growth in Home and Community Based Services both nationally and in Pennsylvania. National Medicaid spending on such services has increased from 19% in 1995 to 42% in 2008 and costs continue to rise. While Federal stimulus funds may have helped delay some of the inevitable fiscal challenges Pennsylvania faced due to this growth, those funds are now gone and ODP faces a challenging fiscal future without reforms.

As the Secretary mentioned in his confirmation testimony, more than half of every new tax dollar taken in by Pennsylvania is spent on human services – an amount projected to grow at a rate of 11% per year through 2014 if we do nothing about it. As a part of the human services program, ODP must find ways to be a better fiscal steward of the tax dollars entrusted to it while also ensuring that quality services can be provided to those in need in an fair and efficient manner.

While ODP's Consolidated Waiver budget of \$1.64 billion appropriated by the Legislature for the current fiscal year is flat, we project that service utilization paid for by ODP will increase by \$58.5 million just for individuals already enrolled in ODP programs. We see that growth in service utilization by existing recipients continuing, not

abating. Additionally, these figures do not include the approximately 16,000 Pennsylvanians with intellectual disabilities on the waiting list for services. It also does not include the potential for estimated cost overruns in ODP's budget for this year, which totals another \$134 million. This \$134 million estimate includes \$104 million for revenue reconciliation, \$46 million of which is state funds, and \$30 million in planned changes that may not be implemented in this fiscal year.

The growth in services provided to individuals already in the system has been dramatic in recent years. For example:

- While ODP's budget has increased \$664 million – 60% – from State Fiscal Year 04-05 to 10-11, the number of individuals served has only increased by 27% during the same period.
- 552 recipients had their individual service plans each grow by \$100,000 or more from one fiscal year to the next. This occurred as a result of both rate increases and a growth in service units.
- Significant variation in the average annual cost per person with the high being \$140,243 in one County (Philadelphia) and the low being \$56,122 in another county (Tioga).
- Even similarly sized counties in the same geographic areas are seeing differences of \$25,000 per person.
- 558 people are in single person community settings at an average cost of \$212,938 in State Fiscal Year 10-11.
- For individuals enrolled in the ID Waiver Program in State Fiscal Year 08-09, they received an additional \$107 million in services in State Fiscal Year 09-10 above what they were receiving in 08-09.
- In the last fiscal year, the Department spent \$30 million in unmatched funds for ineligible vacancy services which means we pay for empty beds

Through “revenue reconciliation” for service providers, a legacy of ODP's effort to ensure a smooth transition from a county-based system to a state-based system, ODP has seen its costs skyrocket, from a net payment of \$41 million in State Fiscal Year 09-10 to an anticipated net payment of \$189 million for State Fiscal Year 10-11. We estimate the total revenue reconciliation remaining to be paid for State Fiscal Year 10-11 will cost the state \$46 million in state funds– even after accounting for Federal matching funds.

In fact, policies that do not maximize the matching of state funds with Federal funds are also a considerable part of the fiscal challenge we face. Over the past two years, the state has spent, on average, in excess of \$150 million that is not matched by the Federal government in order to provide services above and beyond Federal Medicaid guidelines. These state-only dollars are paid as a result of both long standing and more recent policy decisions. It's not necessarily the wrong thing to do, but it has to be closely examined.

Another increase in Consolidated Waiver spending comes as individuals continue to be moved from the Base program to the ID Waiver Program. The Base program is funded entirely by the state with no Federal matching funds from the waiver. Funding for services in the Base program is capped and provides support to individuals in need of services who may not qualify for ID Waiver Program services, or for services that are provided in settings that are not eligible for Waiver funding. Individuals move from the Base program because of changing needs, but also because the ID Waiver Program is more flexible and generous. With the shift away from a county-administered Base program to the uncapped Waiver system, ODP is seeing costs grow at a rapid rate.

Lastly, there is tremendous growth in costs on the immediate horizon due to service utilization increases. In its trend analysis for DPW's State Fiscal Year 11-12 rate setting process, the consultant found:

- Residential eligible service units represent 60% of the ODP State Fiscal Year 2011-2012 budget and are projected to grow by 2.5%, as is the Ineligible portion of these services. These service units are the pre-determined amount of time that can be billed to the state by a provider for services such as home rehabilitation, in-home staffing, and family aides.
- Non-residential service units, which include such services as employment services, behavioral therapy, and speech and language therapy, are the second largest component of the ODP budget and are projected to grow at a rate of 6%.
- Fee Schedule services unit growth is projected to grow 30% in part because more units are being used under the fee schedule than were under the previous system.
- Supports coordination unit growth is projected to grow at 10% during this fiscal year. Supports coordinators are similar to case workers who help individuals with the process of identifying and receiving the treatment and services they need.

How Did We Get Here?

These are stark challenges for ODP. As I mentioned previously, in 2005, CMS directed ODP to address significant issues with its reimbursement process and differences of provider rates in the county-based system. As a result, in 2009 ODP transitioned to a centrally managed system for reimbursing providers. This transition, while necessary to comply with CMS requirements and continue receiving Federal matching funds, has been challenging and in fact led to rapidly increasing costs for several reasons, including:

- Limited fiscal controls and managerial accountability after the transition coupled with an exception-driven culture;

- Unit service and rate growth;
- Waste, excess and poor fiscal governance, both on the part of some providers and on ODP;
- And the introduction of “revenue reconciliation” to ease the transition for providers.

Limited Fiscal Controls: The county-based system had clear fiscal controls in place that allotted funds to each county and allowed the county to determine how much providers would be reimbursed based on those budgets. But when ODP transitioned to a centrally managed system, those controls lapsed and were replaced with limited fiscal governance. The result was that the state set rates paying for nearly everything – in some cases two or three or more times over with few controls in place.

Exception-Driven Culture: Given limited fiscal and programmatic regulations in place since 2009, the state and counties began authorizing services and making programmatic changes without fully realizing the full fiscal impacts. Efforts by ODP staff to decline reimbursements of the more questionable items submitted resulted in provider appeals challenging enforcement initiatives and reimbursement approvals in some circumstances. Claims asserting insufficient fiscal regulations created uncertainty and further compounded the difficulty in establishing and maintaining of fiscal controls and standardized practices. This uncertainty has contributed to the difficulty in budgeting for ODP programs.

Unit service growth: Once an individual is enrolled in the system, Medicaid requires that all of their necessary services be paid for by the state – lack of funds in the budget cannot be used as a justification for denying reimbursement. That requirement, combined with a lack of clear definition of what is a “need” vs. a “want” that should have been a part of service definitions and the associated programmatic and fiscal regulations, led to large year over year growth in services provided to individuals already in the system. This issue is compounded by the fact that there is no clear link between the assessment tool and the development of the individual service plans. It is nearly impossible to achieve uniformity without linking individuals’ assessment with their service plans. If we’re using an assessment to help determine an individual’s eligibility and the priority of their needs, it raises questions as to why we are not using it to help determine what services they should receive.

Waste, excess and bad business practices: First, let me state clearly that ODP has many great providers who are working hard, providing great services to the individuals they serve and managing their cost structures within the established rate structure effectively.

But without strong fiscal controls, it is not surprising that waste and excess crept into the system, arguably as a result of some providers taking advantage of the generous reimbursement policies and limitations in fiscal governance put in place by ODP and the Department of Public Welfare. Concerning examples of how state only funds were expended include:

- Depreciation and Continuing Participation Allowance: The state, via the existing cost reporting process, will reimburse providers for the depreciation on a property, and then pay a use allowance (also referred to as continuing participation allowance) for the same property in perpetuity, essentially paying twice for the same assets. In other words, under the current structure, DPW would pay for the mortgage a provider has on a \$150,000 home. Then after the mortgage is paid off, the ODP allows providers to report up to \$12,000 a year for use of the home for services. However, ODP also considered their existing maintenance costs in establishing the rate they are paid for services.
- Property Transfers: A provider can transfer a property to another provider, who could then get the reimbursement for the depreciation again, along with the future use allowance additions to their cost report, leaving the state potentially paying a third and fourth time for the same asset. So if the provider with the above \$150,000 home sells it to another provider, ODP would pay for the new mortgage and then for the use of the home all over again.
- Temporary vacancy services: ODP pays providers for empty beds, even when these costs are not eligible for Federal matching funds. You heard that correctly. We are paying for empty beds. Under certain, limited circumstances, and for short periods of time, this practice makes sense and the Federal government, through CMS, will match these payments. But ODP has gone well above what CMS will match. For example, if a patient leaves a provider's facility for a short hospital stay or other temporary absence for treatment, CMS will match payments for up to 30 days to keep that patient's bed available to them after the hospital stay. This practice helps ensure providers do not incur financial hardship from lost revenue during the patient's absence. But ODP goes well beyond the 30 days CMS allows. If the patient leaves for therapy, ODP will pay for that empty bed for up to 48 days. And if the patient leaves for medical treatment, there is no limit to how many days ODP will pay to keep that bed empty. As I said, there are good reasons to provide payment for a short period of time in these types of situations. But we have gone well beyond that using state-only funds. Between these temporary vacancies and permanent vacancies, which I will explain in a moment, the policies currently in place have left ODP with \$30 million in state-only costs just in the last fiscal year.
- Permanent vacancy services: In addition to paying for beds that are empty only temporarily, with the patient fully expected to return, ODP currently pays providers for beds that are empty because a patient passes away or moves to a different facility permanently, for example, if a patient's family moves to a

different county and wants the patient closer to the family's new home. Even though Medicaid will not match payments for permanent vacancies under any circumstances, ODP will reimburse a provider for that bed to be empty for up to 60 days. In addition, there have sometimes been exceptions made to that limit. Such policies discourage providers from keeping beds filled, despite a lengthy waiting list.

- Other waste and excess: ODP has approved such use allowance payments through the cost reporting process for futons, video cabinets, parking lot paving, and mulch. In addition, cost report items approved by ODP include a patio, pool fencing, carpeting, driveway paving, chandeliers, luxury cars, and even flea dipping for a "therapeutic" cat.

Although the legality of some of the above practices may be in dispute, it clearly constitutes a violation of behavior the public should expect and demand. ODP and the Department have been working internally and with the appropriate authorities where necessary to examine and ferret out any troubling practices and approval of cost report expenditures.

Revenue Reconciliation: When ODP transitioned from a county-based system of reimbursement to a centrally-managed state-based system, providers raised a concern that they would no longer receive the revenue they had expected under the old system. To ease these concerns and to allow the providers a two year transition period to adjust, ODP set up a process of "revenue reconciliation" intended to ensure providers did not receive less money in the first two years of the new system than they had in the last year of the old system. This process has been costly for the state and the costs continue to increase. For example, in State Fiscal Year 10-11, this process cost \$189 million in state and matching federal funds, compared to just \$41 million in State Fiscal Year 09-10. This is a \$148 million swing over a single year, and revenue reconciliation now accounts for more than 10% of the consolidated budget which more than suggests something is seriously wrong.

Progress and Opportunities

Despite the good work many in the Department and the provider community have done over the years, there is a clear consensus that there is much more work to be done, greater efficiencies to be achieved and greater cost savings that can be made. This effort is essential to preserving and improving services for some of our most vulnerable citizens.

Let there be no doubt that there are many, many great providers. And they are important private sector partners with the state in providing much needed services for persons with intellectual disabilities. Over the years, ODP has closed 12 institutions and transitioned approximately 4,000 individuals to the community. That's something to be proud of and would not have happened without the support of many good providers.

By and large the waste and excess in the system has largely resulted from a lack of good fiscal governance and a lack of clear regulations for everyone to follow. But there is also some fraud in the system, as there unfortunately is in any system. In those cases where fraud is alleged, ODP makes appropriate referrals to the Inspector General and the Attorney General. We will communicate the most egregious cases to put those in the provider community who attempt to defraud the Commonwealth on notice that this behavior will never be tolerated.

To further strengthen the integrity of this program, we will also push for new regulations that make sure providers know the state's expectations for them and can be good corporate citizens here in the Commonwealth. These fiscal and programmatic regulations must be put in place to give providers clear rules of the road and also reduce the culture of appeals and exceptions. ODP will utilize its authority under Act 22 to strengthen its programmatic and fiscal regulations. Our goal is a sustainable and efficient system that provides high quality services to those in need and is accountable to the taxpayers.

We have already made progress towards this goal. As a result of the CMS review prior to the Waiver renewal in 2005, a work plan was developed to address their concerns of inconsistencies in the application of the ID Waiver Program in Pennsylvania. ODP has undertaken a number of efforts to improve the program and provide a transition to the state-run PPS, including:

- Developing Operating Agreements between ODP and the counties that more clearly defined waiver functions being delegated to them
- Engaging the services of Mercer Consulting to develop a rate system that would be standardized statewide for all providers and waiver services, as opposed to the individually negotiated rates between each county and provider
- Engaging Alvarez & Marsal to perform forensic analysis working in conjunction with Mercer and assist ODP in obtaining a much higher level of awareness of our fiscal situation and in identifying a common-sense and cost-effective path to a sustainable future for our programs for persons with intellectual disabilities
- Developing and implementing training for providers prior to enabling them to bill correctly and be paid through PROMISE
- Improving ODP's ability to allocate ID Waiver Program slots; and
- Training counties to ensure they understand their role in the new system

For all of the challenges brought on by the transition from a county-based system to a state-based system, we believe there are also a number of opportunities offered by this transition.

- Persons with intellectual disabilities and their families can now move between counties in the state without worrying that they will lose their place in the system or see the services covered change.
- These individuals also have greater flexibility for enrollment.

- The consistency promised by a statewide system, and the ability of providers to work across multiple counties with one reimbursement system means that there are now more providers in more counties with more choices being offered to individuals in the system. This competition is healthy and greatly beneficial to those in need.
- Consistency will also improve provider planning related to revenue and cash flow.
- With one statewide system, ODP now has data that allows us to identify expectations for providers that will lead to more consistency in standards of care, best business practices, and better state monitoring of providers.
- This data also allows ODP to better understand the trend lines in authorization vs. utilization of services being rendered and the costs they entail. This understanding has a number of benefits, including the ability for the state to begin leveling the playing field for rates.
- We have also found that despite initial concerns, anecdotal evidence indicates that providers have found the PROMISE system particularly helpful.

Conclusion

John and I want to again thank you for this opportunity to appear before you today. The transition to a state run Prospective Payment System has proven challenging to all parties involved. ODP continues to respond to these challenges and is working to improve both the regulatory and fiscal aspects of the program for those we serve. As Secretary Alexander told you in his confirmation hearing, our goal is to work with ODP staff, the provider community, families and advocates, and you the legislature to make DPW and ODP efficient, organized, responsible and accountable.

We understand that anytime there are discussions of changes, providers, families and advocates want to know that those changes will be for the better. Secretary Alexander wants to assure them, and the members of this committee, that we will ensure the forthcoming changes will improve ODP's operations and fiscal controls. Forthcoming changes will provide fair and reasonable rules for families and providers, ensure the program's integrity and ability to deliver quality, necessary services to those in need, and assure taxpayers that their money is being spent wisely and carefully. As we continue to develop these proposals, everyone will have a seat at the table because we are all committed to the same goal.

Thank you very much for hearing this testimony and we will be happy to take any questions you might have at this time.