

LOCAL AND REGIONAL HEALTHCARE TOPICS¹

Like the rest of the nation, the Southwestern Pennsylvania region is concerned with access to healthcare, its cost and quality. Our national healthcare system leaves many people uninsured or underinsured, and the federal government's healthcare safety net, Medicaid, is in crisis. State governments are struggling to replace lost federal government funding.

Healthcare is also a factor in our region's competitiveness. To attract people to live and work in Southwestern Pennsylvania, businesses need to offer healthcare to their employees. But as the costs of healthcare rapidly rise, businesses may eliminate coverage as they attempt to remain viable in the marketplace.

Our region faces some unique healthcare challenges and opportunities.

TOPIC 1. STATE BUDGET CUTS AND PENNSYLVANIA'S MEDICAID PROGRAM

The goal of the Medicaid Program is to provide services for low-income people in Pennsylvania. Recently, Governor Rendell's budget proposal riveted widespread attention on a looming crisis in Medicaid funding. Thanks to a better-than-expected revenues picture, the final state budget softened the blow, but Medicaid recipients will still face new limits on physician and psychiatric visits. The costs of Medicaid continue to rise—propelled by the increase in the number of enrollees and the rising costs of health care—and are now 20% (one-fifth) of the state's general budget. Thus Pennsylvania continues to face the possibility of major cuts to Medicaid in order to control the budget. As of May 2005 there were 1.8 million people enrolled in the Medicaid program in Pennsylvania.

Although the states must meet minimum requirements to qualify for federal funds, they have considerable leeway to structure their own Medicaid programs. Our state can choose among several unattractive options: appropriate more money, tighten eligibility rules, reduce coverage, and/or cut reimbursement rates to providers. A goal of this local deliberative poll is to assess options for implementing cuts that will minimize harm to the residents of Pennsylvania.

¹ This document was prepared by Robert Cavalier with assistance from Julianna Kuchta (Carnegie Library) and Susan Lawrence (Carnegie Mellon). Consultants included Andrew Dick (RAND Corporation), Naida Grunden (Pittsburgh Regional Healthcare Initiative), Judith R. Lave, Chair, Department of Health Policy & Management Graduate School of Public Health (University of Pittsburgh), and Beaufort Longest, Director of the Health Policy Institute at the University of Pittsburgh (University of Pittsburgh). Document designed by Ken Mohnkern (Carnegie Mellon).

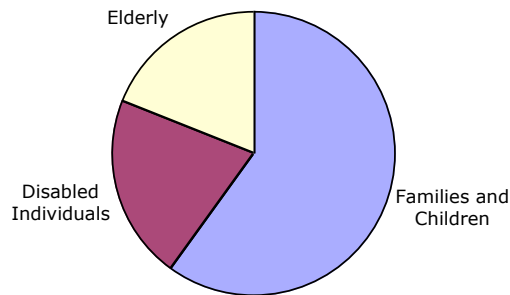
Public Funding of Healthcare in the State of Pennsylvania

While we will be discussing the Pennsylvania Medicaid program, it is important to understand the basic differences between Medicaid and Medicare as they apply to our state. According to current information, 20-25% of the Pennsylvania population is covered by either Medicaid or Medicare (this means that one in every 4 or 5 Pennsylvanians are covered by one of these healthcare programs).

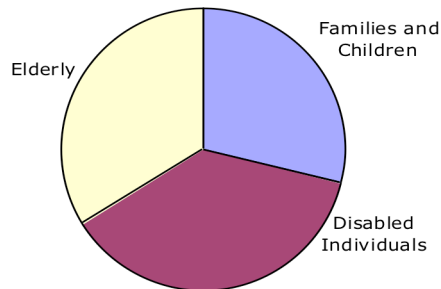
Medicare, enacted along with Medicaid in 1965, was established to provide healthcare coverage for seniors. According to the Kaiser Family Foundation, as of 2003, there were 2,110,470 Medicare beneficiaries in Pennsylvania. This program is funded entirely through federal grants. The benefits received under this plan include the following:

- inpatient hospital, skilled nursing, and home health services
- outpatient services
- preventive screenings
- prescription drug benefits, which will begin in 2006 (enrollment begins on November 15, 2005, and runs through May 15, 2006)

Medicaid is an entitlement program that *provides federal matching grants to states* to finance healthcare focusing on the disabled and those families with children living below the poverty line² or those whose medical costs exceed their income. An interesting fact is that while children and families make up 60% and disabled individuals make up 21% of the population who receive Medicaid, 34% of the dollars were spent on the elderly who are not covered by Medicare (often through long-term care costs) and 37% of the dollars were spent on disabled individuals.



Percentage of recipients



Percentage of dollars spent

Because over two-thirds of the costs of Medicaid go to the elderly and disabled, some say that significant cost cuts will have to focus on families with children.

² According to the Federal Register the 2005 federal poverty guidelines are \$19,350 for a family of four.

Medicaid Recipients

Who's eligible?

Paul Smith is in his mid-50s and has recently become a double amputee (both legs at the knee) due to complications from diabetes. He is unemployed and lives with his elderly mother.

Pam Jones is a single mother in her late-20s living in rural Butler County. She has three young children (one with moderate heart and lung problems) and works in a SuperStore for \$11,500 per year without benefits.

Laura Regis is in her early-70s with early-stage Alzheimer's disease. Widowed and having lived most of her life in an apartment, she has recently been moved to a Nursing Home in Washington, PA.

Who's not eligible?

Jon Burns, 52, is a former construction worker. Now suffering from chronic back pain, he works as a night watchman. He receives minimum pay (at \$7.50 per hour) and no benefits.

Sally Gribbs, 35, lives alone in a North Side apartment in Pittsburgh. She has diabetes and works as a cashier for \$12,500 a year (and no benefits).

While Medicaid benefits differ from state to state, there are *mandatory services that must be covered*. These services include *nursing home care, physician services, and immunizations and other preventive services including early and periodic screenings*.

Medicaid Issues at the State Level

With federal funding decreasing, it is becoming more difficult for states to balance the *needs* of a growing client base (citizens eligible for Medicaid) and the increases in the *costs* of healthcare. As an example of decreased funding, the Intergovernmental Transfer Program—which allows county or city governments to send money to the state that is then used by the state to qualify for additional federal Medicaid funds—will be phased out by 2008. Pennsylvania has received as much as \$820 million dollars annually through this program. Once it is phased out, Pennsylvania will have to shoulder more of the Medicaid costs.

Currently, state revenues are growing at a rate of 3-4% per year while Medicaid revenue needs may exceed 15-20% this year (given no change in benefits). In light of this, Pennsylvania has implemented several cost control initiatives over the past two years, including attempts to reduce perceived fraud and abuse (by flagging suspicious claims, etc.). Some of the cost reductions include reallocating the way available Medicaid funds are used, placing limits on the amount of some services for adult and general assistance Medicaid recipients,



increasing co-pays (the amount that individuals must pay out-of-pocket), and developing a “higher standard” for determining medical necessity for approval of claims after recipients have reached their limits on amounts allocated for them. But further measures are being discussed and there will be a real impact on people currently receiving Medicaid.

Some say, however, that “Medicaid does no one any favors -- least of all the truly needy -- by inducing dependence or enrolling people who could obtain coverage elsewhere. [According to the Cato Institute], Congress should: (1) cap federal Medicaid funding; (2) block grant federal funds to the states; and (3) allow states full flexibility to define eligibility and benefits under their Medicaid programs. States should use that flexibility to reduce dependence and target Medicaid assistance to the truly needy.”³ Others argue that because two-thirds of Medicaid spending goes to treat patients who have multiple concurrent chronic diseases, most of the proposed cuts, below, would automatically shift costs to other members of the economy. Far worse, cutting preventive treatment of the underlying chronic diseases would result in far higher costs being incurred to treat the resulting conditions of these diseases.

Impact of State Budget Cuts on Medicaid Recipients

Budget cuts to the Medicaid program will impact most recipients. In February of 2006 the State Senate could enact the following changes due to proposed budget cuts to Medicaid:

Cuts	Comments⁴
<ul style="list-style-type: none">• <i>Limit hospital admissions</i> to two per year and one per year for rehabilitation services	Looking just at children, very few have more than one hospital admission per year. But a significant number have many admissions. Consider also the case of a patient with chronic schizophrenia who has used up his two admissions, but is in urgent need of admission to be secluded during an episode. Without seclusion and time to recover, the patient would pose a danger to society and him/herself. These cases often show up in our emergency rooms and require immediate treatment whether or not Medicaid is prepared to pay.

³ Michael Cannon, “A Cure for What Ails Medicaid” at www.cato.org/pub_display.php?pub_id=4761

⁴ Personal comments by Andrew Dick, RAND Corporation and Peter L. Perreiah, Pittsburgh Regional Healthcare Initiative. Other members of our Expert Panel may wish to comment as well.

- *Limit the number of visits to physicians and other health care providers to 18 per year.*

This would have an impact on some important subsets of enrollees. For example, many foster care kids in the State of New York have more than 18 visits. In fact, some have over 50 visits per year. Consider also the case of a substance abuser who suffers from depression, diabetes and hypertension. Depending on the stage of rehabilitation, the substance abuse condition may consume all of the 18 allotted visits. Failing to manage the diabetes with regular visits could cause his blood sugar to go out of control, which could result in long term damage, including blindness and amputation. Similarly, the long term risks of not managing the hypertension could result in a stroke
- Provide a \$5,000 *maximum per year* for medical equipment such as wheelchairs and oxygen tanks.

For a disabled patient who needs both a wheelchair and a continuous oxygen supply, the combined costs of the purchases would easily exceed \$5,000 per year.
- *Limit drug coverage to six prescriptions per month.*

Drug needs for a patient with multiple chronic diseases would easily exceed six prescriptions per month. For example, a patient might need four different drugs to manage congestive heart failure, one for diabetes and two for hypertension.
- *Raise the co-pay for brand-name drugs to \$3 from \$1.*

There is evidence that the existence of any co-payments reduces demand. However, increasing co-payments from \$1 to \$3 probably wouldn't decrease demand by very much.
- *Place additional limits and higher co-pays for General Assistance Medicaid recipients.*

These enrollees are the poorest and neediest and there is significant evidence that Medicaid insurance can make a difference in health outcomes. For example, mammogram rates are much higher among the very poor (those covered by Medicaid) than the near poor who are uninsured. Mammogram tests identify early stage breast cancer and in turn significantly reduce mortality and costs.

- *Charge parents of mentally or physically disabled children whose income is 200% above the federal poverty level (approximately \$40,000 for a family of four) a monthly premium, based on a sliding scale.* This has worked pretty well in SCHIP (State Children's Health Insurance Program). In some states there's no upper income limit to quality, but you have to pay a full premium after some limit. While there is only limited buy-in by the higher income groups (because most are privately insured), it is used. There's little evidence that sliding premiums have caused any real harm. The question is, of course, how high do you set the full premium.

Options for lowering the costs of Medicaid-covered long-term care

We are interested in your opinions on the proposed budget cuts and savings listed above. In what follows, we have also included a discussion about costs relating to Medicaid coverage of long-term care.

Currently, Medicaid does not cover long-term medical care for a person until that person's resources fall below a certain level. People who have more resources—income and assets—must pay for their own long-term care until they have “spent down” their assets to the level the state designates. At that point Medicaid will begin paying for their long-term care.

A person's home, or “primary residence,” does *not* have to be sold in order to cover his or her long-term care expenses. Instead, the Medicaid program attempts to recover the cost of care *after* the person's death. The state Medicaid agency claims *the portion of the person's estate* that it has expended on his or her care.

Sometimes, when people realize they may soon need long-term care, they try to “hide” their assets in an effort to get Medicaid to cover their care before they have spent their own assets on it. In such cases, people may transfer their assets to their children, or to trusts or annuities.



Medicaid does not allow this. Before, or sometimes after, the state Medicaid agency has begun to cover a person's long-term care, it reviews, or “looks back” at, that person's assets for the three years prior to the Medicaid application (five years if trusts are involved). *If assets are found to have been transferred during that 3 to 5 year period before the application for Medicaid benefits*, Medicaid will refuse to cover care, or, if the person has already begun to receive Medicaid benefits, Medicaid will stop paying for long-term care. In addition, the person will be required to pay Medicaid back for the money it has already spent. This payment is called the “penalty,” and it is worked out by imposing a “penalty period” during which Medicaid will not pay for the person's care.

The penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. For example, if the monthly private pay rate is \$5,000, and the person in question transferred \$50,000, the penalty period would be 10 months.

Currently, the penalty period begins on the date that the assets were transferred. Using this start date means that Medicaid applicants and beneficiaries may get to keep some of their assets, because they may have entered long-term care *after* the transfer date. In the example above, if the person who transferred \$50,000 entered long-term care 4 months after transferring the funds, she would end up paying only 6 of 10 possible months, and would pay only \$30,000 instead of the full amount.

Voice 1: We should make it harder for people to shift their financial responsibilities onto Medicaid

In order to reduce the costs of Medicaid-covered long-term care, we need to make the look-back period and penalty rules more strict. The system still rewards people for hiding their assets: by having the penalty period begin when the funds are transferred, the program allows people to hold on to some of the assets they'd hidden. Medicaid would recover more money and discourage transfers better if it moved the beginning of the penalty period to the date that such people *apply for Medicaid* long-term care. This change would mean that these people would have to spend *all* the money they transferred. The only exceptions would be for transfers made to spouses or to dependent or disabled children.

In addition, the look-back period should be increased from 3 to 5 years for *all* transfers. Making this change will make it harder for people to “plan ahead” to have Medicaid cover their expenses.

In sum, we should make it harder for people to shift their financial responsibilities onto Medicaid, and we should be tougher on people who do so.

Voice 2: We should encourage people to prepare for long-term care

There is a problem with imposing stiffer penalties on people who have transferred their assets: those assets may have been spent by the time Medicaid discovers the transfer. Children may have spent money transferred to them, or investments may have gone bad. If a penalty is imposed, and the transferred funds have decreased or disappeared, the person in question may, out of necessity, go without care. The states do have “hardship provisions” to help anyone who falls into this category, but there isn't much data on the impact of penalties or on how the hardship provision option is working.

Instead of imposing stricter penalties for people who transfer assets, Medicaid agencies should decrease costs by finding ways to recover the costs of care while beneficiaries are actually receiving that care. This would avoid the “pay and chase” drill of trying to recover funds after beneficiaries die. Individuals would be responsible up-front for their health care costs.

One possibility would be to use “reverse mortgage” loans on peoples' homes. Such loans are available to allow seniors (aged 62 or older) to convert home equity into cash. For this option to work, seniors would have to be relieved of the up-front costs of applying for such loans.

Another alternative to stiffer penalties is to encourage people to purchase long-term care insurance. Currently four states operate partnerships that provide incentives for people to purchase such insurance. People sign up for programs like this to save for their children's college tuition, and if offered similar incentives, they would be likely to do so for their long-term care. Medicaid comes out ahead because it starts paying only after all the long-term insurance has been used up.

Programs like this, which focus on making people responsible for their long-term care up front, are better than those that focus on penalties.

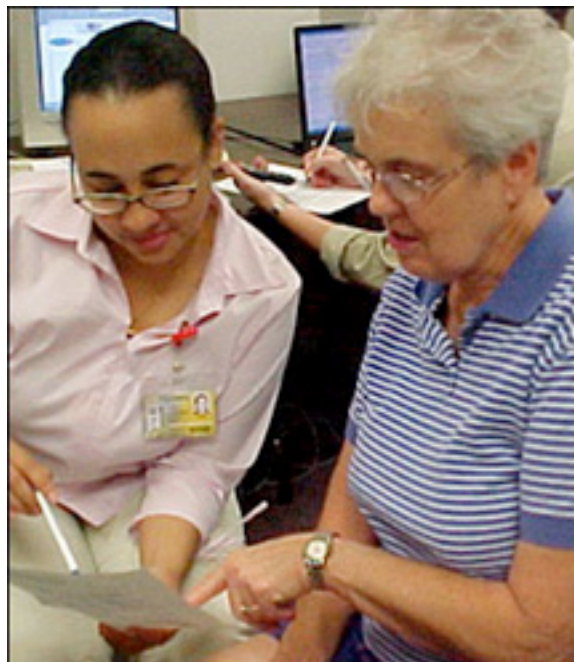
TOPIC 2. A LOCAL INITIATIVE: A COMMITMENT TO QUALITY OF CARE AND COST REDUCTION⁵

Southwestern Pennsylvania is a known leader in healthcare research and treatment advances. The region is also a known leader in determining how the quality of care affects the cost of care. The Pittsburgh Regional Healthcare Initiative, founded by the Jewish Healthcare Foundation, has inaugurated a plan to *reduce* in-hospital infection rates and, in so doing, *improve* the quality of care across a whole range of activities. We need to discuss this initiative and assess its potential to impact the national debate on healthcare and healthcare costs.

Eight states, including Pennsylvania, are now requiring hospitals to track the number of patients who acquire infections while hospitalized. Under a state law enacted last year, the Pennsylvania Health Care Cost Containment Council issued a first-in-the-nation report in July about the incidence of these hospital-acquired infections. According to that report, 11,668 patients contracted infections while hospitalized in 2004, which resulted in 1,800 deaths.

When all Pennsylvania hospitals eventually report in compliance with state law, the totals will be in the range of 50,000 to 100,000 hospital-acquired infections per year in our state, \$3 billion to \$5 billion in costs for private and public payers and 7,500 to 15,000 associated patient deaths. Nationally, hospital-acquired infections add more than 6.7 billion dollars in medical costs.

A significant number of the infections stem from unsanitary conditions and medical equipment used in caring for the patient. The Patient Safety and Quality Improvement Act of 2005 encourages healthcare providers to log and report all medical errors to specific patient safety groups. The data is kept anonymous and the reports may not be used against the hospitals in malpractice suits. The data may, however, be used to monitor the standard of care.



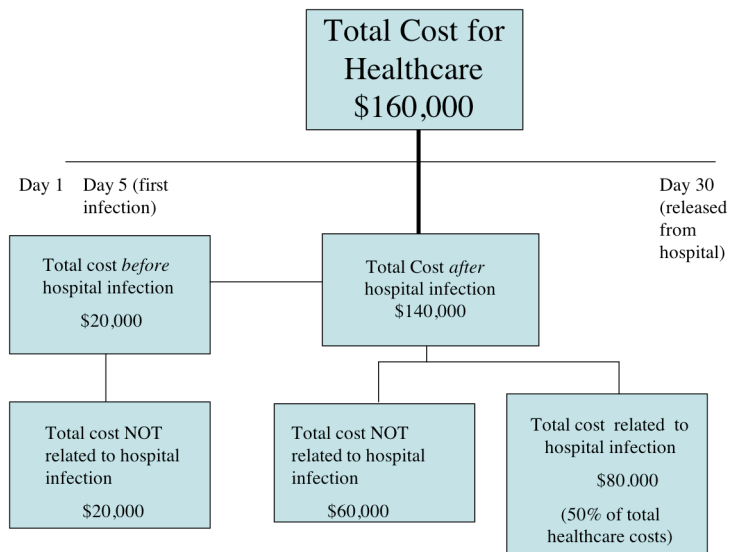
In the Pittsburgh area an innovative model of healthcare, derived from the principles of the Toyota Production System, has been used by local hospitals to dramatically lessen infection rates. The adaptation of these principles to healthcare, created by the Pittsburgh Regional

⁵ See “Quality Pays for Itself: Cost-quality Factors in Healthcare Nationally, and in Southwestern Pennsylvania” (Pittsburgh Regional Healthcare Initiative, 2004).

Healthcare Initiative (PRHI), is called the Perfecting Patient Care System. This improvement method helps healthcare workers to standardize workflow and reduce waste and error by applying a disciplined, detailed approach to solving problems quickly, one by one, in the course of daily healthcare work. Perfecting Patient Care advocates that all healthcare workers be coached in how to reduce ambiguity and improve processes in the daily treatment of patients. By attending to all the details and personnel involved in something as basic as inserting and monitoring a line to deliver medications and fluids, hospitals can greatly reduce eliminate what are called “Central Line-Associated Bloodstream Infections” (CLABs).

Streamlining the delivery of care is not as trivial as it might seem, especially since studies have shown that there can be as many as 100 or more steps involved for a patient just to get a newly ordered medication. Given this level of activity, the possibility of patients contracting a central line infection becomes 1 out of 28.

The chart shows the connection between *increasing* the *quality* of care and the simultaneous *reduction* in the *costs* of care.⁶ It is based on a hypothetical case of a patient entering a hospital with a serious but not fatal health condition. The chart outlines the costs of this patient’s care without “Central Line-Associated Bloodstream Infection” (CLAB) and the costs with the treatment of those infections included.



The following hypothetical case study shows how proponents of the Perfecting Patient Care System view the process of addressing the problems of hospital infections.

Mr. Smith, a 68-year-old man, was admitted with respiratory failure. He received a breathing tube. To be sure he was receiving appropriate antibiotics and fluids, the healthcare team threaded a tiny catheter into a major blood vessel in his right, inner thigh. This catheter is also known as a femoral line. Five days later, Mr. Smith began running a fever. His blood pressure dropped. Samples from the tip of the femoral line, along with Mr. Smith's blood, were sent to the lab to be analyzed. Those samples grew gram negative rods (*E. Coli*, an organism commonly found in and around the lower digestive tract). The femoral line was removed and notification went out immediately to the attending physician, the family, and the requisite reporting authority.

⁶ This hypothetical model is based upon a micro-economic analysis, a business case methodology that has been developed and applied by the Department of Medicine at Allegheny General Hospital. It explores the relationship between error and waste.

Within an hour, the physician was at Mr. Smith's bedside to examine him and survey the entire situation. She determined that the infection occurred because the femoral line had been left in longer than the recommended 24 hours. She ordered the appropriate antibiotics for Mr. Smith, who recovered.

As soon as the cause of Mr. Smith's infection was determined, the physician began working with the nurses to devise a sticker system, so that when a femoral line is placed, it is sure to be removed within the appropriate time frame.

Looking at prior data, they also discovered that femoral lines were being inserted often, when other types of lines might be just as effective and less prone to infection. At the next medical Grand Rounds, the issue was discussed with the entire hospital staff. In time, the hospital implemented new, more effective methods of training young physicians in proper line placement, and nurses in line maintenance.

In the 6 months since the sticker system and Grand Rounds discussion, no patient on that unit has contracted a bloodstream infection caused by a femoral line.

Given the possibility that these methods can reduce costs anywhere from 10–60 percent (where some cases are closer to the 10–15 percent range and others can approach 70 percent), what should our policy be with regard to how hospitals report their instances of hospital related infections?

Options to Discuss

The role of reporting in decreasing infection rates and costs

Voice 1⁷: Reporting of infection rates by hospitals should be confidential

Reporting should be used for learning, not for punishment. The temptation is to get hospitals to report, so that insurers will punish them or pay them less or whatever. Yet using reporting to punish only drives errors underground.

Take, for instance, the airline industry. They have a neutral agency, NASA, that collects reports of errors and near-misses from pilots in exchange for a one-time-only "pass" from punishment, should the FAA discover the error. (Excluded are obviously criminal or really bad violations.) If these voluntary reports were to be made public—say, some reporter discovered that more Delta pilots than USAir pilots were reporting, and believed that this meant Delta was a "worse" airline—you can see how misinterpretations would only STOP error reporting. The purpose of reporting is to LEARN.

Voice 2⁸: Reporting of infection rates by hospital should be made public

Despite the law requiring them to do so, more than 90 percent of Pennsylvania hospitals failed to report fully for 2004. And among the noncompliant hospitals, a handful continue to boycott and report no hospital-acquired infections at all.

As any effective problem-solver will vouch, acknowledging the scope of the crisis is the first, essential step. Until hospitals acknowledge the scope of the patient safety crisis, preventable patient injuries and deaths will continue apace, as will the lapses in hand-washing and other low-tech, everyday mistakes that cause most of these infections.

Resistant healthcare providers won't deal with this with any real urgency until Pennsylvania's biggest healthcare purchasers—including, most of all, state government—take stronger action. ... This is one area in which decisive action by our state government can make a huge (and rapid) difference.

Gov. Ed Rendell ought to speak publicly, loudly and unequivocally about the threat to public health and the need for all hospitals to act immediately to prevent infections. Furthermore, the secretary of health should notify every hospital that noncompliance with the state's infection reporting law will put their state operating licenses at risk.

⁷ From the Pittsburgh Regional Healthcare Initiative.

⁸ An edited version of *Stop The Bleeding: Pennsylvania Must Crack Down On Facilities Not Reporting Hospital-Acquired Infections*. Cliff Shannon. Pittsburgh Post-Gazette. Pittsburgh, PA: Oct 4, 2005.

LOCAL AND REGIONAL HEALTHCARE QUESTIONS FOR DISCUSSION

What do you see as the primary issues facing the State Medicaid program?

Discuss what you see as the impact of the following Medicaid cuts that the State Senate may consider in the next budget year:

Limit hospital admissions to two per year and one per year for rehabilitation services

Limit the number of visits to physicians and other health care providers to 18 per year.

Provide a \$5,000 maximum per year for medical equipment such as wheelchairs and oxygen tanks.

Limit drug coverage to six prescriptions per month.

Raise the co-pay for brand-name drugs to \$3 from \$1.

Place additional limits and higher co-pays for General Assistance Medicaid recipients.

What are the best ways for government to deal with families who want to protect their income and assets and whose parents are elderly are potentially in need of nursing home care?

How do you think the reporting of hospital infections should be handled?

How can the residents of this region effectively become a part of the policy discussion involving healthcare issues?

What kind of constructive comment would you wish to make to our state senators as they deliberative over the State Budget and these proposed cuts to Medicaid?

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Medical assistance in Pennsylvania: A 600-pound gorilla in the State budget

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Pennsylvania's future demographics: Warning signs for policymakers

<http://www.issuespa.net/articles/14391>

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