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Chairman Miller and members of the Senate Democratic Policy Committee, thank you for the opportunity to be here today and to share my perspective as a nurse, a long-term and post-acute care provider, and a proud Pennsylvanian on the Medicaid funding challenges facing our sector—and the people we serve.

My name is Michael Smith. I'm a registered nurse and live in Center Valley. My adult children both went to college in Philadelphia—my son is now a Licensed Nursing Home Administrator, and my daughter is a registered nurse. I serve as the Regional President of Marquis Health Consulting Services.

I'm honored to be here representing our organization and to be part of this panel alongside:

- Rhea Goodwin, Eden East Healthcare Management.
- Mary Kay McMahon of Fellowship Community.
- Garry Pezzano of LeadingAge PA.
- Louise Santee of Phoebe Allentown & SEIU.
- Michael Jacobs of the Pennsylvania Health Care Association (PHCA).

Mike Jacobs from PHCA did an expert job outlining the issues facing our sector regarding rates, funding, and the Budget Adjustment Factor (BAF). I want to add to and expand on that as a clinician and provider.

Marquis Health Consulting Services is a member of PHCA, and I serve on its board alongside my colleague, Joseph DeMattos.

We came into Pennsylvania in 2011, starting with one facility in Philadelphia. Today, we support 27 campuses across the state, providing post-acute care, long-term care, assisted living, and independent living.

Marquis Health Consulting Services supports over 112 campuses across eight states, including facilities like Cedar Crest Post Acute and Riverton Rehabilitation and Healthcare Center. When we compare Pennsylvania to neighboring states, it is clear we are falling behind. Our reimbursement rates are lower than those of every bordering state.

Across the Pennsylvania campuses and facilities, we provide about 1.1 million days of care each year. More than 500,000 of those days are for Medicaid patients.

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That's a big part of what we do—serving as a safety net for people who don't have other options. Without us, many of these individuals would end up in hospitals, which is far more expensive and not the right setting for their needs.

We also employ over 4,200 people here in Pennsylvania.

When I talk about numbers like "days of care" or "staffing," I don't really think in numbers; I think about people.

People taking care of people. That's what this work is. Our job is to help people recover or live with dignity at their highest clinical level when they need long-term care. Most of that long-term care is paid for by Medicaid.

Medicaid has always been the lowest payer in healthcare. The idea used to be that Medicare and private pay would make up the difference. That's just not true anymore.
There are three primary reasons for that.

First, Medicare doesn't pay the way it used to. Stays are shorter, rates are tighter, and more patients are in Medicare Advantage plans, which often pay less and come with more hurdles.
Second, there's a misunderstanding about private pay. It's not a big part of our business. Most of the people we care for rely on Medicare and Medicaid.

Third, Medicaid rates in Pennsylvania haven't kept up with the cost of care—or with what other states are paying. And even when rates are adjusted, the Budget Adjustment Factor, or BAF, limits what providers receive, despite what they are spending to provide quality care, as confirmed by state audited cost reports.

The simplest way to think about the BAF is this: it's like putting a governor on a car. Even if you need to go 60, it won't let you go past 45.

For a state government, such as Pennsylvania or the other four states that use the BAF in their Medicaid rate systems, it is an effective tool for ratcheting down and containing reimbursement, just as a governor would keep a car at a lower speed.

For providers of long-term care, spending resources to provide quality care, our largest expenses are wages and benefits. The BAF forces us to provide that care at places like Cedar Crest Post Acute and Riverton Rehabilitation and Healthcare Center, with one hand tied behind our backs. We routinely incur expenses of $80-100 above the daily PA-paid Medicaid rate to care for a person in one of our centers.

I am here today to sound the alarm that we are at an inflection point, one that could lead to a crisis in our healthcare system.

Specifically:

First, we cannot be assured that quality care will be consistently delivered in Pennsylvania's skilled nursing facilities if the Budget Adjustment Factor (BAF) is not increased. Let's remember that the government put the BAF in place as a temporary measure in 2005.

Second, given the increased demand for healthcare workers across all settings, the specialized nature of the care we provide, and the growing needs of an aging population, we continue to face significant workforce challenges.

Despite increasing wages and benefits, we are struggling to recruit and retain staff, especially registered nurses. At centers like Cedar Crest Post Acute and Riverton Rehabilitation and Healthcare Center, these challenges are not theoretical (they are real) and are daily operational pressures.

Third, we are part of the solution. Skilled nursing facilities in Pennsylvania play a critical role in delivering high-quality chronic and long-term care while also helping to bend the overall healthcare cost curve. Our setting is focused, and our model is more efficient than higher-cost settings such as hospitals and emergency departments.

Right now, the BAF is lower than 0.80. For those of us providing care, that means we are being reimbursed at approximately 20 percent below the actual cost of caring for our residents if the system were fully funded.

At the same time, expectations continue to rise. We are expected to offer higher wages to recruit and retain staff, improve quality outcomes, and care for residents with increasingly complex medical needs.

If this trajectory continues, providers who are committed to doing this the right way (those focused on quality and resident-centered care) will be forced to make difficult decisions. Some may determine they can no longer sustain operations in Pennsylvania.

Fortunately, we are not yet at that point. But we must act now. We must partner today to build a better tomorrow, one where both quality care and good-paying healthcare jobs are preserved in communities across the Commonwealth.

Finally, I would like to briefly highlight three of the specialty healthcare programs we are proud to offer:

The Journeys Memory Care Model. A rigorous, evidence-based approach that includes specialized standards for the physical environment, caregiver training, life enrichment programming tailored to each stage of memory loss, and enhanced dining experiences—all designed to improve quality of life for residents with cognitive impairment.

The OrthoWIN Care Model. A comprehensive post-acute orthopedic recovery program featuring physiatry-led care, coordinated pain management, and targeted rehabilitation. This model is especially effective for patients recovering from surgery or injury, helping restore mobility, function, and independence.

The Chronic Illness Support Model. Designed for individuals living with complex chronic conditions, this program delivers coordinated, holistic care that supports both physical and emotional well-being, improving outcomes and enhancing quality of life.

Thank you again for the opportunity to testify. I welcome your questions.

Respectfully Submitted:

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