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February 7, 2011

MEMORANDUM

TO: Honorable Ryan I. Yamane, Chair
House Committee on Health

Honorable John M. Mizuno, Chair
House Committee on Human Services

FROM: Patricia McManaman, Interim Director

SUBJECT: **H.B. 595– RELATING TO HEALTH**

Hearing: Monday, February 7, 2011, 10:15 a.m.
Conference Room 329, State Capitol

PURPOSE: The purposes of this bill are to 1) change the way that hospitals are reimbursed for Medicaid waitlist long-term care patients to the acute payment rate, and 2) reimburse facilities with long -term care beds for patients with medically complex conditions who had received acute care services in an acute care hospital in a prior stay, at the subacute care rate.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill as it would result in a significant increase in State expenditures.

In addition, State law currently requires that there be no distinction between hospital-based and non-hospital based Medicaid reimbursement rates for institutionalized long-term care. These reimbursements are equitably based on the level of care provided pursuant to section 346D-1.5, HRS.

In FY 2008, there were 17,000 waitlisted days which would have meant an extra $10,000,000 per year in payments to hospitals. The number of waitlisted days and estimated costs for FY 2009 are currently being calculated and will be transmitted to the Committee when finalized. DHS already provides hospitals with more than $20,000,000 in supplement payments per year.

This increased payment to hospitals does not include the cost of effectively rebasing long-term care facility rates. Using the definition of "medically complex condition" for paying the subacute rate means that any patient with a chronic illness taking medications would qualify for the subacute rate. This is essentially everyone in a nursing facility and would cost additional tens of millions. The difference between the average nursing facility rate ($234.62) and average subacute rate ($536.96) is an additional $302.34 per day.

Paying inpatient acute care rates to a patient not requiring, by definition, acute level care, because he or she is awaiting discharge, would be paying for services not needed nor provided.

DHS believes the problem of long-term care patients occupying acute care beds will not be solved by this measure. The Department has already moved to address the waitlist problem through its QUEST Expanded Access (QExA) managed care program that started on February 1, 2009. Waitlisted patients will now have access to a service coordinator as well as increased access to expanded home and community based services. DHS also continues the Going Home Plus program which increases reimbursement to care for complex clients in the community. The future of long-term care is the expansion of home and community based services.

Thank you for the opportunity to provide this testimony.

THE QUEEN'S MEDICAL CENTER

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Rep. John Mizuno, Chair
Rep. Jo Jordan, Jr., Vice Chair
COMMITTEE ON HUMAN SERVICES

Rep. Ryan I. Yamane, Chair
Rep. Dee Morikawa , Vice Chair
COMMITTEE ON HEALTH

February 7, 2011 – 10:15 a.m.
State Capitol, Conference Room 329

In Strong Support of HB 595, Relating to Health

Chairs Mizuno and Yamane, Vice Chairs Jordan and Morikawa and Members of the Committees,

My name is Christina Donkervoet, Director of Care Coordination and Patient Flow at The Queen's Medical Center (QMC), testifying in strong support of HB 595, which adjusts the Medicaid reimbursement rates for waitlisted patients remaining in hospitals and develops sub-acute rates for complex patients being cared for in long-term care facilities.

We have testified on this bill in previous years, and again submit testimony in strong support. QMC continues to be greatly impacted by the limited community resources available to serve people in need of long-term care. There are many patients who remain at Queen's well beyond their acute inpatient medical stay, but who are unable to be discharged because the necessary community resources are not available. Prolonged stays at an acute care facility after the patient no longer needs hospitalization can result in a less than optimal quality of life for the patient and creates a serious financial drain on the hospital. The Medicaid reimbursement for these patients is at a rate that is twenty to thirty per cent of the actual cost of acute care hospitalization. The total loss to Hawaii hospitals in 2008 was estimated at over $72 million.

Our Emergency Department, the busiest in the State, is sometimes forced to go on divert status because we simply do not have the bed capacity to admit patients needing hospitalization. We are often unable to accept patient transfers from hospitals across the state and the Pacific due to patients remaining in hospital beds waiting for long-term care services. This inability to admit acutely ill patients impacts not only QMC, but the health care system state-wide.

QMC understands the challenges of coordinating services between hospitals and long-term care facilities and will continue to work with state agencies and community facilities and programs to ensure access to quality care at the appropriate level for our patients. Thank you for the opportunity to support HB 595.

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Government Relations

Testimony of
Phyllis Dendle
Director, Government Relations

Before:
House Committee on Human Services
The Honorable John M. Mizuno, Chair
The Honorable Jo Jordan, Vice Chair

House Committee on Health
The Honorable Ryan I. Yamane, Chair
The Honorable Dee Morikawa, Vice Chair

February 7, 2011
10:15 am
Conference Room 329

HB 595 RELATING TO HEALTH

Chair Mizuno, Chair Yamane and committee members, thank you for this opportunity to provide testimony on HB 595 that establishes reimbursement guidelines and provides appropriations for Medicaid to hospitals and facilities with long term care beds.

Kaiser Permanente Hawaii supports this bill.

It has been estimated that Hawaii hospitals lost over $73 million in 2008 due to delays in discharging patients waitlisted for long term care. There were on average 200 patients waitlisted daily in acute care hospitals statewide awaiting placement to long term care beds. Duration of these delays ranged from days or weeks, to months and sometimes years.

Because Medicaid reimburses acute care hospitals at a rate based upon the level of care needed by the patient, when a patient is well enough to be transferred to long term care, Medicaid payments to the hospital are reduced to a fraction of the actual cost of care in the hospital acute care setting. This results in an unfair financial burden on the hospitals, who must continue to provide care at a much higher cost to patients who remain waitlisted in acute care hospital beds due to the unavailability of long term care beds.

Kaiser Foundation Hospital's finances are negatively impacted by this waitlist situation, just as are all the other acute care hospitals in the State. Accordingly, Kaiser Permanente Hawaii strongly supports this bill to provide compensation that would fairly cover the costs of care for Medicaid patients waitlisted in acute care hospital settings while transfer to long term care is sought, by providing Medicaid reimbursements at the acute medical services payment rate.

Thank you for the opportunity to comment.

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HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON HUMAN SERVICES
Rep. John M. Mizuno, Chair

HOUSE COMMITTEE ON HEALTH
Rep. Ryan Yamane, Chair

Conference Room 329
Feb. 7, 2011 at 10:15 a.m.

Supporting HB 595.

The Healthcare Association of Hawaii advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. Thank you for this opportunity to testify in support of HB 595, which requires Medicaid to pay hospitals at the rate for acute care services for patients who are waitlisted for long term care. The bill also requires Medicaid to pay long term care facilities at at least the rate for subacute care services for patients with medically complex conditions who were waitlisted in hospitals.

On any given day there are an average of 150 patients in Hawaii's hospitals who have been treated so that they are well enough to be transferred to long term care, but who are waitlisted because long term care is not available. Waitlisting is undesirable because it represents an inappropriate quality of care for the patient and creates a serious financial drain on hospitals. Waitlisted patients also unnecessarily occupy hospital beds that could otherwise be used by those who need acute care. Patients may be waitlisted for a matter of days, weeks, or months, and in some cases over a year.

The waitlist dilemma is unique to Hawaii, largely because Hawaii has one of the lowest ratios of long term care beds for its population in the United States. Whereas the US average is 47 long term care beds per 1000 people over age 65, Hawaii averages 23 (half of the US average). The shortage of long term care beds is the result of high costs of construction and operation, along with low payments for services.

The Healthcare Association has advocated for solutions to the waitlist problem since 2007, when it sponsored SCR 198, which directed the Association to study the problem and propose solutions. The Association subsequently created a task force for that purpose, which studied the problem, wrote a report, and submitted it to the Legislature. However, the Legislature has not yet taken action on it.

Since then the Association has advocated for measures that have been designed to:

(1) Promote the movement of waitlisted patients out of acute care;

(2) Reduce unpaid costs incurred by hospitals and free up hospital resources so that they can be used to treat those who need that high level of care; and

(3) Enable long term care facilities to accept waitlisted Medicaid patients with complex medical conditions while addressing the additional costs related to their care.

Hospitals continue to lose money because of waitlisted patients. A report issued by Ernst & Young in late 2009 reported that Medicaid pays for only 20% to 30% of the actual costs of care for waitlisted patients, representing uncompensated hospital costs of approximately $72.5 million in 2008. Long term care facilities can provide appropriate care to waitlisted patients, but payments should be set at levels that at least cover the costs of care.

Thank you for this opportunity to testify in support of HB 595.

HAWAII DISABILITY RIGHTS CENTER

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THE HOUSE OF REPRESENTATIVES
THE TWENTY-SIIXTH LEGISLATURE
REGULAR SESSION OF 2011

Committee on Human Services
Committee on Health
Testimony in Support of H .B. 595
Relating to Health

Monday, February 7, 2011, 10:15 A.M.
Conference Room 329

Chair Yamane and Members of the Committee:

I am Louis Erteschik, Staff Attorney at the Hawaii Disability Rights Center, and am testifying in support of this bill.

The purpose of the bill is to adequately compensate hospitals under Medicaid rates for the fact that they are housing individuals who are waitlisted for long term care placements and whose level of care status has changed from acute to long term.

We support this bill because it offers potential to assist individuals awaiting placement in community settings. The legislature has seen many examples in the past few years of the long waitlist for community housing experienced by patients in acute facilities. In addition, a few years ago, briefings were provided by the Healthcare Association on the problems of placing "challenging" patients into community settings.

Regarding the payment to hospitals of long term care based reimbursement rates, we are certainly sympathetic to the economic plight faced by the hospitals who are not receiving adequate reimbursement for these patients who really do not need to even be in the hospital after a point. They are often torn between the financial realties they face and the general ethic they do possess which directs them to want to treat and care for these individuals. Any assistance the legislature can render will not only help these facilities; it will also make it more likely that these patients will continue to receive adequate care while they are developing an appropriate community placement

discharge plan. It will alleviate the pressure hospitals may feel to attempt a premature, potentially inappropriate discharge.

Thank you for the opportunity to testify in support of this measure