HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON HEALTH
Rep. Josh Green, M.D., Chair

HOUSE COMMITTEE ON HUMAN SERVICES & HOUSING
Rep. Maile Shimabukuro, Chair

Conference Room 329
February 20, 2008 at 9:00 a.m.

Testimony in support of HR 51 / HCR 53.

I am Coral Andrews, Vice President of the Healthcare Association of Hawaii, which represents the entire spectrum of health care, including acute care hospitals, two-thirds of the long term care beds in Hawaii, as well as home care and hospice providers. Thank you for this opportunity to testify in support of HR 51 and HCR 53, which request the Healthcare Association of Hawaii to continue its efforts to develop solutions to the problem of patients in hospitals who are waitlisted for long term care.

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 beds per 1000 people over age 65, Hawaii averages 23 (half of the US average).

On any given day there are 200, and as many as 275, patients in hospitals who have been treated so they are well enough to be transferred to long term care, but who are waitlisted because long term care is not available. Waitlisted patients are defined as "Patients who are deemed medically ready for discharge and no longer in need of acute care services but who cannot be discharged (due to various barriers) and therefore must remain in the higher cost hospital setting."

Discharge timeframes for waitlisted patients range from days to over a year. This represents a poor quality of life option for the patient, presents an often insurmountable dilemma for providers and patients, and creates a serious financial drain on acute care hospitals with ripple effects felt throughout other healthcare service sectors.

Recognizing the waitlist problem, in 2007 the Legislature adopted SCR 198, which requested the Healthcare Association of Hawaii (HAH) to study the problem and propose solutions. HAH subsequently created a task force for that purpose.

The task force has had a number of meetings, and at the request of the task force HAH has contracted with a consultant to gather information. The task force has identified the following four barrier areas that contribute to the waitlisted patient dilemma: (1) Reimbursement; (2) Capacity; (3) Regulatory/Government; and (4) Workforce. The task force has determined that solving the waitlist problem will require actions in all four of the barrier areas, and that focusing on only one area of need will not create a sustainable solution.

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At this time the task force has developed specific recommendations for legislation. The recommended legislation, contained in House and Senate bills, would adjust Medicaid payments to improve the flow of patients from acute hospitals to long term care facilities. The recommended legislation would also establish a Medicaid presumptive eligibility process that is designed to reduce the period of time for determining whether a waitlisted patient qualifies for Medicaid.

The December 2007 Waitlist Task Force Report identified additional areas of need that are not addressed in the proposed legislation this year. Data collection efforts have been completed but the data needs to be analyzed. Going forward, some solutions can be enabled through public-private partnerships. Others may require legislation in 2009.

The task force looks forward to continuing to meet to complete data analysis, to recommend further legislation in the 2009 legislative session, and, where possible, to strengthen public-private partnerships to solve quadrant issues. Your support of this measure acknowledges the need to continue our efforts on this important issue.

For the foregoing reasons, the Healthcare Association supports HR 51 and HCR 53.