Waitlist Task Force Informational Briefing

2008 Legislature

Senate Health Committee

January 28, 2008

Senate Concurrent Resolution 198

Requested that the Healthcare Association of Hawaii study the waitlisted patient problem and provide a report to the 2008 Legislature.

Healthcare Association of Hawaii Board Guidance

- Establish a 9 member task force (1 acute care CEO, 1 LTC Administrator, 1 acute care CFO, and 6 members-at-large).
- Study the waitlisted patient problem and complete a report to the Legislature as requested in SCR 198.
- Develop short term solutions to provide immediate relief to the waitlist problem.
- Develop long term solutions that will reduce the waitlist problem.

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Definition of Waitlisted Patients

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.

Developed by the Waitlist Task Force (September 2007)

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Charting Our Progress

- The waitlist task force has met 11 times.
- Discussions have moved from problem identification to problem resolution.
- Data from acute and long term care providers has been collected by Ernst and Young and Hawaii Health Information Corporation (HHIC).
- Data analysis is presently underway and will be ongoing throughout 2008.

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Problem Identification Summary

The factors that contribute to the waitlisted patient problem can be categorized into four areas:

- Reimbursement
- Capacity
- Government/Regulatory
- Workforce

Medicaid Reimbursement

- Acute rate of reimbursement drops when patient is waitlisted; doesn't cover the cost of care.
- Long term care rate of reimbursement doesn't cover the cost of care and needs to be revised to account for additional levels or tiers of reimbursement.
- Seek Legislative support of fair payment to providers.

CFO Waitlist Sub-Committee

- **To assist the Waitlist Task Force, a Sub-Committee of the HAH CFO Roundtable was established to refine the estimate of waitlisted patient losses and develop a recommendation for fair waitlisted patient reimbursement to hospitals.**
- **Using HHIC waitlisted patient specific data, losses incurred by hospitals to care for waitlisted patients was $60 million in fiscal 2007, of which $15 million was for Medicaid and Quest patients.**
- **The current reimbursement for Medicaid and Quest waitlisted patients covers approximately 20% to 30% of cost.**

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CFO Waitlist Sub-Committee

- **The Sub-Committee concluded since waitlisted patients are cared for within an acute care setting, the cost of routine care for waitlisted and acute care patients are essentially the same.**
- **The Sub-Committee recommends per diem reimbursement for waitlisted patients be set equal to acute care patients.**
- **No change to the current acute reimbursement methodology is needed. Ancillary services are already reimbursed separately, which differentiates the level of care provided to an acute care patient.**
- **Based on fiscal 2007 data, the impact of the above recommendation would be to increase state-wide reimbursement by $6 million, which covers approximately 60% of cost.**

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Long Term Care Reimbursement (Medicaid)

- The additional costs of delivering care to medically complex patients (waitlisted patients) in LTC are not captured in the acuity based reimbursement system.
- Cost based reimbursement for the additional costs of care would create incentives for LTC providers to admit waitlisted patients.
- Current Medicaid rates for LTC should be utilized as the reimbursement floor for QUEST Expanded.

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Capacity

- There is insufficient capacity (institutional and home/community based) to meet the needs of the waitlisted patients.
- Community outreach has begun to raise awareness about this need and to reduce opposition to growth. Public-private partnership is needed to continue the outreach effort.

Government/Regulatory

- Collaborate with Legislature and DHS to expedite the Medicaid eligibility/re-eligibility application process.
- Collaborate with CMS partners to fill Medicare coverage gaps for patients with complex needs.
- Collaborate with State surveyors to overcome barriers that contribute to the waitlisted patient population.

Workforce

- Workforce shortages exist in all health care settings (acute, long term care, home/community based).
- Health care settings compete for the same workforce and the variations in union/non-union wages contribute to this disparity.
- The waitlisted patient population requires care providers who are trained in the post-acute level of care.

The Unfolding of The Perfect Storm

- The waitlisted patient problem is a "symptom" of The Perfect Storm.
- This is a problem that is unique to Hawaii.

Designing a System-Wide Solution to the Waitlist Problem

- Increase Medicaid reimbursements at all levels of care
- Facilitate targeted growth in the post-acute care market
- Enact Medicaid Presumptive eligibility criteria for aged & disabled consumers
- Utilize electronic discharge referral systems
- Support initiatives that enable growth in the healthcare workforce
- Build cooperation and trust across healthcare delivery systems

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Next Steps

- Pursue legislation that pertains to Medicaid reimbursements and Presumptive Eligibility.
- Task force requests to continue its work in 2008.
- Educate the public about the significance of this issue via community outreach briefings.
- Report to Health Committees in 2009 with further proposed solutions.

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Senate Health Informational Briefing
Hawaii's Waitlist Issue

January 28, 2008

Jennifer Diesman

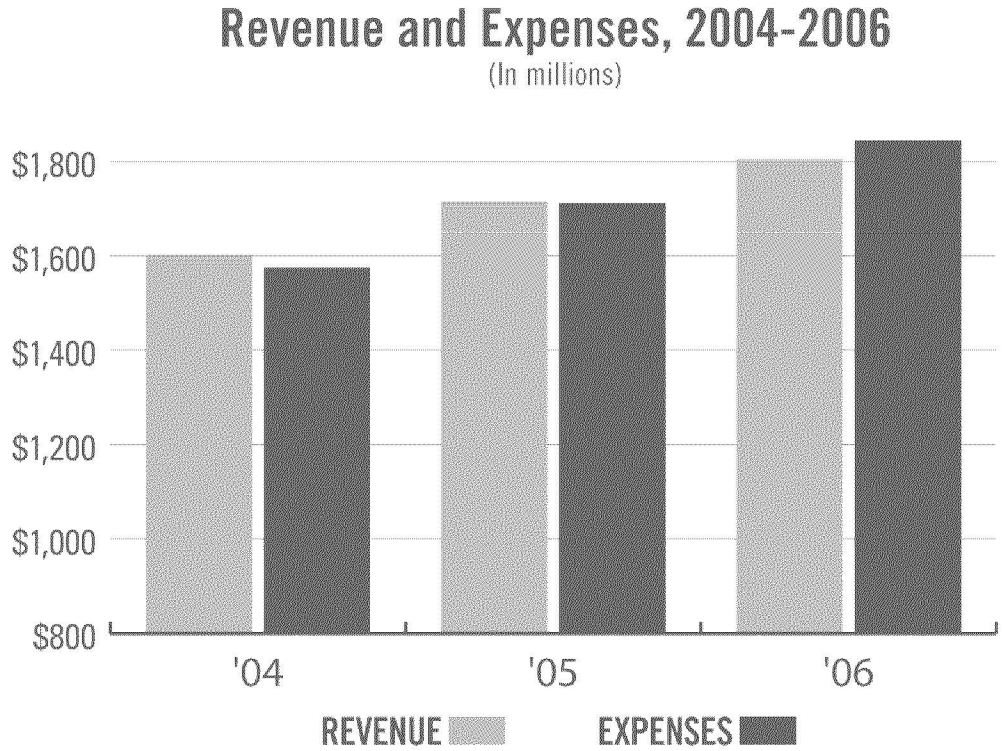
Director, HMSA Government Relations

Overview

- HMSA's Financial Picture
- How HMSA Pays Facilities
  - DRG and HQSR
- HMSA Facility Utilization
- HMSA and Statewide Trends

HMSA's Revenue and Expenses for 2006

In 2006, HMSA applied 93.4 percent of dues to member benefits such as payments for physicians, hospitals and prescription drugs and 8.8 percent was incurred for our operating expenses resulting in a 2.2 percent net operating loss.



HMSA
Blue Cross Blue Shield of Hawaii
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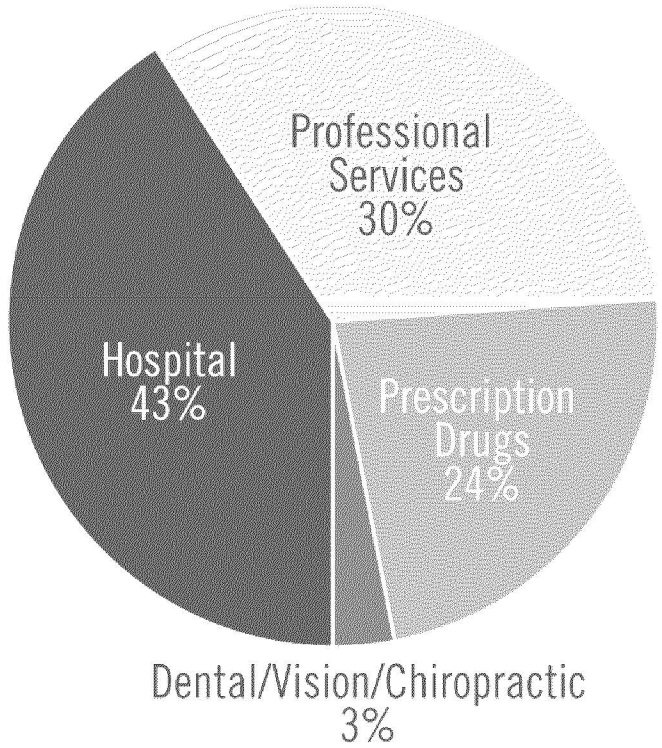
HMSA's Benefit Distribution for 2006



Through our private business and QUEST operations $1.6 billion in benefits were paid in 2006.

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HMSA QUEST Benefit Distribution

HMSA's total QUEST Benefit Payment in 2006 = $155,633,537

This amount can be further analyzed by benefit coverage:

HMSA QUEST Professional Services	$57,468,621
HMSA QUEST Hospital Services	$65,948,219
HMSA QUEST Prescription Drugs	$32,216,697

Hospitals are Paid According to DRGs

- Diagnosis Related Group (DRG) is a system used to classify hospital cases into one of approximately 500 groups expected to have similar hospital resource use.
- Currently most hospitals in Hawaii are paid using DRGs which provide a finance and patient classification system using diagnosis, type of treatment, age and other related factors as screening criteria.

Top Benefit Reimbursements Paid to Acute Care Facilities by Diagnosis (2006)

1. Circulatory Disease (heart attacks, strokes)
2. Cancers (benign and malignant)
3. Injury and Poisoning
4. Diseases and Disorders of the Digestive System
5. Diseases and Disorders of the Respiratory System
5. Pregnancy, Childbirth and Associated Complications
6. Diseases and Disorders of the Musculoskeletal System and Connective Tissue

Hawaii's Hospitals Receive Additional Compensation for Providing Quality Care

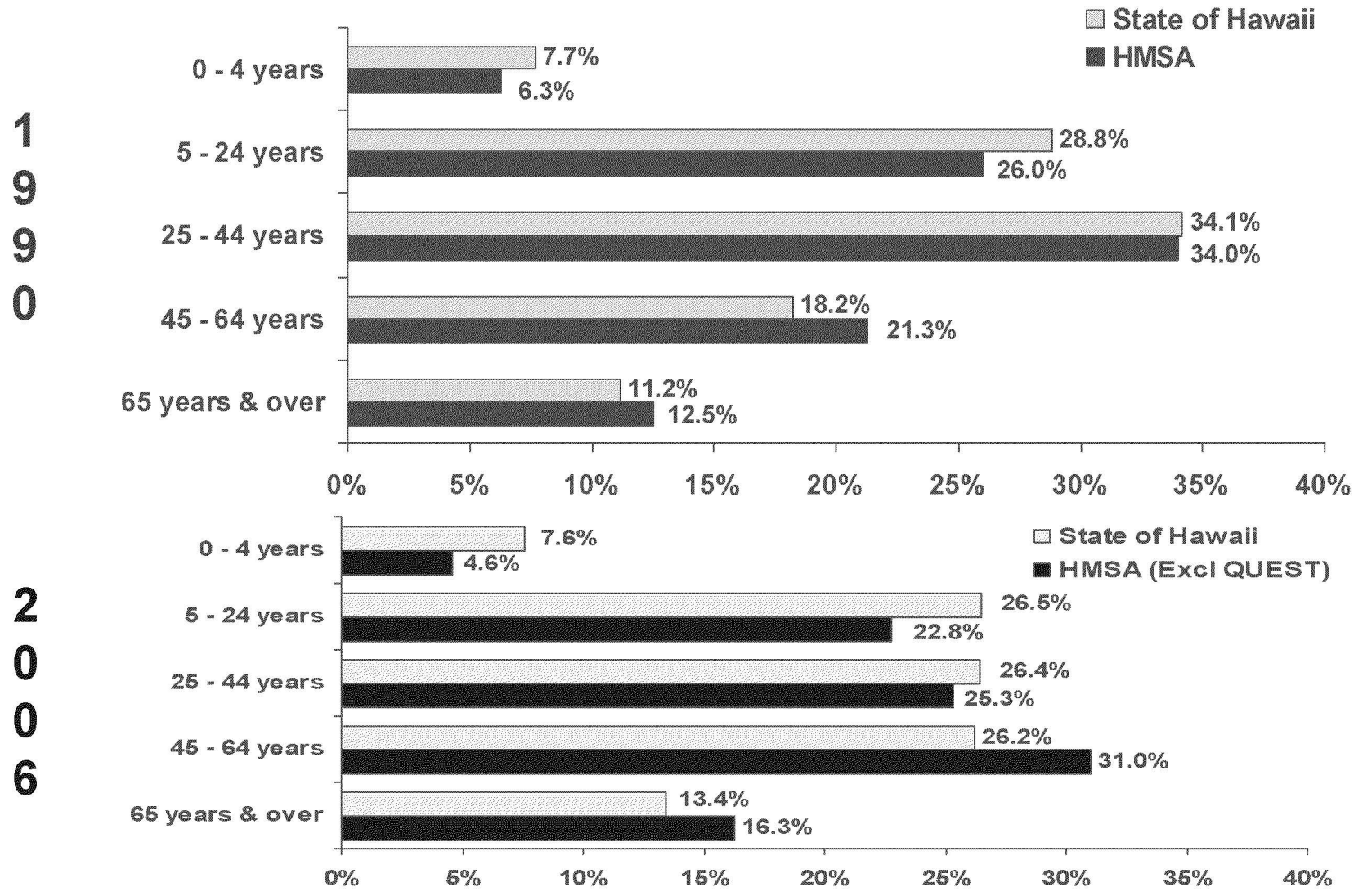
- HMSA's pay-for-performance program for Hawai'i hospitals, the Hospital Quality and Service Recognition (HQSR) program, recognizes participating hospitals for delivering efficient, quality care that focuses on patient safety and patient and physician satisfaction.
- HMSA's HQSR program has been in place for seven years, and hospitals have received more than $40 million for meeting program measures.

HQSR Payments

In 2007, 17 participating hospitals were paid a total of more than $6 million in awards, compared to more than $2 million in 2001.

Year	HQSR Award Total	Number of Facilities
2001	$2,384,833	13
2002	$3,745,655	17
2003	$7,725,854	17
2004	$7,538,652	17
2005	$6,468,686	17
2006	$6,137,727	17
2007	$6,102,573	17

HMSA's Population is Aging Faster than the State's Population



HMSA Data on Hospital Admissions

HMSA Trend Study Report
PPO, HMO and 65C Plus plans (QUEST and QUESTNET not included)

	Admissions per 1,000 Members				
Type of Admission	**2002**	**2003**	**2004**	**2005**	**2006**
Facility Inpatient - Acute	82.99	84.97	85.11	83.51	85.03
Facility Inpatient - SNF	3.04	3.24	3.61	3.51	5.16
Total	**86.04**	**88.21**	**88.72**	**87.03**	**90.19**

The ratio of acute admissions to SNF admissions for HMSA members in 2006 is seventeen to one. This equals approximately 52,000 acute care admissions for HMSA members.

For one of the large hospital systems in the state, on an annual basis, services for HMSA members only make up approximately 18 percent of their total volume.

Statewide Data on Long Term Care

- According to HHIC, Hawai'i's long-term care admission rate increased from 25.1 per 1,000 population aged 65 and older in 1990 to 44.1 per 1,000 population for the same group in 2003.
- Statewide, average length of stay figures for long-term care show a steady decline from 1994, when both average length of stay (368.6 days) and occupancy rates (97.8 percent) were at their highest.
- In 2002, occupancy rates averaged around 93 percent statewide remaining higher than the state's target occupancy of 90 percent.

Conclusions

- As Hawaii's population continues to "gray" the community will be increasingly challenged to meet additional health care demands.
- HMSA will continue to be an active stakeholder in community discussions to ensure our members have access to quality, affordable health care.