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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 28, 2008

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 3258, S.D. 3, H.D.1 - RELATING TO MEDICAID HOSPTIAL AND LONG TERM CARE REIMBURSEMENTS**
Hearing: Friday; March 28, 2008 3:15 p.m.
Conference Room 308, State Capitol

PURPOSE: The purpose of this bill is to establish reimbursement guidelines and provides appropriations for Medicaid hospital and long term care reimbursements.

DEPARTMENT'S POSITION: The Department of Human Services is opposed to this bill for the following reasons.

1) This bill undermines the progress that has been made to achieve equitable reimbursements based on acuity of care, rather than the facility where the care is provided, for nursing home level of care at hospitals and non-hospital based long-term care facilities that was mandated by Act 294, SLH 1998, and codified as chapter 346D-1.5, Hawaii Revised Statutes (HRS). The Department does not support the reversal of Act 294 as this bill proposes to do.

> "**§346D-1.5 Medicaid reimbursement equity.** Not later than July 1, 2008, there shall be no distinction between hospital-based and nonhospital-based reimbursement rates for institutionalized long-term care under medicaid. Reimbursement for institutionalized intermediate care facilities and institutionalized skilled nursing facilities shall be based solely on the level of care rather than the location. This section shall not apply to critical access hospitals."

2) The Department also strongly objects to paying acute care rates to hospitals for patients who are certified long-term care. What this bill proposes is inconsistent with the

methodology currently used to establish these rates pursuant to Act 294. There is clear distinction in the level of routine care between acute services and long-term care services. The difference in these rates is meant to account for this distinction in level of care. The routine acute rate is meant to reimburse for services, equipment usage and supplies that are not necessary as part of the care of a waitlisted or long-term care client. It is not appropriate for an acute care facility to be reimbursed an acute rate for services it did not provide.

Utilizing the Healthcare Association of Hawaii (HAH) conservative number of 200 waitlisted patients on any given day, the Department calculates that it will cost an additional $6,722,444 to reimburse the hospitals the acute care rate that this bill would require.

3) An acute care facility that is reimbursed the acute care rate for a waitlisted patient does not have the same level of urgency to assist in transitioning that waitlisted patient to the appropriate facility. This could cause a waitlisted patient's length of stay at an acute care facility to be extended, thus increasing the length of time the patient would suffer from, as this bill indicates, "a diminished quality of life" from being institutionalized in a hospital.

4) This bill proposes to provide cost reimbursements to non-hospital based long-term care facilities for services provided to patients with "medically complex" conditions who, prior to admission to the long-term care facility, were receiving acute care services in an acute care hospital. "Medically complex condition" is defined as "a combination of chronic physical conditions, illnesses, or other medically related factors that significantly impact an individual's health and manner of living and cause reliance upon technological, pharmacological, and other therapeutic interventions to sustain life."

The Department contends that this definition is overly broad and can be applied to any person evaluated as requiring nursing facility level of care. The Department has conservatively estimated that 30% of the individuals will be deemed "medically complex" at an additional cost of $23,390,594 per year.

A sub-acute level of care reimbursement rate methodology is already in place at a number of Hawaii's long-term care facilities. This rate is meant to reimburse for the services provided to those patients who may fall into the bill's definition of "medically complex." Any patients who do not meet this level of care are accounted for in the computation of the acuity based rate of each long-term care facility. This sub-acute rate of $400 to $600 per day is already significantly higher than the average long-term care rate of $215 per day.

5) As authorized by this bill, reimbursement would be based on the "actual costs" of services to the "medically complex". Cost-based reimbursement is only applied as a reimbursement strategy in Hawaii when specifically indicated as a requirement to receive Federal financial participation from the Centers for Medicare & Medicaid Services (CMS). This has become the typical practice of the vast majority of Medicaid programs around the country. The trend away from cost-based reimbursement was, among other purposes, intended to encourage providers to be increasingly cost-conscious and avoid inflationary business practices.

The Department would strongly advise against expanding any cost-based reimbursement strategy beyond Federal mandate.

6) The Department also submits that this bill's proposal is unnecessary with respect to the long-term care facilities receiving Medicaid payments that are at least equal to the rates in effect immediately prior to the implementation of QUEST Expanded Access (QExA) program which is slated for implementation on November 1, 2008. QExA already addresses reimbursement rates for nursing facilities in Hawaii. In the contract language for the QExA health plans, the following is described for reimbursement for nursing facilities:

> "The health plan shall reimburse nursing facilities utilizing an acuity-based system in accordance with HRS § 346-D-1.5. The health plan shall reimburse nursing facilities the rates as of July 1, 2008 in accordance with HRS § 346-D-1.5. HRS § 346-D-1.5 is Act 294 which was enacted into law in the 1998 Legislative session."

This is a verbatim quote from RFP-MQD-2008-006 Amendment #4 - #60.

Thank you for this opportunity to testify.

HAWAII DISABILITY RIGHTS CENTER

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TESTIMONY TO THE TWENTY-FOURTH STATE LEGISLATURE, 2008 SESSION

To: House Committee on Finance:

From: Gary L. Smith, President
Hawaii Disability Rights Center

Re: Senate Bill 3258 , SD 3, HD1

Hearing: Friday, March 28, 2008 3:15 PM
Conference Room 308, State Capitol

Members of the Committee on Finance:

Thank you for the opportunity to provide testimony supporting Senate Bill 3258, SD 3, HD1.

I am Gary L. Smith, President of the Hawaii Disability Rights Center, formerly known as the Protection and Advocacy Agency of Hawaii (P&A). As you may know, we are the agency mandated by federal law and designated by Executive Order to protect and advocate for the human, civil and legal rights of Hawaii's estimated 180,000 people with disabilities.

We support this bill because it offers good potential to secure the placement of individuals in community settings. The legislature has seen many examples in the past year or two of the long waitlist for community housing experienced by patients in acute facilities. In addition, a briefing was provided earlier in the session by the Healthcare Association on the problems of placing "challenging" patients into community settings. One of the barriers identified has been the low cost of Medicaid reimbursement for these individuals. At the same time, Medicaid payments are made to facilities far in excess of what might otherwise be paid to these home and community based settings. Providing the Department of Human Services with the ability to pay for patient care in a long term care facility based on the actual cost as opposed to an artificially low Medicaid payment schedule should greatly help to facilitate the community placement of such individuals. We need to accept the fact that until the rates for community placements are realistic in terms of the demands required for the care of the more medically complex patients, this problem will never be solved.

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.

Thank you for the opportunity to provide testimony in support of this bill.

TO : HOUSE COMMITTEE ON FINANCE
Representative Marcus Oshiro, Chair
Representative Marilyn Lee, Vice Chair

FROM: Eldon L. Wegner, Ph.D.,
PABEA (Policy Advisory Board for Elder Affairs)

SUBJECT: **SB 3258 SD3, HD1 Relating to Medicaid and Long-Term Care Reimbursements**

HEARING: 3:15pm Friday, March 28, 2008
Conference Room 308, Hawaii State Capitol

PURPOSE: Establishes reimbursement guidelines and provides appropriations for Medicaid and long-term care reimbursements.

POSITION: **PABEA STRONGLY SUPPORTS SB 3258 SD3 HD1.**

RATIONALE:

I am offering testimony on behalf of PABEA, the Policy Advisory Board for Elder Affairs, which is an appointed board tasked with advising the Executive Office on Aging (EOA). My testimony does not represent the views of the EOA but of the Board

- $ Inadequate reimbursements, especially from Medicaid, have serious negative impacts on the availability of a range of long-term care services and further impact the financial viability and access to hospital services for the entire population in Hawaii;

- $ The proposed legislation is intended to provide a solution to the wait-listing of medically complex long-term care patients in our acute care hospitals and also to provide an incentive for the expansion of appropriate long-term care settings for such patients.

- $ Past circumstances enabled the cost-shifting of expenses for Medicaid patients to other payers, but the changes in Medicare reimbursement and in private insurance reimbursement practices have no longer made this a viable adaptation to inadequate Medicaid reimbursements. We need to be realistic and pay the actual cost of care.

In conclusion, we believe the proposed changes in reimbursement are badly needed and will have positive benefits for the health care of the entire population. We strongly urge your passage of this bill.

Hawaii Pacific Health

55 Merchant Street • Honolulu, Hawaii 96813 • hawaiipacifichealth.org

[2 Copies]

Friday, March 28, 2008 – 3:15pm
Conference Room 308
Agenda #2

The House Committee on Finance

To: The Honorable Marcus Oshiro, Chair
The Honorable Marilyn B. Lee, Vice-Chair

From: Virginia Pressler, MD, MBA
Executive Vice President

Re: Testimony in Strong Support of SB 3258 SD3 HD1 - Relating to Medicaid Hospital and Long Term Care Reimbursements

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Dear Honorable Committee Chairs and Members:

My name is Virginia Pressler, Executive Vice President for Hawaii Pacific Health (HPH). For more than a century, families in Hawaii and the Pacific Region have relied on the hospitals, clinics, physicians and staff of Hawaii Pacific Health as trusted healthcare providers. Our non-profit integrated healthcare system is the state's largest healthcare provider and is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through its four hospitals -- Kapi`olani Medical Center for Women & Children, Kapiolani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital -- 18 outpatient centers and a team of 1,100 physicians on the islands of Oahu, Kauai and Lanai.

Hawaii Pacific Health is writing in **strong support of SB 3258 SD3 HD1** which takes steps to solve the hospital waitlist problem by increasing certain Medicaid payments to hospitals and long term care facilities. On any given day there are as many as 275 patients in hospitals across Hawaii who have been treated and are now waiting to be transferred to a long term care facility but who must remain "waitlisted" in a hospital because long term care is not available. 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.

SB 3258 SD3 HD1 would adjust Medicaid payments to improve the flow of patients from acute hospitals to long term care facilities. Payments to long term care facilities would be increased for patients with medically complex conditions that require increased care, as current payments do not cover the actual costs of care. In addition, payments to hospitals for waitlisted patients, although still not covering costs, would be increased so that payments are closer to 60% rather than 20% of the actual costs of care incurred by hospitals. We ask that you pass **SB 3258 SD3 HD1**. Thank you for your time regarding this measure.

HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
March 28, 2008 at 3:15 p.m. (Agenda #2)

Testimony in support of SB 3258 SD 3 HD 1.

I am Rich Meiers, President and CEO 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 strong support of SB 3258 SD 3 HD 1, which takes steps to solve the hospital waitlist problem by increasing certain Medicaid payments to hospitals and long term care facilities.

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.

This bill seeks to accomplish three key objectives to overcome barriers that the waitlist task force has identified as contributing factors to the waitlist problem. The objectives are:

1. To stabilize acute care losses associated with caring for waitlisted patients by maintaining the acute care per diem payment at the acute care services rate while patients are waitlisted in acute care licensed beds. The basis for this request is that

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the cost of routine care (nursing care, medical records and dictation services, laundry, etc.) for waitlisted patients is essentially the same as the cost of routine care for patients across all licensed acute care beds.

2. To stimulate the flow of patients from acute to long term care by recognizing that complex medical waitlisted patients have unique care requirements that are not "captured" or compensated for utilizing the existing level of care assessment tool (1147). Our recommendations are based on the Oregon model.

3. To maintain existing care capacity in acute care hospitals and long term care nursing facilities by mandating a reimbursement floor (no less than the current rate of reimbursement) when QUEST-Expanded is implemented. The QUEST Expanded RFP does not include provisions that protect the reimbursement floor and the waitlist task force is very concerned that the potential to negotiate rates downward will further jeopardize our state's ability to meet the current demand for long term care capacity. The waitlisted patient dilemma is a reflection of unmet demand for long term care capacity, among other things.

The legislation recommended by the task force represents a critical first step that must be taken to solve the waitlist problem.

The bill should be amended by inserting an appropriation of $6.5 million, changing the effective date to July 1, 2008, and deleting the sunset.

With those amendments the Healthcare Association strongly supports SB 3258 SD 3 HD 1.

March 28, 2008

To: Chair Marcus Oshiro
Members of the House Committee on Finance
From: Bob Ogawa, President
Hawaii Long Term Care Association
Re: S.B. 3258, SD3, HD1 - Relating to Medicaid Hospital and Long Term Care Reimbursements

The Hawaii Long Term Care Association (HLTCA) supports S.B. 3258, SD3, HD1 as an essential step toward addressing Hawaii's current hospital waitlist problem.

The HLTCA fully understands, sympathizes with and wishes to find a remedy for the financial "bleeding" waitlisted patients cause our hospitals. Enhanced reimbursement would certainly serve to mitigate that situation.

At the same time, in order to work toward a broader solution, we must find ways to encourage ***targeted*** expansion and development in the long term care provider community specifically aimed at ministering to the medically-complex needs of waitlisted patients. Appropriate reimbursement for the much-more-costly care of these individuals is an important beginning.

We must recognize, however, that dealing with the waitlist problem from the "big-picture" perspective requires a multi-faceted strategy, which also includes such elements as greater waitlist patient information transfer efficiency and transparency, capital cost assistance and critical initiatives in workforce development. Every aspect is vital and interdependent upon every other.

This measure represents a significant cornerstone in our starting to lay the foundation we require, and we urge its passage. Thank you.

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THE QUEEN'S MEDICAL CENTER

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House Committee on Finance
Representative Marcus Oshiro, Chair
Representative Marilyn Lee, Vice Chair

Friday, March 28; 3:15 p.m.
State Capitol, Conference Room 308

RE: SB 3258 SD 3 HD 1- Relating to Medicaid Hospital and Long Term Care Reimbursements

Chair Oshiro, Vice Chair Lee, and Members of the Committee:

The Queen's Medical Center submits written testimony in strong support of this measure.

The Medical Center continues to be greatly impacted by the limited community resources available to serve people in need of community-based care. At times this month, there have been 60 waitlisted patients in the hospital occupying an acute care bed and thereby limiting our ability to respond to our communities needs. The trend line that is attached (See Attachment 1) to your testimony has continued to go up, leading to less availability of acute care hospital beds and additional financial losses for the hospital.

As indicated in the bill, the payment currently received for these patients is only 20-30% of the actual cost. In FY 2007, Queen's experienced a financial loss of approximately $16.3 million due to uninsured/under insured waitlisted patients, with more than $4 million of that loss involving Medicaid patients. Given the waitlisted numbers experienced thus far in 2008, we expect that the financial loss will be even greater this fiscal year. This type of financial shortfall, at Queen's and other hospitals, significantly weakens our health care system as a whole.

The Medical Center agrees with the findings and recommendations outlined in the Healthcare Association of Hawaii (HAH) Waitlist Task Force report provided in accordance with Senate Concurrent Resolution No. 198 (2007), which provides that people on the waitlist often have a less-than-optimal quality of life, and their general health may be negatively impacted by a prolonged stay in an acute care hospital. When we treat these non-acute patients in the acute hospital bed, we are less able to respond to our community's needs for acute care services. Too often it happens that QMC goes on emergency room divert because we simply do not have the bed capacity to admit patients needing hospitalization. This inability to admit acutely ill patients impacts the health care system statewide, as we often serve as a higher level of care, transfer center for many of the hospitals in the state and throughout the Pacific.

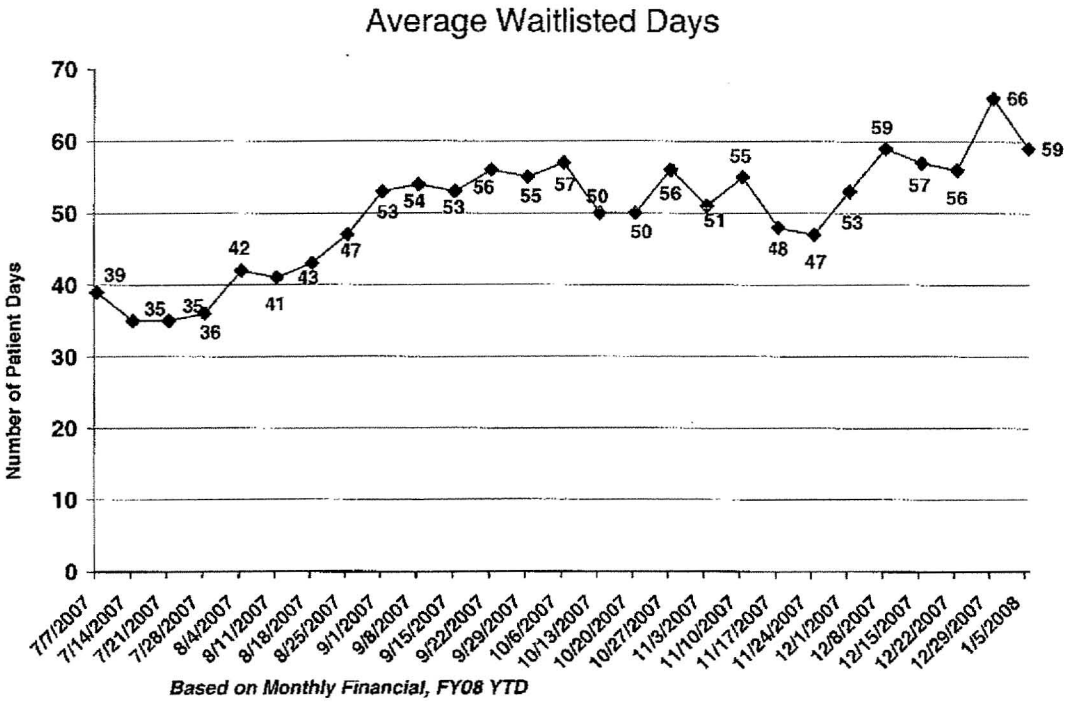
We respectfully request that you support the adjustment of reimbursement rates for patients in acute care hospitals waiting community services or placement. We recognize that the challenges presented to our state are complex and require multiple actions. The action requested in this bill is but one that will help assure sustainable quality health care while we build more community options for our aging population. Your favorable review is appreciated.

Thank you for the opportunity to submit testimony.

Respectfully,

Christina M. Donkervoet, RN, MS
Director, Care Coordination & Patient Flow
The Queens Medical Center

Attachment 1: SCR 198
QMC Waitlisted Patients Data
July 2007 – January 2008



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Government Affairs

Testimony of
Frank P. Richardson
Executive Director of Government Relations

Before:
House Committee on Finance
The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

March 28, 2008
3:15 PM
Conference Room 308

SB 3258, SD3 HD1 RELATING TO MEDICAID HOSPITAL AND LONG TERM CARE REIMBURSEMENTS

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on SB3258, SD3 HD1 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 between $90Million - $110Million last year due to delays in discharging patients waitlisted for long term care. According to a report to the legislature by the Healthcare Association of Hawaii in January of this year, there were on average 200, and sometimes as many as 275, 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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