TO : SENATE COMMITTEE ON WAYS AND MEANS
Senator Rosalyn H. Baker, Chair
Senator Shan S. Tsutsui., Vice Chair

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

SUBJECT: **SB 3258 SD 2 Relating to Medicaid and Long-Term Care Reimbursements**

HEARING: 10:30 am Monday, February 25, 2008
Conference Room 211, Hawaii State Capitol

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

POSITION: **PABEA STRONGLY SUPPORTS SB 3258 SD2.**

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 availibility of a range of long-term care services and further impact the financial viabilitiy 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 inadquate 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 DISABILITY RIGHTS CENTER

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TESTIMONY TO THE TWENTY-FOURTH STATE LEGISLATURE, 2008 SESSION

To: Senate Committee on Ways and Means

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

Re: Senate Bill 3258 , SD 2

Hearing: Monday, February 25,2008 10:30 AM
Conference Room 211, State Capitol

Members of the Committee on Ways and Means:

Thank you for the opportunity to provide testimony supporting Senate Bill 3258, SD 2.

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 recently provided 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.

HAH
Healthcare Association
of Hawaii

SENATE COMMITTEE ON WAYS AND MEANS
Senator Rosalyn Baker, Chair

Conference Room 211
February 25, 2008 at 10:30 a.m.

Testimony in support of SB 3258 SD 2 (with amendments).

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 submit written testimony in strong support of SB 3258 SD 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.

SB 3258 SD 2 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 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.

At this time we would like to suggest several amendments to SB 3258 SD 2.
1. The first amendment sets the $6.5 million, which is now appropriated as the increased reimbursements only to hospitals, as the total appropriation for increased reimbursements for hospitals and long term care facilities.
2. The second amendment is designed to ensure that the increased reimbursements will continue after the implementation of Quest Expanded.
3. Technical, non-substantive amendments are also suggested. The amendments are contained in an attachment to this testimony.

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

With the suggested amendments Healthcare Association strongly supports SB 3258 SD 2.

PROPOSED AMENDMENTS TO SB 3258 SD 2

(1) Page 7, line 17 should be amended to read:

reimbursements to hospitals for patients OCCUPYING ACUTE-LICENSED BEDS who are waitlisted for

(2) Page 7, lines 20-22 should be amended to read:

(b) Medicaid reimbursements to ~~long term care facilities~~ FACILITIES WITH LONG TERM CARE BEDS for patients with medically complex conditions who, prior to admission to the ~~long term care~~ facility were receiving acute

(3) Page 8, line 9 should be amended to read:

(c) Reimbursements received by ~~long term care facilities~~ HOSPITALS AND FACILITIES WITH LONG TERM CARE BEDS

(4) The entire Section 2 of the bill should be added to Chapter 346, HRS.

(5) Page 8, lines 16-18 should be amended to read:

Increased Medicaid reimbursements to hospitals ~~for patients who are waitlisted for long term care, that are equivalent to the acute medical services payment rate.~~ AND LONG TERM CARE FACILITIES.

(6) Section 4 of the bill should be amended by deleting its substance and replacing it with language indicating the effect of Ramseyering, as follows:

SECTION 4. New statutory material is underscored.

February 25, 2008

To: Chair Rosalyn Baker
Members of the Senate Committee Ways & Means
From: Bob Ogawa, President
Hawaii Long Term Care Association
Re: S.B. 3258, SD2
Relating to Medicaid Hospital and Long Term Care Reimbursements

The Hawaii Long Term Care Association (HLTCA) supports S.B. 3258, SD2 as a preliminary step toward addressing Hawaii's current hospital waitlist problem.

However, we have asked the Healthcare Association of Hawaii (HAH) -- and they have agreed -- to propose the following amendment to their bill:

Page 7, line 17 -- Insert "occupying acute licensed beds," so that Section 2 (a) would read: Medicaid reimbursements to hospitals for patients occupying acute licensed beds who are waitlisted for long term care shall be equal to the acute medical services payment rate.

The Chair, as a key partner in the passage of the historic Medicaid Reimbursement Equity Act of 1998 (Act 294) is well-aware of its wording and premise:

". . . there shall be no distinction between hospital-based and nonhospital-based reimbursement rates for institutionalized long term care under medicaid. Reimbursement for institutionalized intermediate facilities and institutionalized skilled nursing facilities shall be based solely on the level of care rather than the location."

While the HLTCA fully understands, sympathizes with and wishes to find a remedy for the financial "bleeding" waitlisted patients cause our hospitals, we must be cautious of the possibility that the acute-bed reimbursement proposed in this measure does not become some foot-in-the-door erosion of the fundamental philosophy of Act 294.

We understand that such is not the intent of this bill, but we wish to fully ensure that this provision will apply only to patients in acute-licensed beds and cannot be construed to include patients in any hospital's "distinct part" long term care unit.

That said, however, we must move forward and begin to explore all avenues open to us in resolving the waitlist problem. This measure is a good beginning, and we urge its passage.

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THE QUEEN'S MEDICAL CENTER

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Senator Rosalyn H. Baker, Chair
Senator Shan S. Tsutsui, Vice Chair
Senate Committee on Ways and Means

Monday, February 25; 10:30 a.m.
State Capitol, Conference Room 211

RE: S.B. 3258, S.D. 2 - Relating to Medicaid Hospital and Long Term Care Reimbursements

Chair Baker, Vice Chair Tsutsui, and Members of the Committee:

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

The Medical Center is greatly impacted by the limited community resources available to serve people in need of community-based care. We agree 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. In December of 2007, for example, we reached a high for the year, with 66 patients awaiting placement (see Attachment 1). 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 support the language in this bill that requires reimbursement rates for waitlisted patients to be at the level of the acute care bed rate. Since these patients reside in the acute hospital bed while waiting for community placement, the cost of patient care remains the same and the loss of the inpatient capacity continues. 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.

We respectfully request that you support the adjustment of reimbursement rates for waitlisted patients that remain in acute care hospitals to ease some of the burden that is placed on our health care facilities due to the limitations in our community services. The fragility of the health care system across the state requires your prompt attention. The longer it takes for action, the more our system is weakened, and the greater the impact to the overall quality of life of our patients.

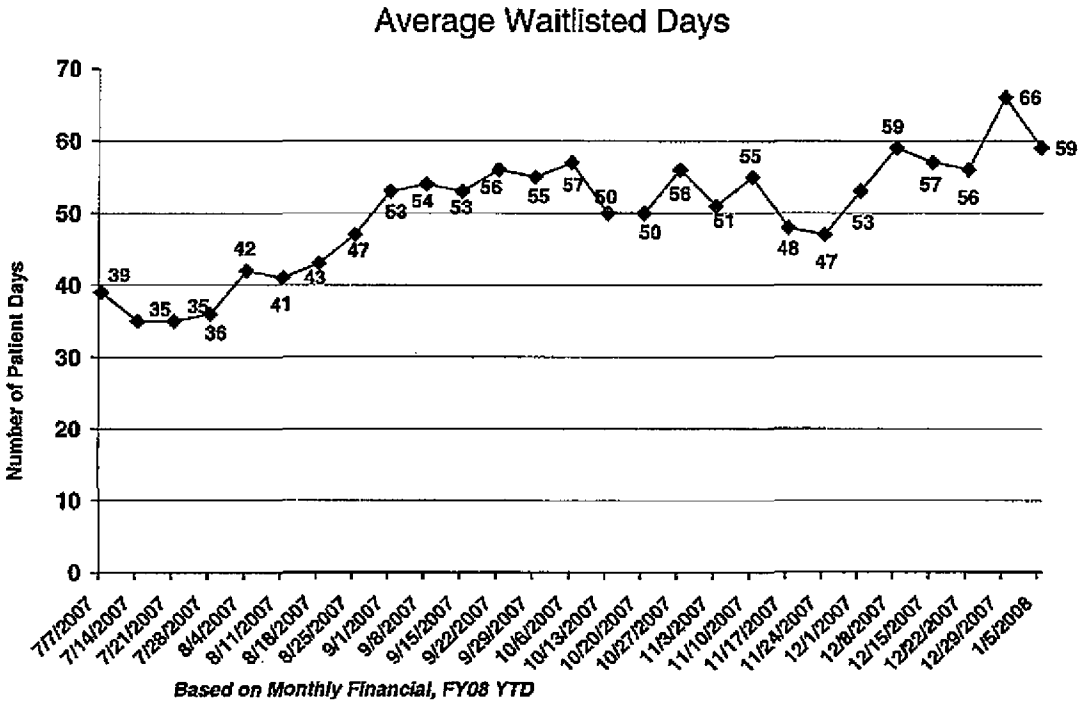
We recognize that the challenges presented to our state are complex and require multiple actions. The action requested in this bill is but one that will help assure sustainable quality health care while we build more community options for our aging population. Your favorable review is appreciated.

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



LINDA LINGLE
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LILLIAN B. KOLLER
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

February 25, 2008

MEMORANDUM

TO: Honorable Rosalyn H. Baker, Chair
Senate Committee on Ways and Means

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 3258, S.D.2 - RELATING TO MEDICAID HOSPTIAL AND LONG TERM CARE REIMBURSEMENTS**
Hearing: Monday; February 25, 2008 10:30 a.m.
Conference Room 211, 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) The Department strongly objects to paying acute care rates to hospitals for patients waitlisted for bed space at a non-hospital based long-term care facility.

This bill is contrary to the methodology currently used to establish these rates. 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 beneficiary. It is not appropriate for an acute care facility to be reimbursed an acute rate for services it did not provide.

This rate difference would put non-hospital long-term care facilities at a distinct disadvantage for reimbursement of similar services. This inequity could provide incentive for long-term care facilities to demand the same acute care rate an acute care facility would receive for nursing facility level of care services causing an unnecessary

and unintended escalation of reimbursement at an extraordinary financial burden to the State.

This bill also undermines the progress that has been made to achieve equitable reimbursements based on acuity of care for nursing home level of care at hospitals and non-hospital based long-term care facilities. This equitable reimbursement was mandated by Act 294, SLH 1998, which was codified as chapter 346D-1.5, Hawaii Revised Statutes. The Department does not support the reversal of Act 294 inherent in H.B. 2170, H.D. 1.

"§346-1.5 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."

The lack of distinguishable reimbursement between acute care and waitlisted rates would also put those facilities that are not experiencing full occupancy at a distinct disadvantage for reimbursement of dissimilar services. Those facilities that are not in the position to "turn away" an acute care patient would be receiving the same reimbursement for providing more services to an acute patient than another facility that is providing less service to a waitlisted patient. This inequity could provide incentive for acute care facilities to demand an increasingly higher acute rate when providing care above that of waitlisted services causing an unnecessary and unintended escalation of reimbursement at an extraordinary financial burden to the State.

Importantly, 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 the 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."

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 rate.

2) The Department also objects to this bill's proposal 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. This bill would authorize that long-term care facilities be reimbursed the actual cost of providing care to "medically complex" beneficiaries that have been transitioned from an acute care facility.

"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 the definition is overly broad and can easily be attributed to any person evaluated as requiring nursing facility level of care.

Should the legislature choose to fund this request, the Department has conservatively estimated that 30% of nursing facility residents transfer from hospitals and the cost increase will be $23,390,594.

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 $400 to $600 per day is significantly higher than the average long-term care rate ($215 per day).

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 and Medicaid Services (CMS). This has become a 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 any cost-based reimbursement strategy.

(3) 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.

The QUEST Expanded Access (QExA) program, which is slated for implementation on November 1, 2008, already addresses reimbursement rates for nursing facilities in Hawaii. In the contract between the QExA health plans and the Department of Human Services, 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.

4) SECTION 4 of this bill states: "There is appropriated out of the general revenues of the State of Hawaii the sum of $_____ or so much thereof as may be necessary for fiscal year 2008-2009 for Medicaid payments to nursing facilities based on the actual costs of long term care..." is contradictory to SECTION 2 (b) of this bill that specifies that the payment shall be forty per cent more than the current rate.

Thank you for this opportunity to testify.