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February 23, 2010

MEMORANDUM

TO: Honorable Donna Mercado Kim, Chair
Senate Committee on Health

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2270, S.D. 1– RELATING TO MEDICAID REIMBURSEMENTS**

Hearing: Tuesday, February 23, 2010, 10:05 AM.
Conference Room 211, State Capitol

PURPOSE: The purposes of this bill are to 1) require Medicaid reimbursement to hospitals for patients occupying acute-licensed beds who are on a waitlist for long-term care to be at least equal to the rate paid for acute care services; 20 require Medicaid reimbursement to long-term care facilities for patients with medically complex conditions to be at least equal to the rate paid for subacute care; 3) appropriate funds for increased reimbursements.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill as it would result in a significant increase in State expenditures when the State is facing a $1.23 billion budget shortfall for the biennium.

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.

DHS faces a currently estimated $84,000,000 shortfall this fiscal year which may potentially delay payments to health plans for three months and an estimated $146,000,000 shortfall next fiscal year if this year's shortfall is not addressed.

Section 1 of S.B. 2270, S.D.1, states that hospitals lost $72,500,000 in 2008 for care to patients waiting to be transferred to long-term care. That is, therefore, how much money will be needed to be newly appropriated to fund this bill that is extremely costly to Hawaii taxpayers. DHS does not believe that we should eliminate eligibility and coverage to low-income vulnerable populations in Hawaii or increase taxes on hard-working struggling families which would be necessary to implement this bill.

This $72,500,000 amount that hospitals would like to receive includes payment for services not provided. Paying inpatient acute care rates for 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, and this reimbursement would not be expected to be eligible for federal matching funds.

In FY 2008, there were 17,000 waitlisted days which would have meant an extra $10,000,000 per year in payments to hospitals. This is based on the number of waitlisted patients from 2008 who were <u>not found eligible for Medicaid</u>. These payments for non-Medicaid eligible patients to nursing homes would have to be made with 100% State general funds.

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 NF rate (234.62) and average subacute rate (536.96) is an additional $302.34 per day.

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.

Because it is expected that funding will not be available this year, this bill would instead establish a different methodology for payment should funds become available. The increased rates would be a moving targeted as the rates would be reduced when the funds are exhausted which makes capitation rate development for DHS and budgeting for facilities extremely difficult.

Provider reimbursement is made by the contracted managed care health plans, and capitation rates are developed in advance and contracted for a specified period of time. Increases and decreases in rates also require approval by the federal Centers for Medicare and Medicaid Services. Changing rates when funds become available and

again when they are exhausted will significantly increase administrative cost and complexity.

Change in reimbursement methodology to hospitals and nursing facilities should not occur when the State is in a financial crisis. Statutory change to reimbursement methodology should not occur unless properly funded to allow proper planning and receipt of federal approval to allow receipt of matching federal funds.

Finally, please note that DHS has also been distributing "DSH-like" federal funds of $7.5 million per year to hospitals statewide since 2005 pursuant to a creative Medicaid 1115 waiver that DHS obtained from CMS. DHS distributes these funds based on the DSH formula developed by the Healthcare Association of Hawaii. The next distribution of these funds is scheduled to occur in February 2010.

DHS has presented private and public hospitals with nearly $84 million in federal-only funds since 2005 through the DHS "waiver." DHS has also given hospitals another $31 million in federal and matching state funds since 2007 through the Congressional Disproportionate Share Hospital program, bringing the total to $115 million to date.

As this bill requires substantial additional State appropriations and the State facing a $1.23 billion budget shortfall for the biennium, DHS strongly opposes this measure as there is not enough State money to increase reimbursements.

Thank you for the opportunity to provide this testimony.

The Chamber of Commerce of Hawaii
The Voice of Business in Hawaii

Testimony to the Senate Committee on Ways and Means
Tuesday, February 23, 2010 at 10:05 a.m.
Conference Room 211, State Capitol

RE: SENATE BILL NO. 2270 SD1 RELATING TO MEDICAID REIMBURSEMENTS

Chair Mercado Kim, Vice Chair Tsutsui, and Members of the Committee:

My name is Jim Tollefson and I am the President and CEO of The Chamber of Commerce of Hawaii ("The Chamber"). The Chamber supports Senate Bill 2270 SD1 relating to Medicaid Reimbursements.

The Chamber is the largest business organization in Hawaii, representing more than 1,100 businesses. Approximately 80% of our members are small businesses with less than 20 employees. As the "Voice of Business" in Hawaii, the organization works on behalf of its members, which employ more than 200,000 individuals, to improve the state's economic climate and to foster positive action on issues of common concern.

This measure establishes reimbursement to hospitals for patients occupying acute-licensed beds who are on the wait list for long-term care and reimbursement to long-term care facilities for patients with medically complex conditions.

Quality health care is critical to the people and economy of Hawaii. As one of the largest private industries in Hawaii, the health care industry plays an important role in our economy, particularly through attractive, well-paying jobs and through the purchase of goods and services that contribute to our state's economy. As such, the health care industry plays a crucial role in the economic development and sustainability of our state and all of Hawaii's businesses. Also, Hawaii's healthcare system provides quality care for our families and serves to attract and retain a professional workforce, new companies, and even tourists to our state.

However, the quality healthcare that Hawaii has enjoyed for years in now in jeopardy. It is on the verge of declining because healthcare providers are no longer being paid for essential services at a level sufficient to cover annually increasing costs. The health care system must be maintained and challenges must be addressed.

Therefore, The Chamber supports improvements that will improve the quality of our health care system, which include legislation that will establish reimbursement guidelines for Medicaid to hospitals and facilities with long-term care beds. This will help increase long term care capacity and access statewide.

In light of the above, The Chamber of Commerce of Hawaii supports SB 2270 SD1. Thank you for the opportunity to testify.

SENATE COMMITTEE ON WAYS AND MEANS
Senator Donna Mercado Kim, Chair

Conference Room 211
Feb. 23, 2010 at 10:05 a.m.

Supporting SB 2270 SD 1.

The Healthcare Association of Hawaii represents 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 SB 2270 SD 1, which takes steps to solve the hospital waitlist problem by setting more appropriate Medicaid reimbursement rates to hospitals for patients who are waitlisted for long term care and also to long term care facilities so they accept patients with complex medical conditions who are waitlisted in hospitals.

On any given day there are an average of 200 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.

Recognizing the waitlist problem, the Legislature in 2007 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 study required information that was not fully available in time for the 2008 session, so an interim report was submitted. Meanwhile, the Legislature adopted HCR 53, which requested HAH to continue to study the waitlist problem.

The task force submitted a final report to the 2009 Legislature. In addition, HAH sponsored SB 417, which contained certain recommendations made in the report as the first step toward solving the waitlist problem. The adoption of these recommendations were 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.

HAH also sponsored HB 705 and companion bill SB 419, which would have created a Medicaid presumptive eligibility process designed to reduce the length of time taken to transfer patients waitlisted in hospitals to long term care.

Unfortunately, at about this time Hawaii began to feel the impacts of the recession, and the 2009 Legislature was faced with severe shortfalls in State revenues. The financial situation became so severe that the State was forced to cut back on existing programs. As a result, SB 417 and HB 705 / SB 419 were not passed. The bill being considered today, SB 2270 SD 1, is similar to SB 417.

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.

For the foregoing reasons, the Healthcare Association supports SB 2270 SD 1.

THE QUEEN'S MEDICAL CENTER

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Senator Donna Mercado Kim, Chair
Senator Shan S. Tsutsui, Vice Chair
COMMITTEE ON WAYS AND MEANS

February 23, 2010 -10:05 a.m.
State Capitol, Conference Room 211

In Support of SB 2270, SD1 – Relating to Medicaid Reimbursements

Chair Mercado Kim, Vice Chair Tsutsui, and Members of the Committees:

My name is Christina Donkervoet. I am the Director of Care Coordination and Patient Flow at The Queen's Medical Center (QMC). My position requires that I regularly monitor, strategize and manage the complex challenges involved with timely and appropriate discharges of acute inpatients. As a representative of QMC, I actively participated in the task force that was convened by the Healthcare Association of Hawaii (HAH) to strategize and manage issues regarding waitlisted patients. Thank you for this opportunity to submit written testimony in strong support of this bill.

QMC is greatly impacted by the limited community resources that are available to serve people in need of community-based care, rather than acute hospitalization. Patients on the waitlist for community based care often have a less-than-optimal quality of life, and their general health may be negatively impacted by a prolonged stay in the acute care hospital. Additionally, 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 our Emergency Department has to go on divert status because we simply do not have the bed capacity to admit patients needing hospitalization. In 2009, there was an average of 55 patients on the waitlist at QMC each day. The inability to admit 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 provides for 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. The increase to the payment rate for these waitlisted patients is a necessary action in order to sustain our health care system. The November 2009 report "Hawaii's Healthcare System – What Lies Ahead?" by the Healthcare Association of Hawaii, found that in 2008, estimated uncompensated costs for waitlisted patients in Hawaii were $72.5 million. This type of financial shortfall, at Queen's and other hospitals, significantly weakens our health care system as a whole.

We support the language in this bill that would ensure that long term care facilities are compensated at a higher rate when they provide services to these non-acute, yet complex, patients. Appropriate compensation to the long term care facilities would assist the acute care hospitals by increasing the discharge options for the patient care team.

In closing, we respectfully request that you adjust the reimbursement rates for waitlisted patients remaining in hospitals and develop sub-acute rates for complex and challenging patients to be served by the community program. 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.

The Queen's Medical Center continues to value and embrace our role within the community. We understand the need for collaboration and will continue to work with state agencies and community facilities and programs to serve these waitlisted patients. We recognize that the challenges presented to our state are complex and require multiple actions. The actions in this bill are a few that will help assure quality health care while we build more community options for our aging population. Your favorable review of this bill is appreciated.

Thank you for the opportunity to testify.