HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON HUMAN SERVICES
Rep. John Mizuno, Chair

Conference Room 329
June 21, 2011 at 10:00 a.m.

The Healthcare Association of Hawaii (HAH) advocates for 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 inviting us to this informational briefing to comment on the 3% Medicaid reduction and the transition of patients from hospitals to postacute care.

Hawaii's Medicaid program contracts with health plans to provide care to Medicaid enrollees, just as employers contract with health plans to provide care to their employees. However, the methodology Medicaid uses to determine payments made to providers is completely different from that which is used in the private market. When physicians, hospitals, and other providers care for Medicaid enrollees they are paid, on average, 20% less than the actual costs of providing the care.

Providers care for Medicaid patients out of their compassion for those with illnesses and injuries. Medicaid covers 270,000 of Hawaii's residents, so providers who care for Medicaid enrollees are experiencing substantial losses. These losses are compounded by losses resulting from non-Medicaid patients who do not have health care insurance and who do not have the financial capacity to pay for their care. Hawaii's hospitals alone experienced $114 million in losses due to bad debt and charity care in 2009.

Although providers are compassionate, they also face business realities. They have financial obligations that have to be met if they are to continue to remain in business and care for their patients. Financial losses associated with caring for Medicaid patients have become so great that some providers have stopped taking new Medicaid patients. As a result, Medicaid enrollees have less access to care than the general population.

The federal government recognizes that access to care would be denied if Medicaid payments are too low. Under section 1902(a)(30)(A) of the Social Security Act, states with Medicaid fee-for-service programs are required to ensure that payments for Medicaid services are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The Centers for Medicare and Medicaid Services (CMS) recognizes that access is also an issue among Medicaid managed care programs and is considering proposals that address access issues.

The Medicaid cuts that DHS is planning to make will reduce the payments to providers, which are already insufficient. Not all providers will be affected equally by the Medicaid cuts. However, the entire health care system will be affected because it consists of interrelated

components. For example, due to cost considerations, a person who is dropped from Medicaid may not seek care during the early stage of an illness that could easily be treated. If the illness gets worse instead of getting better on its own, it may deteriorate to such a degree that the person has no choice but to go to the emergency department of a hospital.

Emergency care is very expensive, and since it is unlikely that the person would be able to pay for it, the hospital would have to absorb the loss. In this case, a substantial loss by a hospital could have been avoided by a relatively small payment to a physician to treat the illness in its early stage, and the person's severe illness could have been prevented.

The Healthcare Association has surveyed its members to determine the effects of the Medicaid cuts. Members of the Association include hospitals, nursing homes, home care agencies, hospices, and medical equipment suppliers. All of them will be adversely impacted in some way. A number of them will be impacted to such a degree that they will be forced to reduce services and programs, with some being forced to make extensive reductions.

Since services and programs are typically offered to the general population, the Medicaid cuts are likely to affect not only Medicaid enrollees, but the general population as well. Untimately, the cuts to the Medicaid program that DHS plans to make that will cost shift to the private sector could adversely affect Hawaii's entire health care system and its interrelated parts, thereby reducing services statewide.

Regarding the issue of transitions of care, the Healthcare Association, along with DHS, health plans, the Executive Office on Aging, HLTCA, and provider representatives from acute care, nursing facilities, home care, and hospice, have been meeting since last fall to seek areas of opportunity to streamline the transition of care from acute to post-acute care. The first area that we have agreed to focus on is the level of care tool that DHS, the QExA Health plans, and HSAG utilize in determining appropriate placement in the post-acute care setting. Care transitions is a priority of the Centers for Medicare and Medicaid, the Quality Improvement Organization (Mountain Pacific Quality Health Foundation), the Executive Office on Aging (Discharge Planning Grant) and many others.

During the 2011 legislative session, HAH and HLTCA worked intensively with DHS during the conference period on SB 787, otherwise known as the waitlist reimbursement bill. While the bill, along with many others, did not pass out of conference, the discussions between HAH, HLTCA and DHS led to an agreement to revise Form 1147 and to revise the sub-acute payment utilized for Medicaid enrollees with medically complex conditions. With updated screening tools, clients will be more appropriately screened to determine the appropriate level of care needed based on their physical and behavioral assessment; incentives for payment can be aligned more appropriately to match the intensity of the services required, and ultimately focus on ensuring patient safety.

Thank you for this opportunity to testify on these issues of critical importance to Hawaii's health care system and their effects on Hawaii's residents.

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Tuesday, June 21, 2011

To: The Honorable John M. Mizuno
Chair, House Committee on Human Services

From: Erhardt H.L. Preituaer
Regional President, 'Ohana Health Plan

Re: Informational Briefing on the Proposed 3% Reduction to Medicaid Providers

Hearing: Tuesday, June 21, 2011; 10:00 a.m.
Hawai'i State Capitol, Room 329

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

Thank you for the opportunity to provide testimony this morning on these very important changes within the Medicaid program, specifically for the Home and Community Based providers listed in the briefing notice. First, I would like to note that we understand the challenging budgetary environment the State is in, and support the fact that reductions must be made for the sustainability of the overall program and for the State of Hawai'i. I would also like to be clear that 'Ohana is being directly impacted as well; administrative dollars, and resources, are being taken away as a part of these reductions - therefore, we are being put in the challenging position of having to do more with less.

There are two major topics I would like to cover. First, I would like to address some of the highlighted changes that we are making as a result of the reductions. Second, I'd like to address some of the points of concern made in the hearing notice.

We have conducted a thorough examination of all of our providers, specifically looking at service requirements for our providers under our upcoming NCQA health plan accreditation, federal health reform guidance, various quality measures and reporting, ease of delegation (where applicable), ease of claims and authorization administration, member complaints, overall quality concerns (like significantly above-average emergency room usage), and, in some cases, fraud waste and abuse concerns.

The bottom line is that, in the near future, we will be ending our relationship with a small number of our providers, including durable medical supply, case management, and potentially other providers. We will assure, of course, that our members have uninterrupted services for any of these proposed changes.

Another major area of change is a reimbursement reduction, which is consistent with the messages that have been delivered by the State in both formal memos as well as in a public forum. These notices are in process, and some of the providers have probably already received them. The effective date of this reimbursement reduction is August 1, 2011.

The second major area that I would like to address is the concern of health plans no longer accepting Community Care Foster Family Home (CCFFH) operators under their plan. Currently, we have a little over 620 CCFFH members, but we have about 1,200 providers. Given that each provider can have between 2 or 3 beds, we have between 2,400 and 3,600 beds contracted, but only about 620 members. Thus, we have between 5 and 6 times more beds than we do members. This signals a serious imbalance in the system that must be addressed, but it is also administratively costly to have providers in our network that do not serve any of our members. Therefore, we will not be contracting with foster homes unless they already have an 'Ohana member. Again, if the foster home has an existing 'Ohana member, we will contract with them.

Finally, I would like to recognize that foster home providers play a very important and valuable role in Hawaii's health care system. It is my hope that these providers are able to come together with one voice and one message to assure that all key stakeholders and decision makers also understand the important role that foster homes play in the healthcare system of Hawaii.

Thank you for this opportunity to provide these comments.

June 21, 2011

Name: Informational briefing on the 3% proposed reduction in pay for RACCP
Committee: Human Services: Rep. John Mizuno, Chair; Rep. Jo Jordan, Vice Chair

To Whom It May Concern:

We, AFHA of the Big Island would like to express our thoughts and concerns about the 3% reduction in pay for the RACCP services. We truly understand that we are in economic crisis and reducing Medicaid Expenditures is the direction that our State has acknowledged to proceed with and we are not against this. In fact, we encourage the State to look at this RACCP microscopically and evaluate further what can be done to downscale the duplicating/unneeded services so the State can save money for the betterment of our economy.

However, we ask that you please dissuade the reduction of 3% from the RACCP pay as that is quite inhumane due to the fact that we are already way underpaid to begin with. Our hourly wage is well below the State and federal minimum wage range. We are barely making 2 dollars an hour, 7 days a week, 30-31 days a month, and 365 days a year. If this is slashed out even further, we'll start losing homes which in return could possibly create a ripple effect and may lead to even more crisis to what we already have. This RACCP program is saving the State tremendously and further avoidable cut backs could definitely lead to a more detrimental effect in the economy.

With this very minimal hourly pay we receive, we need to take into consideration that the clients live in our homes and they take part of our daily family routine. With the ever increasing cost of fuel, electric, telephone, cable, insurances, just to name a few – these home expenditures have soared to the top. Quite frankly at the current state, it's already hard to maintain a well balanced home/business and what more with additional cut backs? It's not that we are not willing to help our economy but further cut backs to an already very minimal pay is quite an insult to our industry and well being. We ask that you please re-consider to not pursue this action but further investigate and/or look at the unnecessary duplicated services this program have that can be further deactivated for the better purpose of our State, Economy, and for All.

Sincerely,

Noemi Arzaga, RN, AFHA BI President, AFH Operator

Name: Informational briefing on the 3% proposed reduction in pay for RACCP

Committee: Human Services: Rep. John Mizuno, Chair; Rep. Jo Jordan, Vice Chair

Date: Tuesday, June 21, 2011

Time: 10:00 a.m. to 11:30 a.m.

Sharing and extending my home, my ohana to care for people with disability and elderly is in it self a community service that rarely gets the proper credit that it deserves. Unfortunately is sometimes the likelihood of negative publicity that caregivers are subjected to rather than respect, and acknowledgement of caregiver's dedication and good service to mankind and to our respective community. Let's keep in mind that caregivers are the backbone of our healthcare industry.

I'm all for the idea of fiscal responsibility specially during this economic hardship however, reducing RACCP pay to 3% is not very logical and fiscally responsible thing to do because the pay is already bottom out to a mere $1.91 per hour (46.06 per day divided by 24 hrs). This amount could be lesser depending on level of care and days of the month. This amount is way below the approved State and Federal minimum wage. And if a substitute caregiver is brought into the picture, we take a big lost because no one would undertake such a huge responsibility and yet so underpaid.

Also with the increasing number of elderly population, decreasing caregivers pay is to dissuade future care home operators thus, less options for long term care and more expenses the State have to incur.

I urge the legislators to **not cut RACCP operators meager pay** but to seriously look at streamlining the so many agencies that could be duplicating services, and maybe going back into how it was before.

Sincerely,

Lolita Paranada, MSW, LSW, MHP, RACCP Operator

Hilo, HI 96721

From: Ruthie Agbayani, Board of Director, Adult Foster Homes of the Pacific (AFHoP)
To: HOUSE OF REPRESENTATIVES, COMMITTEE ON HUMAN SERVICES
Rep. John M. Mizuno, Chair
Rep. Jo Jordan, Vice Chair
Date: Tuesday, June 21, 2011
Time: 10:00 AM
Measure: Informational Briefing to Review the Proposed 3% Reduction for Community Care Foster Family Homes

LATE TESTIMONY

Good Morning. My name is Ruthie Agbayani and I am a professional caregiver. I am a Community Care Foster Family Home (CCFFH) Primary Caregiver since 1998; I am a Certified Nurse Assistant since 1995; I have worked in various health care settings outside of my home between 1996 and 2004; and I am also a family caregiver since the age of 10.

Since my family and I opened our home for caring for the elderly and disabled adults, we have been fairly aware and involved in the on-goings of issues and concerns pertaining to our special services in the community. In 2000, caregivers advocated and lobbied to allow Private Paying individuals fair access to our special services, which were predominantly exclusive to Medicaid Waiver beneficiaries under the Department of Human Services (DHS) Residential Alternative Community Care Program (RACCP). In 2005, caregivers advocated and lobbied to allow more individuals who are in need of intermediate and skilled nursing care but cannot afford such care in a facility (via ICF/SNF facilities) or in the comfort of their own homes (via home health agencies) by allowing CCFFHs to be certified for up to three clients. In 2008, caregivers were willing to work with another special project of the DHS, namely the Going Home Plus (GHP) Program, paving the way for those living in facilities to have continued care within the community in a home environment, such as a CCFFH, when going home to their own homes is not feasible.

Since my family and I started our CCFFH in 1998, we have worked meticulously with our Case Management Agencies (CMAs) to deliver excellent care to our elderly and disabled adult residents. However, in 2005, the State of Hawaii implemented Communities of America (CTA), a separate compliance agency, as a means to remove the "conflict of interest" issues as part of our CMA's job to ensure that Primary and Substitute Caregivers are credibly documented and skilled to perform our services, and that our homes are also documented and safe to live in. Then, in 2009, the State of Hawaii implemented contracts with health maintenance organizations, Health Plans such as 'Ohana and EverCare, as a means to provide managed care services contracted by the DHS's Quest Expanded Access (QExA) program to service persons who have Medicaid and are aged, blind or disabled (ABD). Prior to February 2009, services for the ABD population were provided through the fee-for-service (FFS) system.

When
~~Since~~ my family and I started our CCFFH in 1998, we have received our services reimbursements directly from the DHS accounting department. However, our reimbursements would be two to three months, or more, late. In an attempt to help caregivers receive their reimbursements faster, the DHS handed the payment of services responsibility through our

- **Meal preparation and serving** – Which meals and how many times per week. A nutritious menu must be discussed and approved, consistent with the patient's dietary requirements (high blood pressure, diabetic, renal, etc.).
- **Housekeeping** – Caregiver duties include cleaning, making beds, doing dishes, laundry, ironing as needed, cleaning kitchen and bathroom, and especially maintaining sanitation, which includes regular garbage removal.
- **Transportation** – To and from appointments, stores, entertainment, adult day care.
- **Errands and shopping** – The resident may be able to go out with escort assistance, or majority of the time errands are done solely by the caregiver.
- **Ambulation assistance** – Whether the resident is able to walk or is confined to a wheelchair, it is important to exercise regularly. The doctor may have given guidelines for exercise.
- **Companionship** – Assisting with attendance at social events, escorting to adult day care, or the caregiver provides social activities such as reading aloud to the resident, playing games or doing crafts and hobbies.
- **Management of symptoms** – If the patient suffers from an illness that causes fever, pain, rashes, lesions, swelling, breathing difficulties, etc., the doctor's recommendations for procedures must be followed.
- **Therapy** – Either occupational, physical, or speech.
- **Emergency service** – The caregiver will call 911 and administer CPR, when there are doctor's orders and family wishes to prolong life.
- **Medical care** – Caregivers perform duties that are normally and typically provided by an RN or LPN depending on the circumstances and as recommended by a doctor.
- **Hospice care** – Hospice care is usually in duration of 6 months or less, to keep patient physically and emotionally comfortable during transition period.
- **Short-term respite care** – Caregivers provide temporary care for family or other CCFFH providers who need a break from caregiving duties.
- **Communicating** – Both progress and any issues are communicated between all parties: Primary and Substitute Caregivers, Nurse Case Managers and Social Workers of Case Management Agencies, Physicians, Health Plans, and Family, if any are involved in their love one's health care.

I have also included in this testimony, a list of *The Many Jobs of a Caregiver.* In this document, caregivers ranked their job responsibilities as an operator of a CCFFH. And when researching the corresponding salaries of those occupations, clearly you can see that the State of Hawaii's reimbursement rates are very low. The State of Hawaii is not only delaying payment, but is also underpaying its caregivers. In 2005, in an effort to keep up with escalating costs of living for both personal and business life, caregivers lobbied for a pay increase of $1000 per month above the current cap of that time period in order to break even, as we were already operating at losses of one kind or another. However, we only received a $100 per month pay increase. It is now 2011, and the cost of living today has increased from the 2005 studies.

Caregivers suffer financially trying to deliver excellent services without sacrificing many of those services. To decrease our pay when we are already underpaid is inhumane for all parties.

The Many Jobs of a Caregiver

Chief Executive Officer

Caregivers make critical decisions running a household of direct and indirect reports to support the immediate family and foster care residents, keeping to the standards of privacy and confidentiality.

Annual Salary: $210,700
Hourly Pay: $67.53
Live-in Caregiver: 5.5 Hours a Week
Working Caregiver: 6.1 Hours a Week

Caregiver Job Rank: #1
% of Caregiver's Salary: 19.9%

Psychologist

A caregiver is a skilled communicator who will always listens and provides unconditional love, oversees the mental well-being of everyone in the home, and provides encouragement to build self-esteem and to cope with disappointments.

Annual Salary: $74,000
Hourly Pay: $35.58
Live-in Caregiver: 7.2 Hours a Week
Working Caregiver: 5.2 Hours a Week

Caregiver Job Rank: #2
% of Caregiver Salary: 15.1%

Facilities Manager

A caregiver is the organizer who keeps the home operating smoothly, including home and ground maintenance.

Annual Salary: $70,200
Hourly Pay: $33.75
Live-in Caregiver: 8.6 Hours a Week
Working Caregiver: 5.7 Hours a Week

Caregiver Job Rank: #3
Portion of Caregiver Salary: 14%

Adult Day Health Care Center Provider

With patience, a caregiver is the one who inspires the elderly and disabled to continue to thrive with dignity, respect, and independence in a safe environment.

Annual Salary: $26,700
Hourly Pay: $12.84
Live-in Caregiver: 14.7 Hours a Week
Working Caregiver: 7.1 Hours a Week

Caregiver Job Rank: #4
% of Caregiver Salary: 10. 8%

Cook

Caregivers work hard to ensure that everyone in the family is eating healthy, based on individual diet needs (Hypertension/Diabetic/Renal diets, etc.), by serving nutritious and delicious meals and snacks.

Annual Salary: $27,300
Hourly Pay: $13.13
Live-in Caregiver: 13.1 Hours a Week
Working Caregiver: 6.8 Hours a Week

Caregiver Job Rank: #5
% of Caregiver Salary: 10.1%

Computer Operator I

Modern caregivers use the computer to organize their household's time and keep track of their busy schedules, which include meal planning and grocery shopping; schedules and assignment of household chores; drop off and pick up for school-aged children and extra-curricular activities; medical, dental, and vision appointments for family members and foster care residents; ordering and picking up of medications, household and office supplies; also bill-paying and communicating with pertinent parties via e-mail.

Annual Salary: $31,300
Hourly Pay: $15.05
Live-in Caregiver: 9.2 Hours a Week
Working Caregiver: 4.6 Hours a Week

Caregiver Job Rank: #6
% of Caregiver Salary: 8%

Housekeeper

Caregivers clean up spills, kill germs and make a home comfortable, warm, and safe, keeping infection-control protocols in mind at all times.

Annual Salary: $19,700
Hourly Pay: $9.47
Live-in Caregiver: 16.5 Hours a Week
Working Caregiver: 8 Hours a Week

Caregiver Job Rank: #7
% of Caregiver Salary: 7.7%

Van Driver

Most caregivers' days include caravanning children to school and after-school activities, as well as escorting and transporting foster care residents to medical appointments, and running errands. With the rise of fuel costs, it can get very difficult to keep the tank full.

Annual Salary: $31,600
Hourly Pay: $15.19
Live-in Caregiver: 7.3 Hours a Week
Caregiver Mom: 5.3 Hours a Week

Caregiver Job Rank: #8
Portion of Caregiver Salary: 6.3%

Janitor

One of the dirtiest jobs is grossly underpaid -- emphasis on *gross.* When something breaks at home, a caregiver will usually know how to "Fix It" until a professional is called in to do the actual repairs.

Annual Salary: $20,700
Hourly Pay: $9.95
Live-in Caregiver: 7.1 Hours a Week
Working Caregiver: 4.0 Hours a Week

Caregiver Job Rank: #9
% of Caregiver Salary: 4.7%

Laundry Machine Operator

Making sure everyone has clean clothes and linen means lots of time washing; and with consideration to incontinence of bowel and urine, laundry may be required in a more frequent basis, sometimes almost daily.

Annual Salary: $20,100
Hourly Pay: $9.66
Live-in Caregiver: 7.2 Hours a Week
Working Caregiver: 4.0 Hours a Week

Caregiver Job Rank: #10
% of Caregiver Salary: 3.3%