HAWAII DISABILITY RIGHTS CENTER

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THE SENATE
THE TWENTY-SIIXTH LEGISLATURE
REGULAR SESSION OF 2012

Committee on Ways and Means
Testimony in Support of S.B. 2092, SD1
Relating To Health
Wednesday, February 29, 2012, 9:15 A.M.
Conference Room 211

Chair Ige and Members of the Committee:

The Hawaii Disability Rights Center testifies in support of this bill.

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 several years of the long waitlist for community housing experienced by patients in acute facilities. In addition, briefings have been conducted regarding the problems of placing "challenging" patients into community settings. One of the barriers identified has been the delays in processing Medicaid eligibility for these individuals. We support the provision regarding presumptive eligibility. Delays in processing these applications add to the problems of placing these individuals and are an unnecessary source of difficulty. There is no reason to delay these applications. It is our hope that this provision will help to alleviate the current problem experienced by hospitals as well as their waitlisted patients.

Thank you for the opportunity to testify in support of this measure.

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

Senate Committee on Ways and Means
Senator David Y. Ige, Chair
Senator Michelle N. Kidani, Vice Chair

February 29, 2012
Conference Room 211
9:15 a.m.
Hawaii State Capitol

Testimony Supporting Senate Bill 2092, SD1, Relating to Health. Establishes presumptive Medicaid eligibility for waitlisted patients. Appropriates funds for reimbursements for services provided during the time that waitlisted patients are enrolled and later disenrolled due to determination of ineligibility.

Bruce S. Anderson, Ph.D.
President and Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC), thank you for the opportunity to testify in support of SB2092, SD1.

The waitlist issue is very complex and involves many factors, which the Healthcare Associate of Hawaii (HAH) has spelled out. For HHSC, this is a major issue, both financially and due to quality of care concerns. A patient in an acute care bed who needs long term care, for example, will not be able to set up residence in the long term care unit where the resident can participate in social activities, obtain rehab services, and be afforded other privileges that residents of nursing homes enjoy. For this basic reason, a patient being in an acute setting for a long period of time, when he or she is not acutely ill, is simply not healthy.

Maui Memorial Medical Center presently has a large waitlist population. In December, 2011, there were on average 36 non-acute patients assigned to acute care medical/surgical beds. This is extremely significant because out of 140 (plus 12 overflow) med/surg beds, it amounts to almost one-third of total census. Additionally, there were several people in the emergency department waiting for beds. If a big accident had occurred on the island, the ED would have had trouble handling it because the ED bays were filled with patients who needed inpatient beds. Therefore, the waitlist problem has a great impact on patient care at the acute end of the scale, as well.

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MMMC estimates that it costs approximately $1200 per day for each waitlisted patient. Though this is a complex issue and extremely difficult to quantify exact revenue losses, MMMC estimates it loses approximately $20 million per year due to the waitlist problem.

In response to this chronic situation, MMMC has converted one wing into a waitlist unit for 18 patients so that the unit staffing can be adjusted to fit the lower level of patient acuity. However, the remaining waitlisted patients have to be placed throughout the hospital interspersed with acute care patients in units where a higher level of staffing must be maintained. Unfortunately, MMMC cannot merely change its staffing due to collective bargaining constraints and the fact the waitlist patients are interspersed with other patients.

In short, this is a serious issue that results in wasted resources. The issue is compounded by the delay in getting Medicaid patients eligibility approved, resulting in months of delay in any reimbursement. As pointed out by HAH and in the purpose clause of this legislation, many resources are devoted to getting an application into the DHS, which is necessary in order to start the coverage. Even once it is in DHS, it takes a long time for approval, which causes a cash flow issue. A presumptive eligibility would help with the cash flow issue, at least, and place the burden of determining eligibility where it belongs: on DHS and on the patients and their facilities. In addition, the long term care bed that was open for that patient may be given to another patient who is already qualified, thus keeping the person in a waitlisted bed.

We support this measure which appropriates money to the DHS to be spent on updating technology or other improvements to speed up the eligibility process to this population of patients. This measure will not totally solve the waitlist issue; however, it will only help with the financial burden for acute hospitals with a waitlist problem and should result in the placement of more of those patients in long term care beds.

Thank you for the opportunity to testify before this committee.