ACT 301

S.B. NO. 2388

A Bill for an Act Relating to Human Services.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The legislature finds that the delivery of long-term care in the nation has characteristically been fragmented and uncoordinated. Much of this has to do with how legislation on the federal, state, and local levels has evolved historically. Different programs have their own eligibility requirements, funding mandates, care benefits, provider participation regulations, administrative structure, and service delivery mechanisms. More than eighty federal, state, and local government programs offer direct or indirect assistance to persons with long-term care needs. Help may be in the form of cash, in-kind assistance, or goods and services. Five programs—medicaid, medicare, social services block grants, the Older Americans Act, and supplemental security income—offer major federal financial support for both community-based and institutional long-term care. Consequently, it is difficult to coordinate a comprehensive continuum of long-term care ranging from nursing homes to home- and community-based services for the elderly and the disabled.

The situation is similar in Hawaii. The department of health has partial responsibility for long-term care services for the elderly. The department's Maluhia home health center operates several programs including the home health care program which makes available medically necessary skilled home health care that is reimbursable by the home-bound client's medical insurance. The department of health also operates the Maluhia waitlist demonstration program—a medicaid waiver program established in collaboration with the department of human services. Over three hundred fifty individuals eligible for nursing home care remain in much more expensive acute care hospitals due to a lack of nursing beds. The waitlist program seeks to create a new category of adult residential care homes as an alternative to nursing homes to provide health and assisted living services to these waitlisted individuals.

The department's Maluhia PACE Hawaii project provides all-inclusive care to medicaid-eligible individuals aged fifty-five and older who are at the skilled nursing or intermediate care facility levels. Participants receive medical care; skilled nursing, rehabilitation, and preventive care; adult day health; personal care; and social services from an interdisciplinary team.

Most of the department's community hospitals offer long-term care beds. The department's Waimano training school and hospital (scheduled to close on June

30, 1998) provides long-term care—in the form of twenty-four hour residential services—for persons with developmental disabilities or mental retardation (DD/MR) who cannot be sustained in a community setting. Waimano also operates a medicaid waiver community-based support program for many of Waimano's former residents living in the community.

Furthermore, the department of health's developmental disabilities division, through its community services for the developmentally disabled branch, also has long-term care responsibilities for disabled adults.

On the other hand, programs in the department of human services are the locus of the bulk of the State's expenditures for long-term care. The department's community long-term care branch operates under the Med-QUEST division and serves the long-term care needs of the medicaid-eligible elderly, disabled, the DD/MR, and the catastrophically ill. The department's nursing home without walls program provides an array of health, social, and environmental services tailored to clients' individual needs in their own homes that are otherwise available only in institutions. The program requires that the severely and chronically ill and disabled must be able to be maintained at home with reasonable assurance of health and safety at less than institutional costs. The primary services used are personal care and skilled nursing. The branch is also involved in the home and community based services waiver consolidated program for the DD/MR population in which the department of health and private providers render direct services.

The legislature finds that a single entry point system is conducive to better coordination of long-term care services and to easier and simpler access to the long-term care system for both the elderly and the disabled. Without a coordinated single entry point system, elderly or disabled individuals enter the long-term care system on a hit-or-miss basis. A coordinated single entry point could provide a one-stop shop for all eligible individuals who would no longer need to search among all the individual available agencies for needed services. They would no longer be subject to multiple referrals or undergo multiple screens and assessments by different, and sometimes inappropriate, agencies. Thus, a coordinated single entry point seeks to make access to the long-term care system easier, simpler, and more equitable for the greatest number of eligible individuals. A single entry point does not mean access to long-term care is restricted to one unitary or central physical location. Instead, it means that an entire entry system is made available statewide in which access can be gained at any point in the same fair and uniform way.

A coordinated single entry point also seeks to rationalize service delivery and reduce system fragmentation by matching the individualized needs of clients with appropriate services from a full continuum of services ranging from nursing homes to home- and community-based supports. The existing system encompasses multiple programs with different mandates but often overlapping services. One goal of a coordinated single entry point is to create the full continuum of care which each individual categorical program embraces in rhetoric but cannot by itself achieve. A coordinated single entry point moves in this direction by integrating the operation of the three inter-related processes of client screening, assessment, and case management within one system. Services from previously disparate sources can be pooled. Clients can then be screened to determine financial and functional eligibility in a fair and uniform way at any point in the single entry point system. For example, a uniform screening and assessment tool may find that a person can avoid entering a nursing home and remain at home if provided with adequate home- or community-based supports. Entry through a coordinated single entry point system can thus enhance a client's awareness of service alternatives and improve chances for obtaining more appropriate services. Uniform case management, coordinated with screening and assessment, helps to assure that these services are effectively delivered. Because a full range of services is made available in one system, a single

entry point can flexibly deliver appropriate services even as clients' needs change over time.

A single entry point, through the coordinated operation of uniform screening, assessment, and case management, can also control nursing home utilization rates by determining nursing home eligibility and routing clients to less restrictive and less expensive alternatives. In addition to promoting the rational use of scarce nursing beds, a coordinated single entry point can also act as a gatekeeper in managing the allocation of home- and community-based long-term care resources.

The purpose of this Act is to create a unified single entry point system for elderly and disabled persons to obtain access to, and obtain a full range of appropriate services from, the long-term care system in Hawaii.

SECTION 2. (a) The department of human services shall design and develop a single entry point system for long-term care. For this purpose, there is created a temporary, ad hoc coordinating committee, attached to the department of human services for administrative purposes only, to design and develop a single entry point system for long-term care, including nursing home care and home- and community-based supports, for the elderly and disabled in Hawaii. The department shall serve as the lead agency and utilize the services of a facilitator when appropriate. Long-term care services shall include both nursing home care and home- and community-based services. Members shall serve without compensation.

The department shall convene and support an advisory committee made up of public and private agencies and consumer groups representative of the aging and disabled population, including the area agencies on aging and representatives from each county. The advisory committee shall review and provide input in policy and program options for a single entry point system.

(b) The department of human services and the coordinating committee shall adhere to the following broad guidelines:

(1) Accommodate both elderly and disabled adults, using a comprehensive range of long-term care services, including both nursing home care and home- and community-based supports;
(2) Adopt a flexible generic approach to determine eligibility and to assess clients based on functional limitations;
(3) Design a system that makes the most efficient use of resources;
(4) Attempt to benefit the greatest number while reasonably accommodating individuals with extreme needs;
(5) Develop a standardized functional assessment for the elderly and disabled;
(6) Design a continuing review process to ensure that case management functions do not unnecessarily restrict access to services; and
(7) Develop a system whereby existing services can be placed in and accessed from a continuum of services available to both the elderly and the disabled through the unified single entry point system.

(c) The coordinating committee shall engage in actual, good faith negotiations to reach workable compromises and resolve differences among various programs that provide for the long-term care of the elderly and the disabled. Specifically, the committee shall attempt to determine whether:

(1) Differing financial eligibility criteria can be reconciled, including whether differing funding streams can be usefully consolidated and made available to support services for both the elderly and the disabled;
(2) Sufficient common ground exists for the use of standardized functional assessments for the elderly and the disabled and if provisions for supplementary specialist assessments are necessary, feasible, and can be made available;

(3) Cross-training for entry staff is feasible or can be made adequate to handle the needs of all eligible individuals or, alternatively, whether sufficient ''expert'' knowledge and sophistication can be built in to whatever standardized tools that will be used;
(4) Case management can be consolidated for both elderly and disabled populations;
(5) If the power to authorize services is given to case management agencies, whether case managers will be allowed to provide direct services; and
(6) Existing services can be placed in and accessed from a continuum of services available to both the elderly and the disabled through the coordinated single entry point system.

(d) The coordinating committee shall begin work and the process of good faith negotiations as soon as practicable but no later than two weeks after the effective date of this Act. The committee shall report in writing to the governor and the legislature by December 20, 1996, detailing the results of negotiations and recommending a timetable and process to implement a single entry point system. If necessary, the committee shall include in its report proposed legislation, including any necessary appropriations, to implement a single entry point system.

(e) The department of human services shall begin work on the development of the single entry point system no later than two weeks after the effective date of this Act. The department shall report in writing to the governor and the legislature by December 20, 1996, with a detailed plan for the organization of the single entry point system.

SECTION 3. Expenses for the work of coordinating and advisory committees shall be borne by existing budgeted funds of the department of human services, without the necessity for an appropriation under this Act.

SECTION 4. This Act shall take effect upon its approval.

(Approved July 3, 1996.)