REPORT TO
THE TWENTY FIFTH
HAWAII STATE LEGISLATURE

PURSUANT TO HOUSE CONCURRENT RESOLUTION 53: Requesting the Healthcare Association of Hawaii to continue its efforts to develop solutions to the problem of patients in hospitals who are waitlisted for long term care.

ADOPTED BY THE 2008 LEGISLATURE

JANUARY 2009
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Hawaii’s healthcare system is broken. Symptoms of this broken system are waitlisted patients. These are patients 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.

The 2008 Legislative Session fostered an in-depth discussion about the crisis facing Hawaii’s healthcare system where it pertains to discharging medically and behaviorally complex patients from acute care hospitals to long term care (institutional or home/community-based). Two “waitlist” bills, SB 3257 (Relating to Medicaid Presumptive Eligibility) and SB 3258 (Relating to Medicaid Hospital and Long-Term Care Reimbursements) advanced to conference committee but subsequently died.

Understanding the waitlist concern, the Legislature adopted HCR 53 (Exhibit 1). It requested the Healthcare Association of Hawaii (HAH) to continue its studies of patients in acute care hospitals who are waitlisted for long term care and to propose solutions in the 2009 Legislative Session. HAH represents the full spectrum of healthcare, including acute and long term care facilities, home care and hospice providers. The Waitlist Task Force resumed its work following the 2008 Legislative Session with guidance from the HAH Board of Directors.

This year’s report to the Legislature includes a more detailed accounting of the waitlist issue. Discharge data obtained from acute care hospitals by Hawaii Health Information Corporation (HHIC) allows for a depiction of the types of patients who are waitlisted, the clinical conditions that contribute to the challenges in placing them in long term care settings, the costs associated with their care, and a range of other details. The data allows us to “put a face” on the waitlisted patient and quantify some of the impacts.
Aside from raising awareness about the waitlist problem, our State has made very little progress on the quadrant issues (reimbursement, capacity, regulatory/government, and workforce) that contribute to the waitlisted patient problem despite collaborative efforts with the task force. The economic condition of our state weaves a thread through each of the quadrant areas and complicates our ability to address each quadrant simultaneously, a strategy we believe necessary. Financial difficulties facing our acute care facilities throughout 2008 make it imperative that the waitlist problem be improved in the short term.

Our research in 2008 affirmed that the quadrant areas remain driving issues in our analysis of the waitlisted problem. We affirm that making improvements in the waitlist problem will require actions targeted at all four of the barrier areas simultaneously. Focusing on only one area of need will not create a sustainable solution. We have organized the report and our recommendations into the four barrier categories.

The task force appreciates the attention given by the Legislature to the waitlist problem.
II. WAITLIST TASK FORCE COMPOSITION

The Waitlist Task Force was created under the direction of the HAH Board of Directors. The Board requested that the size of the task force remain small and include a cross-section of acute care hospitals alongside a long term care CEO/Administrator representative. The Waitlist Task Force members are:

**Kathy Bodendorfer, RN**  
Manager, Care Management/  
Medical Social Work  
Kuakini Medical Center

**David Okabe**  
Executive Vice President, CFO/Treasurer  
Hawaii Pacific Health

**Christina M. Donkervoet, RN, MS**  
Director,  
Care Coordination & Patient Flow  
The Queen's Medical Center

**Vicki G. Philben, RN, MPH, CPHQ**  
Managing Director, Quality/Patient Outcomes  
Kuakini Medical Center

**Marsha H. Graham, RN, MSN, CPUR**  
Chief, Medical Management Branch  
Managed Care Division  
Tripler Army Medical Center

**Virginia Pressler, MD, MBA, FACS**  
Executive Vice President  
Strategic Business Development  
Hawaii Pacific Health

**Kathy Mau, LSW**  
Social Work Supervisor  
Kaiser Permanente Medical Center

**Ronald J. Schurra**  
Chief Executive Officer  
Hilo Medical Center

**Bernadette Ledesma, MPH, NHA**  
Administrator  
Pearl City Nursing Home

**M. Kate Thomas, RN, CLNC**  
Director of Case Management &  
Behavioral Health Services  
Castle Medical Center

Chair:  
**Coral T. Andrews, RN, MBA**  
Vice President  
Healthcare Association of Hawaii
Task force members were asked to seek solutions that built upon our discussions with DHS from the 2008 Legislative Session (SB 3257 and SB 3258), to strengthen public/private partnerships that are budget neutral where possible, to remain focused on improving the quality of life of the patient, and to reduce the financial strain on health care providers.

The Waitlist Task Force resumed its meetings following a hiatus during the 2008 Legislature. In response to HCR 53, the first meeting convened on May 19, 2008 and members have met 9 times leading up to the 2009 Legislative Session (Exhibit 2).

The task force identified the following objectives:

1. To work with the Hawaii Health Information Corporation (HHIC) to incorporate discharge data from hospitals aimed at further analyzing the waitlist problem.

2. To reflect on the progress made on the waitlist problem during the 2008 Legislative Session and to develop two to three key short term/immediate solutions that could positively affect the waitlist problem within six to twelve months.

3. To provide recommendations that would create immediate and long term solutions to the waitlist problem.

This report summarizes our work on these objectives.
The Waitlist Task Force represents a cross section of personnel who participate, either directly or indirectly, in the placement of waitlisted patients. While we are all very familiar with the day-to-day challenges in facilitating their movement from acute to post-acute settings, the task force expressed that it was important in this year’s report to assist the reader in understanding the medical and social issues that contribute to placing these patients.

CASE STUDY #1

R.W. is a 44 year-old female who was admitted to an acute care hospital in 2007 with a preliminary diagnosis of Guillain-Barré (a disorder in which the body’s immune system attacks part of the peripheral nervous system). The first symptoms of this disorder include varying degrees of weakness or tingling sensations in the legs. In many instances the weakness and abnormal sensations spread to the arms and upper body. These symptoms can increase in intensity until certain muscles cannot be used at all and, when severe, the patient is almost totally paralyzed.

This patient is indigent and her only income is monthly SSDI, which is on hold while the patient has been hospitalized. The patient’s medical coverage is Medicaid. She is not eligible for disability due to lack of time spent in the workforce.

R.W. has progressed from being bed-bound and dependent on staff for most of her activities of daily living (ADL’s) to being quite independent, requiring minimal assistance, but remains wheelchair bound. Following extensive rehabilitation therapy and registered dietitian intervention, the patient was able to lose approximately 50 pounds (current weight 280 pounds), gain strength and balance, and to finally graduate to being independent with transfers from bed to wheelchair and most of her ADL’s. She remains incapable of performing her own perineal care, which contributes to difficulty in placing her in a post-acute care setting. Psychiatry was consulted for the patient’s depression.
symptoms and insomnia. Medications and behavioral modifications have been effective in managing symptoms.

Despite all of the above progress, significant barriers to placement persist, which include her obesity, poor medical coverage, lack of adequate support persons, poverty and her documented behavioral outbursts. There have been no behavioral outbursts for several months, as patient exerts more control over her daily routine by being more independent.

During R.W.’s acute care hospitalization, she has been waitlisted statewide for a period of 596 days at the skilled nursing and/or intermediate nursing level of care, to no avail. Recent efforts to place the patient in a skilled nursing facility were unsuccessful due state regulatory constraints for this age and type of client. The skilled nursing facility also expressed concern regarding future Medicaid reimbursement for rehabilitation therapies, should the need arise. Detailed conversations have occurred among many long term care facilities on Oahu. All have declined consideration due to R.W.’s ongoing financial and care-related issues.

Additional efforts to place this patient in appropriate and supportive settings included enrollment in DHS’ Going Home Plus Program. A patient advocate was also engaged. The patient was recently assigned a Transitional Care Provider via Going Home Plus and steps are being taken to seek not only placement for this patient, but also vocational training, as the patient is quite intelligent and somewhat motivated. The patient is eligible for RACC home placement but all caregivers that have evaluated her have not accepted due to her weight and complexity of care issues.

**CASE STUDY #2**

G. B. is a 70-year-old male patient admitted to an acute care facility in 2008 from a long term care facility for respiratory distress and hypoventilation syndrome. He has also demonstrated mental status changes. He had been on BiPAP (positive airway pressure support) at night in the nursing facility prior to re-hospitalization, but was found to need additional ventilator support via a
tracheostomy. Multiple medical problems include Diabetes Mellitus Type 2, chronic obstructive pulmonary disease, vascular dementia and morbid obesity.

Once stabilized and determined to be eligible for discharge to a post-acute care setting, placement was explored. G.B. was able to cover post-acute care as a private pay (personal pay) patient and has a very supportive, cooperative family. The acute care facility was not able to locate any post-acute care provider willing/able to accept G.B.

Some of the post-acute care placement challenges described to us included:

- **Level of care is too heavy/intense for the nursing facilities**
- **Tracheostomy (trach):** none of the 3 community nursing facilities certified by Medicaid for ventilator-dependent patients is able to manage his type of trach and need for BIPAP (assisted respiratory support).
- **The intensity of G.B.’s pulmonary care is not adequately reimbursed to allow for the facility to cover the cost of labor required to support his care.**
- **Size/weight:** 300+ lbs., therefore in need of bariatric bed. In addition to the labor intensity involved in providing total activity of daily living (ADL) assistance, the size of the bed itself reduces the number of beds/patients per room which contributes to negative financial outcomes for the post-acute care provider.
- **G.B. is tube fed via PEG tube and is full code (full resuscitation effort if he experiences a life-threatening acute event).**
- **Long term prognosis is that he will likely continue to need this or higher intensity of care for the long term. Indefinitely.**

Exhibit 4 “Waitlist Patient Flow from Acute Hospital to Long Term Care Facility” (located on page 51 of this report) offers a depiction of the decision-making process that may be utilized when determining appropriate placement. This flow chart is just an example and is not intended to represent a complete list of all of the unique medical/social needs of waitlisted patients. Additionally, the flow chart could apply similarly to home and community-based pre-admission screening.
In an effort to further understand the clinical presentations of waitlisted patients, the Hawaii Health Information Corporation (HHIC) utilized discharge data based on calendar year 2006, to complete a preliminary analysis report entitled “Acute Care Waitlisted Patients”.

Diagrams 1-4 offer additional insight into the clinical profiles that require consideration when developing: 1) essential capacity in the post-acute care setting, 2) reimbursement models tailored to this population, and 3) skillsets required by the workforce in order to insure quality care, and 4) when streamlining regulatory mandates to enable movement of these patients from acute to post-acute care settings.

Diagram 1.

Contrary to the age distribution of the population at large, the distribution of waitlisted patients is skewed towards the elderly.
Patients aged 35 to 74 take a longer time to place. Many of these patients have mental health diagnoses and/or other issues.

Diagram 3.

Waitlisted Patients Older and Sicker and Stay 3.5x longer

**Acute Care Admission**
- Average Age: 52 yrs.
- SOI*: 48
- ALOS: 6.2 days

**Waitlisted Patient**
- Average Age: 69 yrs.
- SOI: 67
- ALOS: 21.5 days

*SOI: Severity of illness, based on 3M’s APR-DRG grouper. Score converted to 100 point scale with 0 least severity, 100 most severity. Excludes newborns and maternal.

The severity of illness score indicates the relative level of sickness using a score ranging from 0 to 100.
Data suggests that patients who have a higher severity of illness, co-morbidities (the presence of one or more disorders or diseases in addition to a primary disorder or disease), and who have social challenges are the most difficult to place. Additionally, the fact that older patients are more likely to be waitlisted means that the number of patients difficult to place will continue to grow. It is imperative that short term solutions be implemented immediately while we continue to address the longer term solutions. This is a societal problem, not just a hospital problem.

Nationally, CMS recognizes the importance of better understanding the transition from acute to post-acute settings. Currently, CMS is field testing a uniform assessment tool to capture information on patients moving from acute care to post-acute care settings. While this tool will be essential for standardizing information on these patients and thereby facilitating our knowledge of the issues associated with these transitions, the field test for this tool will not be available until 2011. In the meantime, we will continue to implement a variety of solutions based on the knowledge developed to date, and we will continue build our local knowledge base.

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During its first meeting following the 2008 Legislative Session, the Waitlist Task Force reviewed the four categories that encapsulate the barriers that contribute to the waitlisted patient problem in our state. As a review, the categories are: Reimbursement, Capacity, Regulatory/Government, and Workforce. A quadrant tool (Exhibit 3) was developed to facilitate an understanding of the barrier categories and the individual situations that contribute to these barriers. **Two additions/modifications were made to this year’s quadrant tool:** Workforce: “Seek opportunities to enable workforce training in the care of medically and behaviorally complex patients” and Regulatory/government: “Guardianship.”

When reviewing the quadrant tool, as stated in the 2008 report, the following principles apply to the four categories:

1. They are not arranged in a hierarchical order; however, they are interrelated. For example, a fair payment for services based on the costs associated with caring for waitlisted patients can reduce losses and serve to stimulate growth in long term care capacity.

2. Making improvements in the waitlist problem will require action to address issues associated with all of the barrier categories. Actions may include legislative and non-legislative options, in both the short term and long term.


The task force remains committed to the development of successful outcomes that would focus on an improved quality of life for waitlisted patients and their families, improved access to acute and long term care (LTC) statewide, a reduction in the financial losses associated with caring for waitlisted patients,
strengthened public/private partnerships to overcome barriers and implement recommendations described in this report, and an effort to build cooperation and trust across the healthcare delivery system.

We have observed a raised awareness in the waitlisted patient problem since the task force began its work in 2007. Efforts at community outreach, therefore, have been successful. This suggests promise in our opportunities to collaborate statewide to reduce the waitlist problem.

REIMBURSEMENT

Waitlisted patients in acute care hospitals are reimbursed by Medicaid at a waitlisted rate. The acute care hospital setting is a higher cost setting and there isn’t a cost reduction in routine care for a waitlisted patient, so the reimbursement amount does not cover the actual cost of care. In other words, the acute services per diem rate drops while the service provided remains the same. Therefore, the room and board costs are the same for an acute care patient as they are for a waitlisted patient.

Based on the 2008 Ernst and Young Study, Financial Trends of Hawaii’s Hospitals, Nursing Facilities, Home Care and Hospice Providers, acute care hospitals receive a payment rate for waitlisted patients that covers only 20-30% of the waitlisted days. Medicare does not pay any additional money to the hospital for the additional days spent by the patient in the hospital waiting for long term care placement. If appropriate placement for Medicare patients could be found prior to the consumption of the Medicare DRG period, then this would help to off-set the losses currently being realized by the hospitals.

Estimated uncompensated costs for waitlisted patients in Hawaii were approximately $73,500,000 in 2008, up from $60,000,000 in 2007. As a result of the uncompensated costs, SB 3258 Relating to hospital and long term care Medicaid reimbursements (a bill that advanced to conference committee during the 2008 Legislative Session) sought to maintain the Medicaid acute per diem rate of payment to acute care hospitals while patients are waitlisted for long
term care placement. In addition to working toward stabilizing the hemorrhaging losses that acute care facilities experience due to waitlisted patients, the task force recognized that insufficient reimbursements to long term care facilities contribute to the “lack of flow” of waitlisted patients to long term care settings. Therefore, they included a provision in the SB 3258 that was modeled after Oregon and would require a 40% add-on to the base Medicaid reimbursement rate for the care of medically and behaviorally complex waitlisted patients.

As the task force reflected on outcomes from the 2008 Legislative Session, they conferred with the Waitlist Subcommittee on Reimbursement (comprised of acute care hospital Chief Financial Officers) and also the Long Term Care Reimbursement Committee (comprised of nursing facility Chief Financial Officers).

The HAH Waitlist Subcommittee on Reimbursement generally agreed with the recommendations of the HAH Waitlist Task Force to pursue the provisions included in SB 3258 with the following clarifications:

- Maintaining an acute care services per diem rate while patients are waitlisted in acute care settings will not make the acute care hospitals whole. Rather, it seeks to recognize the ongoing services required by acute care hospitals while maintaining waitlisted patients in their care until a post-acute care setting is identified for transfer.

- The existing Medicaid reimbursement structure does not create an incentive for QUEST Expanded Access health plans to transition waitlisted patients to post-acute care settings. It would actually cost them money to move the patients. Acute care hospitals are not a substitute for post-acute care.

- QUEST Expanded Access goes “live” on February 1, 2009. The Waitlist Task Force suggests that health plans will also experience difficulty in transitioning waitlisted patients without offering sufficient reimbursement to post-acute care providers for the cost of caring for
medically and behaviorally complex patients. Waitlisted patients require more intensive services than the average skilled nursing resident.

Therefore, the Waitlist Task Force recommends that waitlisted patients who transfer from acute to skilled nursing facilities will be reimbursed at the sub-acute rate (also known as level D). The rationale for the more specific language in this year's bill that transitions from a 40% add-on to the sub-acute rate is because of the implementation of QUEST Expanded. Health plans are required to pay no less than the current rate paid to providers. The sub-acute rate already recognizes trach and ventilated patients. However, the sub-acute rate needs to be expanded to recognize and provide reimbursement for the care needs of those patients included in the data provided by HHIC.

In order for this to be an effective solution to encourage long term care providers to care for waitlisted patients, the sub-acute payment needs to be passed through to the provider without retaining any portion for the health plans.

- Expanding the sub-acute reimbursement rate to recognize the increased costs of caring for higher acuity long term care patients is a trend across the US. Factors that may be contributing to this are the increasing age of the population and the incidence of co-morbidities (medical + behavioral diagnoses).

While Medicaid is addressed in these bills, the task force felt it was imperative that we emphasize that Medicare remains a significant contributor to the reimbursement shortfalls in caring for waitlisted patients. Additional recommendations of the reimbursement sub-committee focused on addressing reimbursement shortfalls across payer sources. Examples may include a consideration that would call for private insurers to reimburse hospitals for sub-acute days since most private insurers take the position that DRG-related reimbursement covers the entire patient stay. The shortfall in reimbursement occurs when the DRG “runs out” and the waitlisted period becomes an uncompensated acute care stay.
Example: A nursing home patient is admitted to the hospital with pneumonia. Medicare, utilizing DRGs, estimates the average hospitalization for pneumonia is 4 days and pays $3,500 for the treatment. The patient is ready for discharge after 5 days; however, the patient’s bed at the nursing home is no longer available. The patient stays in the hospital for an additional 5 days waitlisted for discharge, for which there is no additional payment.

In Hawaii, Medicare pays an average of 77.37% of cost. The total cost of care for this patient was $9,050, leaving the hospital with $5,550 in costs that do not get paid. ($4,524 of the shortfall is for the 5 days of waitlisted stay and $1,026 is from the Medicare stay where reimbursement didn’t cover costs.)

Since this issue of reimbursement shortfalls is multi-faceted, the solution should involve various stakeholders. As the economy improves, state and private funding sources/foundations could provide grants to fund the upfront cost of post-acute care capital investment, the development of specialized training for sub-acute care, and other initiatives aimed at reducing facility losses and providing for appropriate placement of waitlisted patients.

HHIC plans to continue its efforts of data collection on waitlisted patients to demonstrate trends, pending grant funding to cover database development costs. The preliminary analysis of “Acute Care Waitlisted Patients in Hawaii” drawn from 2006 discharge data provides insight into the financial challenges associated with the care of waitlisted patients.

*Diagrams 5-11 illustrate the broad financial impact that waitlisted patients have on Hawaii hospitals.*
The highest net annual losses come from Medicare and Medicaid, the two payers with the highest volume of patients. On a per patient basis, the losses are highest for Medicaid, Self Pay and Medicare patients.

* Based on CY2006 waitlisted discharges; Insurance based on primary payer. Note: Kapiolani Medical Center for Women & Children include only 4 months of data.

The Cost of Waitlisted Patients: Private Insurers*

* Based on CY2006 waitlisted discharges; Insurance based on primary payer. Note: Kapiolani Medical Center for Women & Children include only 4 months of data.
Diagram 7.

**The Cost of Waitlisted Patients: Government Insurers**

<table>
<thead>
<tr>
<th>Primary Payer Type</th>
<th>Total No. Discharges</th>
<th>Days</th>
<th>Total Cost</th>
<th>Total Expected Reimbursement</th>
<th>Net Annual Loss</th>
<th>Net Loss per Patient</th>
<th>Net Loss per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>2,505</td>
<td>25,388</td>
<td>$26,200,605</td>
<td>$1,372,814</td>
<td>($24,827,791)</td>
<td>($9,911)</td>
<td>($978)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>658</td>
<td>9,393</td>
<td>$9,716,398</td>
<td>$2,251,585</td>
<td>($7,464,813)</td>
<td>($11,345)</td>
<td>($795)</td>
</tr>
<tr>
<td>HMSA 65C+</td>
<td>1,023</td>
<td>7,648</td>
<td>$7,499,899</td>
<td>$164,780</td>
<td>($7,335,139)</td>
<td>($7,170)</td>
<td>($959)</td>
</tr>
<tr>
<td>Kaiser Senior Advantage</td>
<td>356</td>
<td>5,093</td>
<td>$5,420,097</td>
<td>$2,158,065</td>
<td>($3,262,032)</td>
<td>($9,163)</td>
<td>($640)</td>
</tr>
<tr>
<td>HMSA QUEST</td>
<td>133</td>
<td>1,218</td>
<td>$1,341,459</td>
<td>$222,502</td>
<td>($1,118,957)</td>
<td>($8,413)</td>
<td>($919)</td>
</tr>
<tr>
<td>AlohaCare</td>
<td>141</td>
<td>1,228</td>
<td>$1,359,366</td>
<td>$399,370</td>
<td>($960,199)</td>
<td>($6,810)</td>
<td>($782)</td>
</tr>
<tr>
<td>Kaiser QUEST</td>
<td>20</td>
<td>168</td>
<td>$231,792</td>
<td>$141,540</td>
<td>($90,254)</td>
<td>($4,513)</td>
<td>($537)</td>
</tr>
<tr>
<td>QUEST (Any other QUEST plan)</td>
<td>1</td>
<td>13</td>
<td>$13,069</td>
<td>$14,448</td>
<td>$1,379</td>
<td>$1,379</td>
<td>$106</td>
</tr>
</tbody>
</table>

Totals: 4,837 50,149 $51,782,888 $6,725,104 ($45,057,784) ($9,316) ($898)

*Based on CY2006 waitlisted discharges; insurance based on primary payer. Note: Kapiolani Medical Center for Women & Children include only 4 months of data.

Source: Hawaii Health Information Corporation

Diagram 8.

**The Cost of Waitlisted Patients: Uninsured and Other**

<table>
<thead>
<tr>
<th>Primary Payer Type</th>
<th>Total No. Discharges</th>
<th>Days</th>
<th>Total Cost</th>
<th>Total Expected Reimbursement</th>
<th>Net Annual Loss</th>
<th>Net Loss per Patient</th>
<th>Net Loss per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay/Uninsured</td>
<td>104</td>
<td>924</td>
<td>$1,004,500</td>
<td>$0</td>
<td>($1,004,500)</td>
<td>($9,659)</td>
<td>($1,087)</td>
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<tr>
<td>No Fault</td>
<td>123</td>
<td>869</td>
<td>$989,438</td>
<td>$276,921</td>
<td>($712,517)</td>
<td>($5,793)</td>
<td>($820)</td>
</tr>
<tr>
<td>Veterans Administration (VA)</td>
<td>74</td>
<td>674</td>
<td>$667,914</td>
<td>$24,754</td>
<td>($643,160)</td>
<td>($8,691)</td>
<td>($954)</td>
</tr>
<tr>
<td>TRICARE/CHAMPUS/Other Gov</td>
<td>18</td>
<td>189</td>
<td>$198,523</td>
<td>$55,986</td>
<td>($142,537)</td>
<td>($7,919)</td>
<td>($754)</td>
</tr>
<tr>
<td>Workers' Compensation</td>
<td>54</td>
<td>262</td>
<td>$298,733</td>
<td>$192,707</td>
<td>($106,026)</td>
<td>($1,963)</td>
<td>($405)</td>
</tr>
</tbody>
</table>

Totals: 373 2,918 $3,159,108 $550,368 ($2,608,740) ($6,994) ($894)

*Based on CY2006 waitlisted discharges; insurance based on primary payer. Note: Kapiolani Medical Center for Women & Children include only 4 months of data.

Source: Hawaii Health Information Corporation
The Queens Medical Center and Maui Medical Center, with the greatest volume of waitlisted patients, experienced net annual losses at least 3 times those of other hospitals.

Source: Hawaii Health Information Corporation

The Payer Distribution Varies by Hospital*

Source: Hawaii Health Information Corporation

*Based on CY2006 waitlisted discharges; Insurance based on primary payer and grouped into Payer Type groupings.
Diagram 11.

The Average Cost per Day for Waitlisted Patient Days...*

- Range in daily costs narrow:
  - Minimum: $797/day
  - Maximum: $1,390/day

- For waitlisted patient days, the daily costs primarily reflect per diem costs, labs, and pharmaceuticals costs.

*by average charge per day where annual discharges ≥ 25; cost based on waitlisted days only. Based on CY2006.

Source: Hawaii Health Information Corporation

An examination of the clinical conditions that contribute to the difficulty in placing waitlisted patients was explored in detail as it pertained to the cost of care. The Waitlist Task Force members, in their day-to-day experiences with this population, recognized the importance of expanding the “picture” to include the secondary diagnosis accompanying the primary reason a patient was admitted to acute care. This is important because the secondary diagnosis (ex: behavioral problem, infection, obesity, malnutrition) may be the reason why the post-acute care provider is reticent to accept the patient. It is imperative that the “whole picture” of medical and social conditions be included in the planning efforts to find appropriate placement for these patients.
Diagrams 12-19 focus on high volume and high cost diagnoses which account for one third of all waitlisted patients. Further, more than half of the high cost diagnoses are complicated by the presence of at least one of the secondary conditions known to be barriers to placement: morbid obesity, behavioral health problems, malnutrition, and certain infections.

Diagram 12.

Conditions with the Greatest Total Annual Cost*

<table>
<thead>
<tr>
<th>Condition (APR-DRG)</th>
<th>Hospitalizations</th>
<th>ALOS</th>
<th>Cost per Day</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>STROKE</td>
<td>293</td>
<td>9</td>
<td>$991</td>
<td>$2,579,504</td>
</tr>
<tr>
<td>CELLULITIS</td>
<td>261</td>
<td>9</td>
<td>$1,054</td>
<td>$2,487,897</td>
</tr>
<tr>
<td>INFECTIOUS DISEASES INCLUDING HIV W/Q.R. PROCEDURE</td>
<td>76</td>
<td>24</td>
<td>$1,126</td>
<td>$2,080,090</td>
</tr>
<tr>
<td>SEPTICEMIA</td>
<td>195</td>
<td>11</td>
<td>$099</td>
<td>$2,059,637</td>
</tr>
<tr>
<td>TRACHEOSTOMY W/ LONG TERM MECHANICAL VENTILATION W/ EXTENSIVE PROCEDURE</td>
<td>52</td>
<td>22</td>
<td>$1,085</td>
<td>$1,926,008</td>
</tr>
<tr>
<td>MAJOR RESPIRATORY INFECTIONS</td>
<td>220</td>
<td>8</td>
<td>$1,009</td>
<td>$1,825,034</td>
</tr>
<tr>
<td>HIP FRACTURE</td>
<td>208</td>
<td>7</td>
<td>$1,044</td>
<td>$1,528,185</td>
</tr>
<tr>
<td>SKIN ULCERS</td>
<td>60</td>
<td>20</td>
<td>$1,053</td>
<td>$1,455,893</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>183</td>
<td>9</td>
<td>$797</td>
<td>$1,216,773</td>
</tr>
<tr>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS</td>
<td>116</td>
<td>11</td>
<td>$1,008</td>
<td>$1,280,072</td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td>186</td>
<td>6</td>
<td>$952</td>
<td>$1,117,692</td>
</tr>
<tr>
<td>RENAL FAILURE</td>
<td>126</td>
<td>8</td>
<td>$1,014</td>
<td>$1,003,737</td>
</tr>
<tr>
<td>Totals (Top 12):</td>
<td>1,986</td>
<td></td>
<td></td>
<td>$20,670,446</td>
</tr>
</tbody>
</table>

*Sorted by total annual cost. Annual cost for waitlisted stay, CY 2006; does not include acute care cost.

Source: Hawaii Health Information Corporation

Diagram 13.

Conditions with the Greatest Total Annual Cost* (continued)

- Based on ‘Total Annual Cost’, the top 12 conditions represent:
  - 33% of annual waitlisted hospitalizations
  - 33% of annual waitlisted hospital costs

*Total annual cost serves as a good overall measure that can be used to identify the most common conditions associated with the waitlisted patient.

Source: Hawaii Health Information Corporation
Diagram 14.

<table>
<thead>
<tr>
<th>Condition (APR-DRG)</th>
<th>Hospitalizations</th>
<th>Percent with Problem Secondary Diagnosis*</th>
<th>ALOS with Problem Secondary Diagnosis*</th>
<th>ALOS without Problem Secondary Diagnosis*</th>
<th>ALOS Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>STROKE</td>
<td>293.</td>
<td>30%</td>
<td>12.8</td>
<td>5.8</td>
<td>7.2</td>
</tr>
<tr>
<td>CELLULITIS</td>
<td>261.</td>
<td>70%</td>
<td>10.3</td>
<td>6.2</td>
<td>4.1</td>
</tr>
<tr>
<td>INFECTIOUS DISEASES INCLUDING HIV W/O PROCEDURE</td>
<td>76.</td>
<td>44%</td>
<td>24.8</td>
<td>24.5</td>
<td>0.4</td>
</tr>
<tr>
<td>SEPTICEMIA</td>
<td>195.</td>
<td>61%</td>
<td>11.1</td>
<td>10.0</td>
<td>1.1</td>
</tr>
<tr>
<td>TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE</td>
<td>53.</td>
<td>45%</td>
<td>14.2</td>
<td>40.5</td>
<td>-26.3</td>
</tr>
<tr>
<td>MAJOR RESPIRATORY INFECTIONS</td>
<td>220.</td>
<td>69%</td>
<td>9.5</td>
<td>5.4</td>
<td>4.1</td>
</tr>
<tr>
<td>HIP FRACTURE</td>
<td>208.</td>
<td>48%</td>
<td>9.3</td>
<td>4.8</td>
<td>4.6</td>
</tr>
<tr>
<td>SKIN ULCERS</td>
<td>69.</td>
<td>57%</td>
<td>12.6</td>
<td>11.5</td>
<td>1.1</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>183.</td>
<td>43%</td>
<td>8.3</td>
<td>6.1</td>
<td>2.2</td>
</tr>
<tr>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS</td>
<td>116.</td>
<td>65%</td>
<td>10.9</td>
<td>11.0</td>
<td>-0.1</td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td>186.</td>
<td>55%</td>
<td>7.7</td>
<td>4.7</td>
<td>3.0</td>
</tr>
<tr>
<td>RENAL FAILURE</td>
<td>128.</td>
<td>42%</td>
<td>12.1</td>
<td>4.9</td>
<td>7.2</td>
</tr>
<tr>
<td>Totals (Top 12):</td>
<td>1,986</td>
<td>54%</td>
<td>11.4</td>
<td>8.6</td>
<td>2.8</td>
</tr>
</tbody>
</table>

*CY 2006. Problem Secondary diagnosis include Behavioral Health disorder (ICD9 2900-319), Obesity (ICD9 27801), MRSA (ICD9 V090), VRE (ICD9 V098x), and Malnutrition (ICD9 261-2639).

Source: Hawaii Health Information Corporation

Diagram 15.

*CY 2006. Problem Secondary diagnoses include Behavioral Health disorder (ICD9 2900-319), Obesity (ICD9 27801), MRSA (ICD9 V090), VRE (ICD9 V098x), and Malnutrition (ICD9 261-2639).

Source: Hawaii Health Information Corporation
Diagram 16.

Total waitlisted cost linear relationship with total days stay.

Source: Hawaii Health Information Corporation

Diagram 17.

 Neighbor Islands
Top 10 Conditions*

<table>
<thead>
<tr>
<th>Big Island</th>
<th>Kauai</th>
<th>Maui</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cellulitis</td>
<td>• Stroke</td>
<td>• Cellulitis</td>
</tr>
<tr>
<td>• Major Depressive Disorders*</td>
<td>• Hip Fracture</td>
<td>• Stroke</td>
</tr>
<tr>
<td>• Kidney, Urinary Tract Procedures*</td>
<td>• Skin Ulcers*</td>
<td>• Hip Fracture</td>
</tr>
<tr>
<td>• Knee &amp; Lower Leg Procedures*</td>
<td>• Rehabilitation</td>
<td>• Skin Ulcers</td>
</tr>
<tr>
<td>• Heart Failure</td>
<td>• Seizure*</td>
<td>• Heart Failure</td>
</tr>
<tr>
<td>• Pneumonia</td>
<td>• Cellulitis*</td>
<td>• Kidney &amp; Urinary Tract Infections</td>
</tr>
<tr>
<td>• Degenerative Nervous System Disorders*</td>
<td>• Skin Graft*</td>
<td>• Back &amp; Neck Disorders, Fractures &amp; Injuries</td>
</tr>
<tr>
<td>• Stroke</td>
<td>• Degenerative Nervous System Disorders*</td>
<td>• Amputation Of Lower Limb Except Toes*</td>
</tr>
<tr>
<td>• Osteomyelitis*</td>
<td>• Other Musculoskeletal System &amp; Connective Tissue Diagnoses*</td>
<td>• Acute Myocardial Infarction</td>
</tr>
<tr>
<td>• Septicemia</td>
<td>• Major Respiratory Infections</td>
<td></td>
</tr>
</tbody>
</table>

*by annual cost for waitlisted stay; does not include acute care cost. Conditions bolded are same, as overall top conditions 'by annual cost'. Based on CY2006 discharges. Note: Some conditions in Top 10 by Neighbor Island have cell sizes of 10 or fewer (annual); these are noted with **.
### Diagram 18.

**Conditions with the Greatest Number of Hospitalizations**

<table>
<thead>
<tr>
<th>Top Conditions (APR-DRG)</th>
<th>Hospitalizations</th>
<th>ALOS</th>
<th>Cost per Day</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>STROKE</td>
<td>293</td>
<td>8.89</td>
<td>$891</td>
<td>$2,579,504</td>
</tr>
<tr>
<td>CELLULITIS</td>
<td>261</td>
<td>9.04</td>
<td>$1,054</td>
<td>$2,487,897</td>
</tr>
<tr>
<td>MAJOR RESPIRATORY INFECTIONS &amp; INFILMATIONS</td>
<td>220</td>
<td>8.22</td>
<td>$1,009</td>
<td>$1,825,034</td>
</tr>
<tr>
<td>HIP FRACTURE</td>
<td>208</td>
<td>7.04</td>
<td>$1,044</td>
<td>$1,526,185</td>
</tr>
<tr>
<td>SEPTICEMIA</td>
<td>195</td>
<td>10.67</td>
<td>$990</td>
<td>$2,059,637</td>
</tr>
<tr>
<td>OTHER PNEUMONIA</td>
<td>186</td>
<td>6.31</td>
<td>$553</td>
<td>$1,117,692</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>183</td>
<td>9.03</td>
<td>$797</td>
<td>$1,316,773</td>
</tr>
<tr>
<td>OTHER BACK &amp; NECK DISORDERS, FRACTURES &amp; INJURIES</td>
<td>150</td>
<td>6.35</td>
<td>$1,031</td>
<td>$924,610</td>
</tr>
<tr>
<td>RENAL FAILURE</td>
<td>126</td>
<td>6.35</td>
<td>$1,031</td>
<td>$803,737</td>
</tr>
<tr>
<td>HIP JOINT REPLACEMENT</td>
<td>119</td>
<td>6.56</td>
<td>$1,114</td>
<td>$870,282</td>
</tr>
</tbody>
</table>

Same list of conditions as ‘by Total Annual Cost’ unless bolded.

*by total annual hospitalizations; waitlisted days only.

Source: Hawaii Health Information Corporation

### Diagram 19.

**Conditions with the Longest Average Length of Stay**

<table>
<thead>
<tr>
<th>Top Conditions (APR-DRG)</th>
<th>Hospitalizations</th>
<th>ALOS</th>
<th>Cost per Day</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG ABUSE &amp; DEPENDENCE</td>
<td>3</td>
<td>134.3</td>
<td>$98</td>
<td>$39,448</td>
</tr>
<tr>
<td>CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION</td>
<td>5</td>
<td>77.6</td>
<td>$328</td>
<td>$360,094</td>
</tr>
<tr>
<td>OTHER KIDNEY, URINARY TRACT &amp; RELATED PROCEDURES</td>
<td>9</td>
<td>62.0</td>
<td>$1,265</td>
<td>$706,094</td>
</tr>
<tr>
<td>MAJOR DEPRESSIVE DISORDERS &amp; OTHER/UNSPECIFIED PSYCHOSES</td>
<td>11</td>
<td>44.7</td>
<td>$666</td>
<td>$327,567</td>
</tr>
<tr>
<td>MENTAL ILLNESS DIAGNOSIS W O.R. PROEDURE</td>
<td>4</td>
<td>43.8</td>
<td>$1,108</td>
<td>$193,926</td>
</tr>
<tr>
<td>EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT</td>
<td>2</td>
<td>37.5</td>
<td>$1,166</td>
<td>$87,425</td>
</tr>
<tr>
<td>OTHER NERVOUS SYSTEM &amp; RELATED PROCEDURES</td>
<td>4</td>
<td>38.3</td>
<td>$867</td>
<td>$122,209</td>
</tr>
<tr>
<td>URETHRAL &amp; TRANURETHRAL PROCEDURES</td>
<td>2</td>
<td>39.7</td>
<td>$761</td>
<td>$76,865</td>
</tr>
<tr>
<td>TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE</td>
<td>53</td>
<td>33.5</td>
<td>$1,086</td>
<td>$1,926,008</td>
</tr>
<tr>
<td>ORGANIC MENTAL HEALTH DISTURBANCES</td>
<td>21</td>
<td>32.4</td>
<td>$921</td>
<td>$626,466</td>
</tr>
</tbody>
</table>

Three conditions with the longest length of stay are Psychiatry-related.

*by average length of stay; waitlisted days only. Conditions in blue text are psychiatry-related. Bolded in common with top conditions by total annual cost. Based on CY2008.

Source: Hawaii Health Information Corporation
CAPACITY

As evidenced by the waitlisted patient problem, long term care capacity in Hawaii remains insufficient to meet current and future demand. To engage in a prudent discussion about capacity and to forecast supply and demand, we must include in our assumptions that capacity building requires the development of appropriate long term care services to match demand. The Waitlist Task Force, in its mission, focused only on waitlisted patients.

Often, in our discussions outside of the task force, we recognized that modeling supply and demand for long term care capacity was “one-dimensional”. This means that the forecasting did not include specificity to the medical and social drivers of demand. Planning for the appropriate supply of long term care services must include more than a summary of who might need long term care services and how many total beds we have in the state across institutional and home/community-based long term care settings. If we do not do so, we will continue to fall short in forecasting and deliberately planning for our long term care needs.

Advanced modeling and predictive tools are available through accounting and consulting firms, “think tanks” and universities. The value of these tools allows for variable data (ex: changes in Medicaid budgets, changes in current supply of long term care beds, reductions or growth in workforce supply, etc.). It is a dynamic tool that focuses on deliberate planning.

The task force recommends that SHPDA make an earnest effort to move toward predictive modeling in our state to enable deliberate planning for capacity building in long term care. In addition, Hawaii needs the ability to utilize a snapshot/real time method to “see” where vacancies in institutional and home/community-based settings exist. These snapshots will provide for a daily picture of opportunities for post-acute care placement of waitlisted patients. This will be addressed in more detail under the regulatory/government section in conjunction with a proof of concept model for an electronic discharge tool that bridges acute to post-acute care discharges.
Incentives for capacity building were discussed during the 2008 Legislative Session where the task force proposed the use of state land as a means of balancing the pro forma for businesses interested in expanding long term care capacity. The Department of Health came forward with an RFI to build a nursing facility on state land adjacent to the existing state mental health facility. The task force members invited Dr. Kawika Liu, Project Coordinator for the proposed facility, to meet and discuss the unique needs of the waitlisted population. Task force members provided background information on the medical and social needs of this population and Dr. Liu was receptive to the information. He expressed that the exchange of information allowed for additional tailoring of the RFI to consider the unique needs of the waitlisted population.

The RFP for the new facility is anticipated soon. Reports from LTC providers, however, still indicate that initial estimates of an up-front capital investment to compete for this bid exceed what they can pursue.

Expanding LTC capacity, whether institutional or home/community-based will require a concerted effort to address the financial challenges facing providers as they simply contemplate an expansion of existing services to care for more complex patients. Advancing our recommendations for reimbursement tailored to this population will assist in capacity building.

Medicaid’s QUEST Expanded Access and Going Home Plus ($10 million grant over 5 year period) will also be challenged in their efforts to implement the objectives of the programs without expanded capacity to care for medically and behaviorally complex patients.

HHIC’s data pertaining to occupancy rates and bed availability offers additional insight into this challenge.

Diagrams 20-22 illustrate that insufficient facility-based long term care capacity exists and that the volume of waitlisted patient days could fill a mid-sized hospital, 365 days per year.
Diagram 20. 

**Demand for Long Term Care Beds Exceeds Supply. The Overall Occupancy Rate for Long Term Care Facilities Exceeds 94% on All Counties.**

Long term care occupancy rates exceed 94% on all counties. Essentially, there is no excess capacity. For the occasional bed that is available, long term care facility operators have the option of selecting the least costly patient rather than one who is morbidly obese, has mental health issues, is malnourished, or who has an infection.

Diagram 21.

**Long Term Care Waitlisted Patients have a Significant Impact on the Availability of Beds from Many of Hawaii’s Acute Care Hospitals.**

*Annual, based on CY2006*  

Source: Hawaii Health Information Corporation
Diagram 22.

A Total of 165 Acute Care Beds are Occupied Each Day by Long Term Care Waitlisted Patients.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Waitlist Days*</th>
<th>Beds used per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUEEN'S</td>
<td>13,816</td>
<td>30</td>
</tr>
<tr>
<td>MAUI</td>
<td>10,773</td>
<td>30</td>
</tr>
<tr>
<td>KAISER</td>
<td>6,260</td>
<td>17</td>
</tr>
<tr>
<td>HILO</td>
<td>5,385</td>
<td>15</td>
</tr>
<tr>
<td>WILCOX</td>
<td>4,480</td>
<td>12</td>
</tr>
<tr>
<td>PALI MOMI</td>
<td>4,250</td>
<td>12</td>
</tr>
<tr>
<td>HMC-EAST</td>
<td>4,211</td>
<td>12</td>
</tr>
<tr>
<td>CASTLE</td>
<td>2,990</td>
<td>8</td>
</tr>
<tr>
<td>KUAKINI</td>
<td>2,660</td>
<td>7</td>
</tr>
<tr>
<td>STRAUB</td>
<td>2,596</td>
<td>7</td>
</tr>
<tr>
<td>HMC-WEST</td>
<td>1,989</td>
<td>5</td>
</tr>
<tr>
<td>KONA</td>
<td>857</td>
<td>2</td>
</tr>
<tr>
<td>KAPIOLANI</td>
<td>61</td>
<td>&lt;1</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>60,328</strong></td>
<td><strong>165</strong></td>
</tr>
</tbody>
</table>

*Annual, based on CY2006. **Beds per day** based on waitlisted patient days. ***Kapiolani data based on 4 months of data only.

Source: Hawaii Health Information Corporation
REGULATORY / GOVERNMENT

1. Hawaii State Medicaid eligibility/re-eligibility determinations:

a. During the 2008 Legislative Session, the Waitlist Task Force decided to focus its efforts in this category primarily on Medicaid eligibility and re-eligibility. SB 3257 (Relating to Medicaid Presumptive Eligibility) advanced to conference committee and then died. When the task force resumed its meetings following the session, they made collaboration with DHS on this issue a priority. Over this past year, they met with representatives from DHS and contractors who focus on the completion of Medicaid eligibility applications for hospitals.

The task force took a proactive approach that they hoped would allow for progress on this issue following the 2008 Session.

- In July, we were informed that DHS planned to embark on a pilot project over the next three months with the Queen’s Medical Center, to focus on process improvement for each step in the eligibility process. Their goal was to incorporate process improvement findings into the process and expand it across Oahu. The project, however, did not get off the ground until November due to delays in funding the small purchase request and therefore made it difficult for the task force to evaluate the effectiveness of this approach. To clarify, this pilot project was not focused solely on waitlisted patients. Rather, the intent was to improve the eligibility application-to-determination process overall. We look forward to reviewing their data.

- DHS intends to move the eligibility process to an electronic platform. It will be a “ground up” build focused on making changes to existing systems and/or the incorporation of future systems. Performance standards will be applied to each worker within DHS to insure that timelines, even in an electronic format, will be met. This process is expected to take two years.
• DHS, in their interactions with HAH last year, expressed the need for training of discharge planning staff to reinforce what constituted a completed Medicaid application. DHS does not process a Medicaid application unless it is completed. We agreed to work with DHS to participate in this training effort.

• The expedited eligibility process that DHS expressed to the 2008 Legislature would offer an alternative to presumptive eligibility was reviewed. Task force members asked for clarification on the definition of waitlisted patients that DHS was using in the expedited eligibility process because the acute care facilities did not observe a uniform application of the process to waitlisted patients requiring transfer to institutional setting as opposed to community-based settings.

The task force remains very concerned about the amount of time it takes to complete the Medicaid eligibility and re-eligibility process. The paper driven eligibility process is obsolete. Waiting two years to move to a “ground up” build electronic platform is not going to offer a timely response to what is a backlogged system. The current economic environment will contribute to additional demand on the Medicaid system thereby necessitating efficiencies in the system to insure timely access to benefits. The implementation of QUEST Expanded Access does not address improvements in the eligibility process.

Labor costs (losses) are incurred by acute care, post-acute care and the state as a result of these inefficiencies. Putting time and attention to this matter NOW will result in costs savings by the public and private sector. Data from other states that have migrated to an electronic platform for Medicaid eligibility has shown that there is a reduction in the duplicate applications received. Medicaid workers have to make a determination on all applications whether they are duplicates or not.
The task force supports presumptive eligibility for waitlisted patients to enable timely determinations on a population that is difficult to place.

The task force appreciates the opportunity to dialogue with DHS on the eligibility process but has determined that this past year’s efforts did not result in a timely resolution of the problem. Additionally, they do not recommend putting any additional effort in at DHS to reassign staff to special units as a way of managing the eligibility process. They have not seen improvements in the timeliness of determinations for waitlisted patients this past year.

The task force is seeking legislative support of presumptive Medicaid eligibility legislation for aged and disabled consumers as has been done for pregnant women and children nationwide. Presumptive eligibility means that the Department of Human Services shall make a preliminary or “presumptive determination” to authorize medical assistance in the interval between application and the final Medicaid eligibility determination based on the likelihood that the applicant will be eligible. We believe that mandating eligibility/re-eligibility and enforcing determination timeframes will improve access to care for Medicaid recipients.

b. Shifting responsibility for consumer assistance in completing the Medicaid application from the provider of service to the State Department of Human Services: Consumers and their families must be accountable for the submission of documents necessary to complete the Medicaid application. Due to the complexity of medical and social needs of waitlisted patients, providers are left to rely on family members to assist them in this process. Yet, there is no penalty if this does not occur and DHS, as a social services agency, does not “engage” in making a determination of the application until it’s completed. Providers are left in a “held hostage” position when their focus should be on providing health services. When the health services needed have been completed, the
discharge to the next appropriate level of care should follow. Health care settings are not substitutes for housing.

The task force continues to assert that Hawaii needs to explore Attorney General involvement, similar to other states (ex: Nevada) to curtail fraudulent activity as a reason for non-compliance by family members/guardians in the completion of the Medicaid eligibility/re-eligibility applications.

The challenges that providers and DHS face in getting consumers to participate in the application process offer an area for “common-ground” discussions. As a state, we need to insure that consumers are supported with the knowledge and assistance to complete an application while at the same time enforcing penalties on consumers who deliberately avoid being forthcoming with substantiating documents that are necessary to complete the Medicaid application. This process cannot be fixed without also addressing the consumer challenges.

2. Pursue funding to develop an electronic discharge referral and database system. The Waitlist Task Force discussed the following proposed proof of concept model:

Problem: The administrative discharge processes that support the exchange of information about the patient being discharged to post-acute care rely on telephones, faxes, and paper processes that can be labor intensive and inefficient. The resultant impact is a more costly system that does not support timely discharges to post-acute care.

Impact: The opportunity to migrate the administrative discharge processes that support the exchange of information between acute and post-acute care providers to an electronic web-based platform could result in a more timely determination of the post-acute care admission, reduce labor costs incurred by acute and post-acute care providers, and allow for inclusion of an on-line Medicaid eligibility application process.
Successful solution: A successful outcome would demonstrate that an electronic platform offers a more efficient discharge option than a paper-driven system, equal accessibility to information in the post-acute care market thereby maximizing the use of available capacity, reduced labor costs, and an improved quality of life of the patient resulting from a timely discharge.

Position statement: The Waitlist Task Force believes that an electronic discharge system that links acute and post-acute care providers via a web-based platform aligns with the future direction of health care reform (migration to health IT) and offers a viable alternative to the inefficiencies of the paper-driven discharge system.

Estimated costs over a three year period to implement: $3 million. Supportive data: Information Technology vendors with healthcare support software have already tested this concept in other same-size and larger size markets.

3. Streamline the state licensing/regulation process:

The task force, upon review of this topic, affirmed the need to balance the state and federal regulatory requirements that long term care providers are required to meet. Nursing facilities who accept Medicare reimbursement are surveyed by the Office of Health Care Assurance (DOH). Chapter 94, the Administrative Rules that guide the survey process, has been under revision for almost 10 years and will soon progress to public hearings. The lengthy timeframe from review to implementation results in differing survey standards between the federal and state government. Even though the federal standard (more current) may be a higher standard, long term care providers incur expenses to comply with the state and federal survey standards. Home and community-based LTC providers are surveyed by the Department of Human Services. Medical tasks/services that are administered in an institutional setting are more highly regulated which leads to a higher cost. These same services are regulated differently in the home/community-based settings. The task force recognizes that there needs to be a balance between regulatory oversight that insures resident/consumer safety while also allowing for fair market competition.
The Departments of Health and Human Services need to come closer together in their regulatory standards for medical tasks/services that are provided for the waitlisted population. (Ex: A feeding tube protocol that focuses on quality of care should be the same whether it is administered in a facility or in a community-based setting.) Little to no evidence-based research data is available to substantiate the assurance of consumer safety when medical services are administered in a more loosely regulated social model of care.

More discussion is needed in this area to balance regulatory oversight, particularly as the intensity of services and acuity of patients increases in long term care facilities and the community.

4. **Medicare three-day qualifying stay:**

With the implementation of QUEST Expanded Access, the three-day qualifying stay can be waived by the health plans. The task force supports the waiver of the three-day qualifying stay to facilitate the discharge of waitlisted patients, particularly if it insures that they are able to return to the post-acute care provider who cared for them prior to the most recent acute care stay.

The duration of stay in an acute care facility should be determined based on medical necessity not as a result of an arbitrary requirement.

5. **Pursue guardianship hearing determinations within 5 days rather than the routine 60 days:**

The waitlist task force added Guardianship to the quadrant tool this year. The current process of requesting guardianship begins in the hospital. Legal teams within the hospitals work to prepare paperwork to request a guardian. A hearing, through the Office of the Public Guardian, gets scheduled and subsequently held. This process can take up to 60 days for non-urgent cases. A post-hearing assignment of a public guardian follows. This may take up to 3 weeks (the timeframe results from a waiting period that culminates following the judge’s decision and potentially the assignment of a guardian).

There is an existing process that the Judiciary utilizes for Emergency Guardianship determinations. However, emergency guardianships are limited
to medical emergencies. Therefore, discharge planning arrangements don’t qualify for the expedited process. In the interim, hospitals are left to complete the up front work to locate family/friends who are willing to serve as decision makers on behalf of the patients as they await the scheduling process to ensue for a guardianship hearing.

The timeframe to complete the guardianship determination process contributes to delays in transferring waitlisted patients from acute to post-acute care settings.

**WORKFORCE**

Workforce shortages in health care were addressed in several bills during the 2008 Legislative Session. Our capability to care for waitlisted patients outside of acute care hospitals requires that we have an adequate supply of trained workers to care for them. Collaboration between acute and post-acute care settings is underway informally. The ability, however, for LTC providers to attract workers to long term care settings requires that they be able to afford to pay them and cover the cost of ongoing training. The Medicaid reimbursement bill seeks to address this need indirectly.

We anticipate that the development of a sustainable long term care system will be high on the list of issues addressed by the new Administration at the Federal level. Our national affiliate organizations, the American Health Care Association (AHCA)/National Center for Assisted Living (NCAL) are working with Congress to stimulate these discussions. On December 11, 2008, AHCA/NCAL issued a press release thanking U.S. Senator Herb Kohl (D-WI) for introducing the “Retooling the Health Care Workforce for an Aging America Act of 2008”. It would provide grants of $150,000 to up to 24 geriatric education centers that offer short-term, intensive courses on geriatrics, chronic care management, and long term care. The courses could count as continuing medical education training.

Workforce data substantiates the need to address workforce shortages in long term care:
AHCA’s recently-released Nursing Position Vacancy and Turnover Study estimated that nearly 110,000 health care personnel full-time equivalents (FTE) were needed nationwide to fill vacant nursing positions. Of those vacancies, the study found, approximately 19,400 were for registered nurses and 24,200 for licensed practical nurses, while the significant majority was for Certified Nurse Assistants (CNAs) – nearly 60,300 open positions.

A recently released Institute of Medicine (IOM) report, “Retooling for an Aging America: Building the Health Care Workforce,” concluded that there is an urgent need to prepare the health care workforce to better serve our aging population. The study found less than one percent of all nurses are certified gerontological nurses, even as the population of older people is on track to double by 2030.

Absent any change, by 2020, the supply of nurses in the United States will fall 29 percent below projected requirements – resulting in a severe shortage of nursing expertise relative to the demand for care of medically complex, frail older adults.

The State’s Center for Nursing has made progress in identifying opportunities to attract workers to long term care. We look forward to continuing to work with them and various stakeholders to strengthen the focus on long term care as a health care career opportunity.
The Waitlist Task Force would like to acknowledge the efforts of the Hawaii Health Information Corporation (HHIC) to create a “picture” of the waitlisted patient and to support the quadrant tool areas of focus with detailed data.

The discharge data enabled the task force to focus on information produced as a result of the duration of the acute care hospital stay. However, the one-calendar year discharge data does not allow us to examine the challenges acute care facilities face when caring for patients who can’t be discharged. The reason for this is that the patient data is only captured upon discharge; so if a patient remains hospitalized beyond the calendar year data period (for example, over 365 days), then that data would not be reflected in this waitlist report.

The continued development of HHIC’s waitlist database, incorporating multiple years of data, will address this limitation and allow for a more detailed evaluation of our progress on the waitlist issue over time.

Another area where more detailed data is needed pertains to admission practices that lead to waitlist stays. The task force members, in their day-to-day work with waitlisted patients, report repeat admissions for this complex group of patients. They report that some factors contributing to ER visits may be decisions made by the post-acute care provider or caregiver to return the patient to an acute care setting because of: 1) increasing acuity in caring for the patient, 2) a realization that the patient is more difficult to care for than originally conceived, and 3) reportedly some reasons that pertain to the inappropriate use of emergency departments as alternative care sites.
Diagram 23.

Almost 70% Waitlist Patients Admitted via ER; Transfers have highest Severity of Illness.

<table>
<thead>
<tr>
<th>Admission Source</th>
<th>Admissions</th>
<th>Percent</th>
<th>ALOS*</th>
<th>Ave Age</th>
<th>SOI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room (ER)</td>
<td>4,110</td>
<td>68.4%</td>
<td>9.7</td>
<td>70</td>
<td>68</td>
</tr>
<tr>
<td>Physician referral</td>
<td>1,561</td>
<td>26.0%</td>
<td>10.0</td>
<td>68</td>
<td>64</td>
</tr>
<tr>
<td>Transfer from a hospital**</td>
<td>187</td>
<td>3.1%</td>
<td>12.6</td>
<td>62</td>
<td>76</td>
</tr>
<tr>
<td>Clinic referral</td>
<td>60</td>
<td>1.0%</td>
<td>23.3</td>
<td>68</td>
<td>70</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>1.5%</td>
<td>9.4</td>
<td>66</td>
<td>75</td>
</tr>
</tbody>
</table>

*Waitlisted days, Severity of illness (SOI), based on 3Ms APR-DRG grouper. SOI based on 100 point scale with 0 = lowest, 100 = highest SOI. ALOS based on waitlisted days only.

**46% transfers go to QMC

Source: Hawaii Health Information Corporation

Diagram 24.

One in Every Two Waitlisted Patients Go Home. ICF Bound Patients are Sicker, Older, and Stay Longer.**

<table>
<thead>
<tr>
<th>Discharge Destination</th>
<th>Percent</th>
<th>ALOS*</th>
<th>Ave Age</th>
<th>SOI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>50%</td>
<td>9 days</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>SNF</td>
<td>28%</td>
<td>7 days</td>
<td>76</td>
<td>67</td>
</tr>
<tr>
<td>ICF</td>
<td>3.5%</td>
<td>28 days</td>
<td>79</td>
<td>70</td>
</tr>
<tr>
<td>Expired</td>
<td>7%</td>
<td>16 days</td>
<td>74</td>
<td>81</td>
</tr>
</tbody>
</table>

*As measured by severity of illness (SOI), based on 3Ms APR-DRG grouper. SOI based on 100 point scale with 0 = lowest, 100 = highest SOI. ALOS based on waitlisted days only.

**ICF compared to SNF and Home-bound patients. Patients that died waiting for placement excluded from comparison.

Source: Hawaii Health Information Corporation
Healthcare is delivered through a system of services. Therefore, it is imperative as we analyze the waitlisted patient problem that we collect data to allow for an analysis of the system (in a circular format). In this report, we have been able to examine the challenges contributing to the acute care stay for the waitlisted patient and why it’s difficult to discharge them from acute care to post-acute care. We have more to learn about “why” they become acute care waitlisted patients. What are the factors that bring them to the hospital? Can additional training in post-acute care settings reduce the frequency of admissions and emergency department visits? Capturing data across the continuum of care, i.e., beyond the acute care hospital, would greatly facilitate both analysis and development of specific tactics to ease the flow of patients to the most appropriate setting.

See Recommendations section for ways the task force feels that we can make progress in this area.
The task force has formulated recommendations that target the four barrier categories. The task force reviewed each of the quadrant areas to assure relevance of the issues in 2008 and offered two modifications. Additionally, the task force recommended that we pursue the same legislative priorities this year as we did last year. They are detailed below. Those items for which the task force is requesting Legislative support are identified below with a “♦”. Others can be improved through non-legislative means by maintaining our focus and strengthening public-private partnerships to resolve the quadrant areas of need.

The recommendations are as follows:

**REIMBURSEMENT**

♦ **Increase the Medicaid per diem payment rate for waitlisted patients in acute care hospitals to equal the per diem payment rate of an acute care patient.** Acute care hospitals are reimbursed by Medicaid for the care provided to waitlisted patients at the skilled nursing facility level of care rate. This represents payment at a rate that is 20-30% of the actual cost of care (2007 E&Y Study). The Waitlist Task Force prepared a bill for introduction in the 2009 Legislature. (Exhibit 5)

♦ **Revise the LTC reimbursement structure to include additional tiers of reimbursement for complex waitlisted patients (all levels of the continuum).** Waitlisted patients have complex care needs for which the acuity based reimbursement system for LTC does not adequately provide compensation. Therefore, the payment system lacks incentives to post-acute care providers to admit/receive more complex patients from acute care hospitals. The current payments do not cover the additional costs of caring for these individuals (ex: additional staffing/equipment that is needed to care for severely obese patients). The Waitlist Task Force prepared a bill for introduction in the 2009 Legislature that seeks to apply the sub-acute
reimbursement rate to waitlisted patients once transferred from an acute care hospital into a long term care setting. The current sub-acute care Medicaid reimbursement rate that DHS uses is only applicable to patients with trach or ventilator needs.

**Create incentives for alternative sources of long term care (LTC) funding (LTC insurance tax credits, public/private LTC insurance option, etc).**

Consumers need to take an active role in planning for long term care and the long term care needs of their loved ones. While many advocacy groups are actively involved in seeking solutions to the LTC financing challenge, consumers need to understand that it’s not feasible to rely on government aid as the sole source of financing for long term care. It’s not sustainable, particularly as we experience a growth in the numbers of elderly as the baby-boomer generation ages.

The creation of a new federal long-term care benefit is one of the proposals presented by HAH’s national affiliate partners, the American Health Care Association (AHCA) and the National Centers for Assisted Living (NCAL). As the Administration discusses health care reform, AHCA & NCAL, along with the Alliance for Quality Nursing Home Care have proposed the creation of a new federal long-term care benefit, transferring the responsibility from state Medicaid programs to the federal government.

Individuals eligible for Medicare and who exhaust their personal responsibility requirement will be eligible for the federal benefit as will be all aged Medicare low-income beneficiaries who meet income and assets requirements (similar to the eligibility requirements under Medicaid today). Individuals will become eligible for LTC benefits when they have a certified long-term care need. States will be required to maintain their current budget levels of effort, paying the federal government a monthly payment, similar to the state requirement under Medicare Part D. The federal benefit will begin no later than 2017, providing the Secretary sufficient time to establish new LTC financing vehicles, to promote the new personal responsibility requirement (up to $100,000), and to give individuals sufficient time to plan for new requirement. Additional discussions and recommendations about post-acute care reform can be found at
http://www.ahcancal.org/advocacy/Documents/FinancingReformProposal.pdf. Consumer advocacy groups, such as AARP, also assert that affordable financing options for long-term care are a necessity.

**CAPACITY**

**Use state land for building long term care facilities to eliminate land cost:**

**Work with executive branch to expedite this process within DLNR.** Statewide, we’ve seen little to no growth in specialized care facilities (nursing facilities, assisted living, etc.) because the pro forma for executing a business plan does not provide for financially feasible results. Exploring opportunities to reduce the start-up costs would encourage growth in capacity. The main start-up cost is capital (land plus the cost to build in Hawaii). A process to expedite long term care capacity building is imperative to meet current and future demand.

**Add more long term care bed capacity (institutional and home/community-based); tailor to specific needs of waitlisted patients based on HHIC data collection summary.** Data included in this year’s report “puts a face” on the waitlisted patient. Use of this data supports the need to build long term care capacity throughout the state, with consideration being given to those populations with specialized medical and/or behavioral needs. Without this attention, gaps in capacity will continue to contribute to the waitlisted patient problem. Behavioral health services are an essential link to successfully building out capacity.

**Add Assisted Living Facility beds/overcome regulatory barriers.** In addition to the issues summarized under the land lease option, regulatory barriers associated with stunted growth in assisted living facilities in our state were addressed in the 2006 Legislative Session in SCR 144 “Urging the development of a long term care infrastructure plan for Hawaii to ensure public safety while supporting aging in place.” A report was prepared by a myriad of stakeholders for the 2007 session in response to SCR 144. We recommend that the Joint Legislative Committee on Aging in Place incorporate those findings into their proposed Home for Life Task Force discussions.
Include the needs of the behaviorally complex waitlisted patients in the State's Transformation Grant for Mental Health. Hawaii needs a comprehensive plan to address gaps in mental health resources statewide. In addition to resources that are available through government and private insurance coverage, the plan should also include a listing of services available from non-profit organizations to allow for a full summary of all behavioral resources in our state.

Transitioning patients from acute care hospitals to long term care settings requires that health care providers are resourced to care for these patients. Additional training and access to behavioral health specialists is essential to stabilizing the care of the behavioral health patients in an institutional or community-based long term care setting. Without these safeguards, behavioral health patients experience re-entry into the acute care hospitals for episodes of care that can be managed outside of the hospital setting with adequate training and access to behavioral health specialists. This is a serious problem.

Both the Department of Health and the Department of Human Services manage programs and oversee services provided to patients with behavioral health needs. Coordination of services between the departments and with the community is needed to streamline access to services for patients and clarify the administrative process for providers.

REGULATORY/GOVERNMENT

Strengthen disease prevention programs and foster the public’s interest in wellness to help allay the requirement for long term care services in the future by promoting a healthy aged population. Additionally, promoting the use of standardized clinical protocols for community-based providers and caregivers will assist in reducing the potential for admissions to acute care facilities including readmissions from the patient population that had been previously waitlisted but was subsequently placed in a long term care/post-acute care setting. Based on data contained in this report, behavioral health diagnoses made up the top three out of 12 high length of stay conditions.
Therefore, this is a reflection of the difficulty in placing them successfully in the post-acute setting. Standardized protocols would provide greater consistency in the care of these patients, thereby reducing the need for acute admissions.

- **Pursue Presumptive Medicaid eligibility for aged and disabled.** Establish presumptive eligibility criteria for aged and disabled to eliminate the delays in Medicaid eligibility/re-eligibility determinations. If the minimum criteria are met, then the patient will be presumed eligible for Medicaid. Delays in processing applications result in missed opportunities to place waitlisted patients in available long term care settings, create challenges for long term care providers who are reticent about taking a patient without a guaranteed source of payment, and have negative financial impacts on providers throughout the healthcare continuum. Work aggressively to migrate the Medicaid eligibility/re-eligibility processes to an electronic platform for improved efficiency and timeliness of determinations.

- **Shift responsibility for Medicaid application service support from the provider to the Department of Human Services.** Establish and enforce compliance standards required by family members/guardians in completing Medicaid eligibility/re-eligibility applications. The responsibility for assisting families with applications and completing them in a timely manner needs to shift from the provider of care to the Department of Human Services. This will be bundled into the bill referred to in the preceding paragraph.

Pursue funding to develop an electronic discharge referral and database system. **Health IT is an integral part of health care reform.** Developing interoperable systems is critical to sustainable success in sharing information across the continuum.

Initiate a pilot program that builds upon the proposed proof of concept model included in this report. Expand statewide within three years.

Development of a reporting database that encompasses the continuum of care would facilitate the identification of trends and highlight barriers. Currently
HHIC carries out this function using hospital data alone. Expanding our state’s capability to report on the full continuum of care would benefit the entire state.

**Streamline State Licensing/regulation process.** Work with DOH and DHS to streamline and shorten the licensing process, balance the regulatory oversight for similar or “like” services so that there is parity among post-acute providers and collaborate to overcome barriers that contribute to the waitlisted patient population.

**WORKFORCE**

Support initiatives that seek to address the workforce shortages that exist throughout the healthcare continuum. As stated in this report, our ability to improve the waitlist problem requires that we address all of the quadrant tool areas simultaneously. Therefore, we must ensure that our post-acute care workforce – essential in caring for medically and behaviorally complex patients – is trained to provide quality care and are sufficient in number statewide.

Work with the Joint Legislative Committee on Aging in Place and the Kupuna Caucus to support programs and legislation that train and provide monetary support to family caregivers.
Exhibit 1.  HCR 53

Exhibit 2:  Meetings of the Waitlist Task Force

Exhibit 3:  HCR 53:  Waitlist Task Force Quadrant Tool

Exhibit 4:  Waitlist Patient Flow from Acute Hospital to Long Term Care Facility
REQUESTING THE HEALTHCARE ASSOCIATION OF HAWAII TO CONTINUE ITS EFFORTS TO DEVELOP SOLUTIONS TO THE PROBLEM OF PATIENTS IN HOSPITALS WHO ARE WAITLISTED FOR LONG-TERM CARE.

WHEREAS, the Legislature adopted S.C.R. No. 198 in the 2007 legislative session to address the problem of patients who must remain in acute care hospitals because they cannot be transferred to a long-term care facility due to insufficient numbers of long-term care beds in nursing facilities; and

WHEREAS, patients in hospitals who are waitlisted for long-term care represent a serious problem in Hawaii because valuable acute care beds may not be available for those with serious illnesses or injuries; and

WHEREAS, this situation also results in high costs to hospitals that are avoidable; and

WHEREAS, S.C.R. No. 198 requested the Healthcare Association of Hawaii to study the waitlist problem and report findings and recommendations prior to the Regular Session of 2008; and

WHEREAS, in response, the Healthcare Association of Hawaii created the Waitlist Task Force (Task Force), which included representation from acute hospitals and long-term care facilities to identify and clarify issues, gather data, and develop solutions to the waitlist problem; and

WHEREAS, the Task Force met a number of times and reported to the Legislature on its efforts, but due to the complexity of the waitlist problem the Task Force has not yet completed its work in gathering data and finalizing solutions; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-fourth Legislature of the State of Hawaii, Regular Session of 2008, the Senate concurring, that the Healthcare Association of Hawaii is requested to continue its work in developing solutions to the waitlist problem; and

BE IT FURTHER RESOLVED that the Healthcare Association of Hawaii is requested to submit a second report of its findings and recommendations to the Legislature no later than 20 days prior to the convening of the Regular Session of 2009; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Governor, Director of Health, Director of Human Services, and President of the Healthcare Association of Hawaii.
### Exhibit 2

**Meetings of the Waitlist Task Force**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topics Discussed</th>
</tr>
</thead>
</table>
| May 19, 2008  | - Legislative recap  
                   - Reviewed Concurrent Resolution HCR 53  
                   - Reviewed Quadrant Tool priorities  
                   - Discussed presumptive eligibility and DHS’ proposed 5-day expedited eligibility  
                   - Capacity: discussed the DOH RFI for a skilled nursing facility to be built on the grounds of Hawaii State Hospital as it pertained to waitlisted patient needs.  
                   - Discussed the DHS grant application/person-centered hospital discharge  
                   - Electronic platform for acute to post-acute care discharge coordination: Mike Espy, ECIN, made a presentation on discharge planning software. |
| June 30, 2008 | - Dr. Kawika Liu, DOH, met with the task force to discuss the capacity objectives for the proposed facility on the grounds of Hawaii State Hospital.  
                   - Discussed the process of HHIC data collection  
                   - Considered updates to the Quadrant Tool  
                   - Identified the need for a meeting with DHS and contractors to overcome barriers in the Medicaid eligibility determination process  
                   - Discussed guardianship issues and problems  
                   - Shared information on the hemodialysis crisis  
                   - Reviewed wording in workforce section  
                   - Talked about accountability of outpatient case manager groups  
                   - Discussed problems in supporting caregivers to care for complex patient cases. Challenges vary by County. |
| July 28, 2008 | - Patty Johnson, DHS; Kookie Moon Ng, DHS; Cassandra Stewart, Outreach Services, and Scott Gardner, Gardner and Associates provided a progress update on the Medicaid eligibility application process, including an overview of the organizational changes at DHS and a pilot project for expedited processing of applications.  
                   - Discussed the 1147 (Level of Care), 1149 (Request for Emergency Processing of a Medical Application), 1128 (Disability Report), and 1129 forms  
                   - Task Force will work with DHS to pursue training opportunity for providers on what constitutes a completed Medicaid application. |
<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 29, 2008</td>
<td>Susan Forbes, HHIC Executive Director, discussed the HHIC Waitlist Report and provided answers to previous questions while members gave input for further clarification.</td>
</tr>
<tr>
<td>Oct. 27, 2008</td>
<td>Discussed and provided feedback on the HHIC Report</td>
</tr>
<tr>
<td></td>
<td>Eligibility Determinations Update: are we making progress?</td>
</tr>
<tr>
<td></td>
<td>Reviewed key elements of the 2008 Waitlist Report</td>
</tr>
<tr>
<td>Nov. 17, 2008</td>
<td>Kookie Moon-Ng (DHS) provided an update on the expedited eligibility process and pilot project at The Queen’s Medical Center.</td>
</tr>
<tr>
<td>Dec. 1, 2008</td>
<td>Continued revisions of powerpoint slides to incorporate HHIC waitlist data into report.</td>
</tr>
<tr>
<td>Dec. 15, 2008</td>
<td>Reviewed the coordinated care information from Quest Ex A Informational Briefing provided by DHS</td>
</tr>
<tr>
<td></td>
<td>Reviewed progress made in each of the four quadrants of Regulatory, Reimbursement, Capacity and Workforce since last year's report</td>
</tr>
<tr>
<td></td>
<td>Proposed bills for the 2009 Legislative Session: presumptive eligibility and Medicaid reimbursement (technical review)</td>
</tr>
<tr>
<td></td>
<td>Eligibility determination process: final recommendations</td>
</tr>
<tr>
<td></td>
<td>Facility to be built on grounds of Hawaii State Hospital: update on timeline</td>
</tr>
</tbody>
</table>
### REIMBURSEMENT

- **Increase the Medicaid per diem payment rate for waitlisted patients in acute care hospitals to equal the per diem payment rate of an acute care patient.** Current methodology reimburses at 20-30% of cost. (2008 E&Y Study)

- **Revise LTC reimbursement structure to include additional tiers of reimbursement for complex waitlisted patients (all levels of continuum)**

Create incentives for alternative sources of LTC funding (ex: LTC insurance tax credits, public/private LTC insurance option)

### CAPACITY

Use state land for building long term care facilities to eliminate land cost: Work with executive branch to expedite this process within DLNR

Add more long term care bed capacity (institutional and home/community-based); tailor to specific needs of waitlisted patients based on HHIC data collection summary

Add Assisted Living Facility beds/overcome regulatory barriers

Include the needs of the behaviorally complex waitlisted patients in the State’s Transformation Grant for Mental Health

### REGULATORY/GOVERNMENT

- **Pursue Presumptive Medicaid eligibility for aged and disabled**

- **Shift responsibility for Medicaid application service support from the provider to the Department of Human Services. Establish compliance standards required by family members/guardians in completing eligibility/re-eligibility applications.**

Pursue funding to develop an electronic discharge referral and database system

Streamline the State licensing/regulation process

Support the national initiative to eliminate the 3-day qualifying stay (Medicare/Federal)

Guardianship: pursue guardianship hearing determinations within 5 days rather than the routine 60 days

### WORKFORCE

Support initiatives that include a workforce assessment of the supply vs. demand of non-licensed paraprofessional workers (essential to enabling post-acute care market growth)

Seek opportunities to enable workforce training in the care of medically and behaviorally complex patients

### LEGISLATIVE PRIORITIES FOR 2009

- **= LEGISLATIVE PRIORITIES FOR 2009**
Exhibit 4

Waitlist Patient Flow from Acute Hospital to Long Term Care Facility

Source: Hawaii Health Information Corporation