



**REPORT TO  
THE TWENTY-FOURTH  
HAWAII STATE LEGISLATURE**

**PURSUANT TO SENATE CONCURRENT RESOLUTION 198:**

*Requesting the Healthcare Association of Hawaii to examine  
the problem of patients in acute care hospitals waitlisted for  
long term care and to propose solutions*

**ADOPTED BY THE 2007 LEGISLATURE**

**JANUARY, 2008**

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## I. EXECUTIVE SUMMARY

The 2007 Legislative Session set the stage for discussions 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).

On average, there are 200, and as many as 275, complex patients waitlisted daily for long term care in acute care hospital settings across our State. Waitlisted patients are defined as "*Patients who are 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.*" Discharge timeframes for waitlisted patients range from days to over a year. This represents a poor quality of life option for the patient, presents an often insurmountable dilemma for providers and patients, and creates a serious financial drain on acute care hospitals with ripple effects felt throughout other healthcare service sectors.

Recognizing the waitlist concern, the Legislature adopted SCR 198 (Exhibit 1), which requested the Healthcare Association of Hawaii (HAH) to conduct a study of patients in acute care hospitals who are waitlisted for long term care and to propose solutions in the 2008 Legislative Session. HAH represents the full spectrum of healthcare, including acute and long term care facilities, home care and hospice providers. A waitlist task force was created with guidance from the HAH Board of Directors.

The task force has identified four (4) barrier areas that contribute to the waitlisted patient dilemma. They are reimbursement, capacity, regulatory/government, and workforce. The task force has determined that making improvements in the waitlisted patient problem will require actions targeted at all four of the barrier areas; simultaneously and focusing on only one area of need will not create a sustainable solution. Contained in this report are recommendations that focus on solutions in all four barrier categories.

The waitlist dilemma as described above is unique to Hawaii. Hawaii has one of the lowest ratios of long term care beds for its population in the United States. Based on the 2006 AARP Public Policy Institute "Across the States" report, Hawaii ranks 48<sup>th</sup>. Where the US average is 47 beds per 1000 over age 65, Hawaii averages 23 (half of the US average).

The task force appreciates the attention given by the Legislature to the waitlist problem. At this time, some of the proposed solutions are in detailed form. Others are not as detailed because data analysis is not yet complete. The task force requests an extension of one year to continue its work on the waitlist dilemma (Exhibit 5) and to provide recommendations in the 2008 Legislative Session.

## **II. WAITLIST TASK FORCE: Composition and Mission**

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:

**Rida Ching, MSW**

Manager, Medical Social Workers  
and Kaiser Community Case Management  
Kaiser Permanente Medical Center

**Christina M. Donkervoet, RN, MS**

Director, Care Coordination & Patient Flow  
The Queen's Medical Center

**Marsha H. Graham, RN, MSN, CPUR**

Chief, Medical Management Branch  
Managed Care Division  
Tripler Army Medical Center

**Bernadette Ledesma, MPH, NHA**

Administrator  
Pearl City Nursing Home

**David Okabe**

Executive Vice President  
& Chief Financial Officer and Treasurer  
Hawaii Pacific Health

**Vicki G. Philben, RN, MPH, CPHQ (Alternate: Kathy Bodendorfer)**

Managing Director, Quality/Patient Outcomes  
Kuakini Medical Center

**Virginia Pressler, MD, MBA, FACS**

Executive Vice President, Strategic Business Development  
Hawaii Pacific Health

**Ronald J. Schurra**

Chief Executive Officer  
Hilo Medical Center

**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

Following the selection of the task force members, the first meeting convened on July 25, 2007 and members have met 10 times leading up to the 2008 Legislative Session (Exhibit 2).

In response to SCR 198, the immediate priorities of the task force were:

1. To embark on a study that collects data from hospitals and nursing facilities aimed at further analyzing the waitlist problem.
2. To develop 2-3 key short term/immediate solutions that could positively affect the waitlist problem within 6-12 months.
3. To provide recommendations that would create long term solutions to the waitlist problem.

Task force members were asked to seek solutions that strengthen public/private partnerships, that are budget neutral where possible, that improve the quality of life of the patient, and reduce the financial strain on health care providers.

### **III. ISSUES IDENTIFICATION: Quadrant Tool**

Following a lengthy series of discussions and meetings, the Waitlist Task Force identified four categories that encapsulate the barriers that contribute to the waitlisted patient problem in our State. The categories are: Reimbursement, Capacity, Regulatory/Government, and Workforce. A quadrant tool (Exhibit 4) was developed to facilitate an understanding of the barrier categories and the individual situations that contribute to these barriers.

The following principles apply to these 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.
3. Current and future demand for long term care necessitates this approach.

HAH reached out broadly to state executive colleagues in the American Hospital Association and the American Health Care Association for information about the waitlist problem, but have not been able to identify any other states that are grappling with this problem. Hospitals on the mainland confirmed that they have medically complex patients that are also challenging to place; however, when local options for discharge are not available, they utilize intrastate or interstate transfers as placement options. Thus, they do not often have waitlisted patients in acute care settings for extended periods of time.

For Hawaii, successful outcomes would focus on an improved quality of life for waitlisted patients and their families, improved access to acute and long term care, 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.

Community outreach is needed to raise awareness about this need and to reduce public/neighborhood opposition to growth in long term care capacity. A public health focus on wellness can help to allay the requirement for long term care services in the future by promoting a healthy aged population.

### **REIMBURSEMENT**

Waitlisted patients in acute care hospitals are reimbursed by Medicaid at a rate equivalent to a skilled nursing facility level of care rate. This means that the acute care hospital is paid the same amount of payment that a nursing facility would receive for caring for a waitlisted patient. 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. Therefore, the room and board costs are the same for an acute care patient as they are for a waitlisted patient. Based on the 2007 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 cost of care. A subcommittee of the Waitlist Task Force, comprised of acute care hospital Chief Financial Officers, was created to advise the waitlist task force on matters pertaining to the financial impact of waitlisted patients on acute care hospitals. A full analysis of the financial impact of the waitlisted patient problem is underway.

In addition to the losses incurred by acute care hospitals for caring for waitlisted patients, the Medicaid reimbursement system needs to be reviewed so that it includes additional payment to long term care facilities for the medically and behaviorally complex patients. Up to a point, nursing facilities receive the same rate of payment for a less complex patient as they do for a medically or

behaviorally complex patient. Therefore, the reimbursement methodology lacks the financial incentive to providers because the reimbursement does not cover the actual costs of care.

Medicaid reimbursements need to be increased to insure that the complex needs of caring for waitlisted patients demonstrate fair payment to providers in all healthcare settings. The task force believes this will create additional options for placement.

## **CAPACITY**

Long term care capacity in Hawaii is insufficient to meet current and future demand. The waitlist situation will worsen unless action to build long term care capacity is taken.

Based on the high occupancy rates of long term care beds as reported by the State Health Planning and Development Agency (SHPDA) (Exhibit 3, Table 1), comparisons to percentage of long term care beds available in other states (Exhibit 3, Table 2), projections of population growth for Hawaii (Exhibit 3, Table 3) and the case management experiences shared by the acute and long term facilities, the Waitlist Task Force believes there is a shortage of long term care beds and community based health care options.

In Table 1, the occupancy trends vary by county but show an overall increase in the five years between 2001 and 2005. There are current initiatives within the Department of Human Services to increase long term care community based options, such as QUEST Expanded (November 2008) and Going Home Plus (August 2008). Following a review of these initiatives, the task force believes that additional effort is needed to propel growth in long term care capacity at all levels (institutional and home/community based) to meet the current unmet demand for long term care services.

Table 2 indicates that Hawaii has less than half the number of long term care beds per 1000 residents over age 65 than the United States average. Table 3 shows that Hawaii's population over 65 years old is expected to be the fastest

growing sector of the population between 2000 and 2020. In order to maintain the current ratio of long term care beds to Hawaii residents over age 65, Hawaii would need to increase the available long term care beds by 2,392 calculated as follows:

103,926	Projected increase in Hawaii population over age 65 by 2020
÷ 1000	Divided by 1000
104	Increased population over age 65 in 1000's
X 23	Multiplied by current number of long term care beds per 1000 residents over age 65
<u>2392</u>	Additional long term beds required to maintain current ratio

The Hawaii SHPDA “Health Care Utilization Report 2005 Data” Table 2 shows a total of 4482 institutional long term care beds. An increase of 2392 beds would be a 53% increase.

The Waitlist Task Force asserts that the current long term care bed capacity is not adequate, and therefore, believes that increasing the beds just to maintain the current ratio may not be sufficient to meet future needs. We need to be aggressive in pursuing nursing facility and community based options to meet the current and forecasted demand. The lack of capacity pertains not only to the insufficient supply of beds but also to the lack of specialized services (ex: ventilated patients, behaviorally complex) to care for waitlisted patients. Data collection is ongoing to identify the specific needs of this under-served population.

**REGULATORY / GOVERNMENT**

Regulatory and government mandates create barriers to placing waitlisted patients. Federal and State standards differ. As such, creative solutions to the waitlist problem (ex: leasing equipment to a long term care provider by an acute care hospital) may not be possible due to these mandates.

Some of the regulatory barriers can be streamlined at the State level while others will need to be challenged at the Federal level. Since we are able to work with the state to effect change at the state level more readily than addressing necessary changes at the federal level, the task force chose to focus its efforts at the state level.

Three regulatory/government areas are summarized:

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

- a. Presumptive eligibility/re-eligibility: The task force is very concerned about the amount of time it takes to complete the Medicaid eligibility and re-eligibility process. Staff within hospitals, nursing facilities, etc. report spending a significant amount of time assisting families with Medicaid applications, following up with families to ensure their compliance in submitting the required documentation to support the application, hand carrying applications to the Medicaid eligibility office, following up with eligibility workers on the status of applications, etc. They report that hand-carried applications are often misplaced, the time clock for eligibility does not start until the application is located within DHS, family members may be non-compliant in completing the necessary paperwork since the patient is being cared for safely and the facility has no option for discharging the patient, and the providers believe that they have taken on a beneficiary services role of assisting consumers that should be assumed by DHS.

The Medicaid eligibility and re-eligibility application process in Hawaii is obsolete and unable to handle the current volume. It relies on a paper-driven system that receives a high volume of applications per day. Delays in processing applications in a timely manner translates to delays in access to care for Medicaid beneficiaries. Acute care hospitals report that in many cases they have not been able to transfer patients to long term care because the delay in making a determination of Medicaid eligibility resulted in too long a delay in placement in a nursing facility or home and community based setting. By the time the Medicaid eligibility was approved, the bed in the long term care facility/setting was taken. The direct labor hours involved in following up on the process negatively impact providers across the continuum. Many have hired outside contractors to assist in the application process.

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 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: Providers have taken on the role of consumer services representatives when patients/families need to submit applications for Medicaid eligibility or to reapply for eligibility. Often, providers end up spending hours to days “tracking down” required documentation to include with the Medicaid application and it has become labor intensive. Many have hired external organizations to assist in this process. Delays by patients/families in completing Medicaid applications result in bad debt and charity care incurred by providers and they have no recourse but to hold the family members accountable and/or discharge the patient due to non-payment.
- c. Non-compliance by family members/guardians in completing Medicaid eligibility/re-eligibility applications: In other states (ex: Nevada), legislation was passed to impose financial penalties on family members/guardians who did not actively participate in completing/submitted documentation for Medicaid eligibility/re-eligibility determinations when fraudulent activity was suspected. Attorney General involvement is needed to address non-compliance. Engage in discussions with the Attorney General’s office on this issue.

## **2. State interpretation and implementation of Federal regulations:**

Nursing facilities are required to comply with federal and state rules and regulations. They are surveyed by the Office of Health Care Assurance (DOH) annually. They may be cited for non-compliance of a federal (F-tag) or state requirement. One particular area where there is concern of strict interpretation of the federal requirement pertains to psychosocial services that are age-appropriate.

As the population of young disabled persons on the waitlist grows, acute care facility discharge planners and long term care providers have identified that this is a barrier to discharge. Nursing facilities are mandated to have age- and care-appropriate activities and services, which may not be available and results in not admitting specific patient populations. The task force members believe that this, and other examples like this, present opportunities to collaborate with DOH surveyors to overcome these barriers and seek win-win solutions.

## **3. Medicare 3-day qualifying stay:**

In the data collection process, we are trying to determine if the population of waitlisted patients represents a recurring group of medically and behaviorally complex patients that are difficult to discharge each time they are admitted. Acutely ill patients may stabilize in less than 72 hours. However, the patient cannot be discharged even if the long term care bed they previously held is available because Medicare will cover skilled care only if certain conditions are met, among which is the requirement for a minimum of three days in an acute care bed.

This presents a problem because the bed in the nursing facility or home and community based setting that the patient previously occupied might be released to a new admission. If filled due to the 3-day delay, the acute care hospital must try to locate another option for discharge. The task force believes that the 3-day qualifying stay is not necessary in all admissions and creates a barrier to timely discharge when a long term care placement option might exist. The 3-day qualifying stay is being

challenged by national organizations in Washington. The task force suggests that the Attorney General consider supporting these efforts.

### **WORKFORCE**

Workforce shortages exist in all health care settings and the financial impact is felt statewide. The task force felt that there were many initiatives already underway to address workforce shortages, to include efforts supported by the Legislature in recent sessions. We encourage continued support in mitigating the shortage of health care workers, to include outreach programs to high school students, caregiver support incentives, and fair payment to providers.

#### **IV. DATA COLLECTION**

The Waitlist Task Force, with approval from the Healthcare Association of Hawaii's Board of Directors, contracted with Ernst and Young to collect waitlist data from acute and long term care facilities in response to SCR 198. In addition, Hawaii Health Information Corporation (HHIC) completed an extensive data collection sampling from acute care hospitals focused on waitlisted patients and this data is being combined with the Ernst and Young data for the task force to analyze.

The data collection process was designed for the purpose of creating a snapshot of the waitlisted patient situation, identifying future challenges associated with this situation, and performing a gap analysis of the data. Some examples of the data being collected are:

- Information from individual acute care hospitals on the impact the waitlisted patients have on their hospitals.
- Information from individual nursing facilities on the impact to the nursing facilities of admitting waitlisted patients.

Due to the duration of time needed to complete the detailed data collection and analysis process, the task force has requested the opportunity to continue its work in 2008 to complete an analysis of the data and refine its recommendations.

## V. RECOMMENDATIONS

The task force has formulated recommendations that target the four barrier categories. Some recommendations will require assistance and support from the Legislature. The task force is requesting Legislative support at this time for those items identified with an asterisk (\*) below. Additional requests for support will follow as deemed appropriate by the task force. Others can be improved through non-legislative means by strengthening public-private partnerships.

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.** The Waitlist Task Force is preparing a bill to be introduced in the 2008 Legislature. (Exhibit 5)

- 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).

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

### **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, whether due to a catastrophic illness/injury or as a result of aging. Thus far, long term care insurance purchases have not grown in concert with the demand for long term care because it is expensive. Alternative financing to federal and state funding sources needs to be encouraged. Past efforts to seek approval of LTC tax credit legislation has not been effective. This is substantiated by the December 2007 National Commission for Quality Long Term Care Final Report that can be found at: <http://www.qualitylongtermcarecommission.org>.

### **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 HAH data collection summary**

- Medically complex patients have been difficult to place in long term care settings because their needs may dictate a specialized care setting that does not exist in our healthcare market. The intensity of the services that they require can be time consuming. Some community based settings are precluded from caring for complex behavioral patients. As we build long term capacity throughout the state, consideration must be given to those populations with specialized medical and/or behavioral needs.

### **Add Assisted Living Facility beds/overcome regulatory barriers (SCR 144)**

- 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 and 2007 Legislative Sessions.

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

- Hawaii is currently developing a comprehensive plan to address gaps in mental health resources statewide. 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. 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**

#### **\*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. Hand carried and faxed Medicaid applications are often lost and unaccounted for by DHS. This results in the “clock” of eligibility starting over. DHS needs to be accountable for applications submitted and should expeditiously seek an electronic application process statewide. The Waitlist Task Force is preparing a bill to be introduced in the 2008 Legislature.

**\*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 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 private grant funding to develop an electronic discharge referral and database system**

- Technology should be leveraged to streamline the discharge process, to reduce direct labor costs incurred by discharging and admitting providers, enable ongoing data collection of barriers to discharge, and create transparency to institutional and community based providers of patients in need of long term care services, and to insure efficiency in the utilization of existing long term care capacity. Outcome will result in a statewide care coordination network.

**Streamline State Licensing/regulation process**

- Work with DOH and DHS to streamline and shorten the licensing process. Collaborate to overcome barriers that contribute to the waitlisted patient population.

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

- Collaborate with national affiliate organizations (American Hospital Association, American Health Care Association, etc.) to fill Medicare coverage gaps for patients with complex needs.

**WORKFORCE**

- Review the report to the Legislature on SCR 212, SD 2 (Requesting the Director of Health and the Department of Labor and Industrial Relations Workforce Development Council to convene a temporary task force to examine strategies that may prevent the exodus of physicians from the State) and consider a follow-on resolution that would be broadened to assess the availability of non-licensed paraprofessional workers.
- Support programs and legislation that train and provide monetary support to family caregivers.

**Continuation of the Waitlist Task Force:**

- Request that the Waitlist Task Force continue its work in 2008 with a subsequent report to the 2009 Legislature.

## **VI. APPENDIX**

Exhibit 1. SCR 198

Exhibit 2: Meetings of the Waitlist Task Force

Exhibit 3: Data Tables

Table 1 – Long Term Care Occupancy Rates 2001-2005

Table 2 – Nursing Facility Beds per 1000 age 65+ 2005

Table 3 – Hawaii State Projected Population Change 2000-2020

Exhibit 4: SCR 198: Waitlist Task Force Quadrant Tool

Exhibit 5: Proposed Senate Concurrent Resolution requesting that the Waitlist Task Force continue its work through 2008 with a second report due to the 2009 Legislature.

**Exhibit 1**

THE SENATE  
TWENTY-FOURTH LEGISLATURE,  
2007  
STATE OF HAWAII

S.C.R. NO. 198

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SENATE CONCURRENT RESOLUTION

*REQUESTING THE HEALTHCARE ASSOCIATION OF HAWAII TO EXAMINE THE PROBLEM OF PATIENTS IN ACUTE CARE HOSPITALS WAITLISTED FOR LONG TERM CARE AND TO PROPOSE SOLUTIONS.*

WHEREAS, many patients in acute care hospitals whose conditions have improved so that they may be transferred to long term care will stay and receive treatment at hospitals because beds are not available for them at skilled nursing facilities; and

WHEREAS, according to Hawaii Pacific Health, approximately one fourth of their waitlisted long term care patients are from Oahu, another fourth are from the Pacific Islands, and up to one-half are neighbor island patients who are transferred to one of Hawaii Pacific Health's hospitals on Oahu or Kauai for care; and

WHEREAS, patients who should be receiving long term care can spend several months occupying an acute care bed at a hospital while waiting for an available bed at a skilled nursing facility; and

WHEREAS, hospitals bear the additional costs for caring for waitlisted patients and are forced to offer their already scarce acute care beds while patients wait for an available space at a skilled nursing facility; and

WHEREAS, most skilled nursing facilities are unable to accommodate patients who are on dialysis, have a tracheotomy, or have mental health issues; thus, these patients are unable to be discharged from the hospital and must stay for an extended period of time; and

WHEREAS, skilled nursing facilities on the neighbor islands are frequently at maximum capacity, which makes it difficult for patients receiving care on Oahu to transfer back to their home island for long term care; and

WHEREAS, the lack of beds available at skilled nursing facilities in Hawaii has caused patients, particularly those with mental health issues, to transfer to mainland facilities, which takes these patients away from their families and a familiar environment; and

WHEREAS, hospitals are forced to incur the expenses for transferring a long term care patient to the mainland, including travel expenses, nurse care costs, and any additional fees to assist a patient's family member with making the necessary guardianship arrangements for the transfer; and

WHEREAS, skilled nursing facilities will not accept patients until they have a source of payment; thus, hospitals must also bear their patients' health care costs while their applications for Medicaid or QUEST is being considered; and

WHEREAS, hospitals do not receive a full payment, and sometimes no payment at all, from commercial payers for the patient's waitlisted days that are spent in the hospital, creating a growing unsustainable financial burden on acute care hospitals throughout the State; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-fourth Legislature of the State of Hawaii, Regular Session of 2007, the House of Representatives concurring, that the Healthcare Association of Hawaii is requested to conduct a study of patients in acute care hospitals who are waitlisted for long term care, and to propose solutions to the problem; and

BE IT FURTHER RESOLVED that the Department of Human Services and the Department of Health cooperate with the Healthcare Association of Hawaii in the study; and

BE IT FURTHER RESOLVED that the Healthcare Association of Hawaii is requested to submit a report of findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2008; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, the Director of Human Services, the Chief Executive Officer of the Healthcare Association of Hawaii, the Chief Executive Officer of Hawaii Health Systems Corporation, the Chief Executive Officer of Hawaii Pacific Health, the Chief Executive Officer of the Queen's Medical Center, the Chief Executive Officer of Kaiser Permanente Hawaii, and the Director of the Hawaii Long Term Care Association.

OFFERED BY: \_\_\_\_\_

## Exhibit 2

<b>Meetings of the Waitlist Task Force</b>	
<b>July 25, 2007</b>	<ul style="list-style-type: none"> <li>▪ Initial meeting</li> <li>▪ Background on SCR 198</li> <li>▪ Defined goal of Task Force</li> <li>▪ Reviewed data collection progress</li> <li>▪ Report on work of Challenging Clients work group</li> <li>▪ Identification of several developing themes</li> <li>▪ Developed definition of waitlisted patients</li> <li>▪ Task Force members will work with their discharge planning staffs to develop a process flow chart for a Medicaid patient discharge</li> </ul>
<b>Aug. 27, 2007</b>	<ul style="list-style-type: none"> <li>▪ Identified State government departments, constituent/community groups and advocates to include in discussions resulting in broadened awareness</li> <li>▪ Reviewed the Medicaid patient discharge process flow charts submitted by discharge planners</li> </ul>
<b>Sept. 10, 2007</b>	<ul style="list-style-type: none"> <li>▪ Identified four major barrier categories: Reimbursement, Capacity, Regulatory/Government, Workforce</li> <li>▪ Finalized the definition of a waitlisted patient</li> <li>▪ Feedback from CMS Region IX conference call</li> <li>▪ Discussed alternative funding for long term care</li> <li>▪ Reviewed Nevada Medicaid legislation pertaining to Medicaid eligibility/fraud penalties</li> <li>▪ Discussed the waitlist presentation to be provided at the Healthcare Association of Hawaii's September 14th Advocacy meeting</li> </ul>
<b>Sept. 24, 2007</b>	<ul style="list-style-type: none"> <li>▪ Guest presenter: Patti Johnson (DHS Adult and Community Care Services Branch) attended and provided an overview of the community based programs managed by DHS.</li> </ul>
<b>Oct. 29, 2007</b>	<ul style="list-style-type: none"> <li>▪ Update on data submission</li> <li>▪ Discussed waitlist presentation for the Healthcare Association of Hawaii's (HAH) annual membership meeting on November 8<sup>th</sup></li> </ul>

<p><b>Nov. 14, 2007</b></p>	<ul style="list-style-type: none"> <li>▪ Joint meeting: Challenging Clients Work Group invited to participate for an update</li> <li>▪ Reviewed waitlist presentation made at HAH Annual Membership Meeting on November 8th</li> <li>▪ Madi Silverman (DHS, Going Home Plus Project Officer) discussed Money Follows the Person/Going Home Plus grant</li> <li>▪ Explanation of data collection tools</li> <li>▪ CMS Post Acute Care Reform Demonstration Project (Hawaii not included), CARE Instrument initiative – a tool to help clinical continuity designed to be used at discharge, admission and other critical points of care</li> </ul>
<p><b>Nov. 26, 2007</b></p>	<ul style="list-style-type: none"> <li>▪ Update on CFO Roundtable Waitlist Sub-Committee</li> <li>▪ Developed quadrant tool for four barrier areas (Reimbursement, Capacity, Regulatory/Government, and Workforce)</li> </ul>
<p><b>Dec. 3, 2007</b></p>	<ul style="list-style-type: none"> <li>▪ Focus on briefing of CEOs and preparing draft legislation</li> </ul>
<p><b>Dec. 10, 2007</b></p>	<ul style="list-style-type: none"> <li>▪ Joint meeting: Challenging Clients Work Group invited to participate for an update</li> <li>▪ Review of quadrant tool, following discussions with Directors Fukino and Koller</li> <li>▪ Discussed leveraging technology to streamline the transition process from acute to long term care</li> <li>▪ Will ask for samples of discharge tools used by other states</li> <li>▪ Recommendation made to get Department of Health’s Administrative Rules, Chapters 93 (Acute Care Hospitals) and 94 (Skilled Nursing Facilities) approved by the Attorney General</li> <li>▪ Informational briefing to Legislature tentatively planned for January 2008</li> <li>▪ Department of Land and Natural Resources will be contacted, to clarify the process of requesting State land to assist in capacity building for long term care</li> <li>▪ Discussed Medicaid eligibility/re-eligibility application barriers</li> </ul>
<p><b>Dec. 17, 2007</b></p>	<ul style="list-style-type: none"> <li>▪ Prepare draft legislation for Medicaid reimbursement</li> <li>▪ Final discussions prior to preparation of report to the 2008 Legislature</li> </ul>
<p><b>Jan. 7, 2008</b></p>	<ul style="list-style-type: none"> <li>▪ Review of SCR 198 Report to the Legislature</li> </ul>

**Exhibit 3**

Table 1

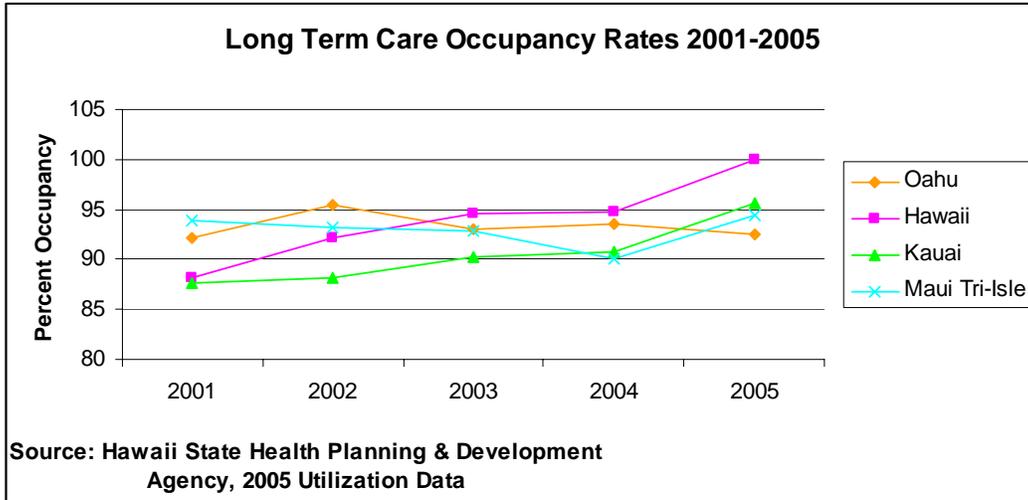


Table 2

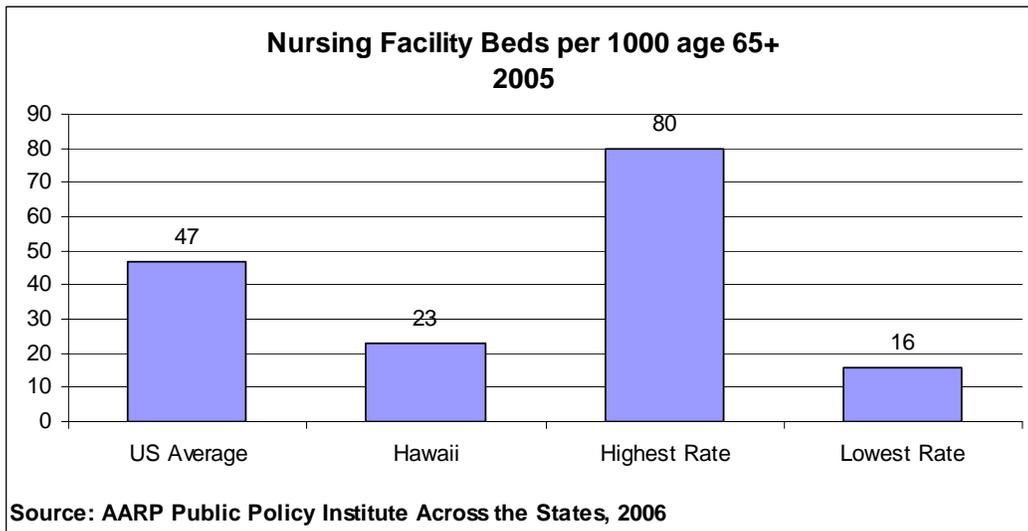
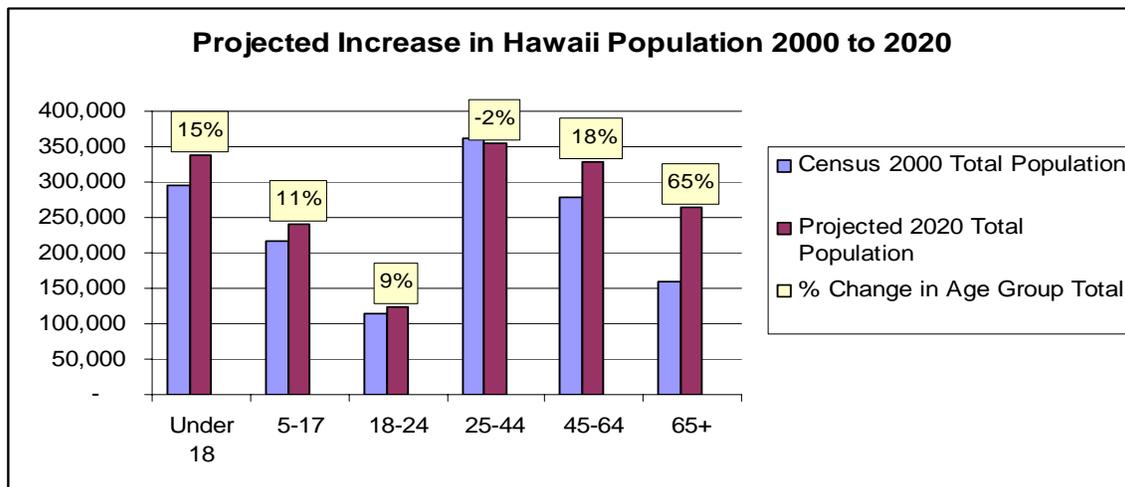


Table 3



**Exhibit 4**

**SCR 198: Waitlist Task Force Quadrant Tool**

<p align="center"><b><u>REIMBURSEMENT</u></b></p> <p>◆ <b>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.</b> <i>Current methodology reimburses at 20-30% of cost. (2007 E&amp;Y Study)</i></p> <p>Revise LTC reimbursement structure to include additional tiers of reimbursement for complex waitlisted patients (all levels of continuum)</p> <p>Create incentives for alternative sources of LTC funding (ex: LTC insurance tax credits, public/private LTC insurance option) <i>(2007 Nat'l Commission for Quality Long Term Care, Final Report, 12/3/2007)</i></p>	<p align="center"><b><u>CAPACITY</u></b></p> <p>Use state land for building long term care facilities to eliminate land cost: Work with executive branch to expedite this process within DLNR</p> <p>Add more long term care bed capacity (institutional and home/community based); tailor to specific needs of waitlisted patients based on HAH data collection summary</p> <p>Add Assisted Living Facility beds/overcome regulatory barriers (SCR 144)</p> <p>Include the needs of the behaviorally complex waitlisted patients in the State's Transformation Grant for Mental Health</p>
<p align="center"><b><u>REGULATORY / GOVERNMENT</u></b></p> <p>◆ <b>Pursue Presumptive Medicaid eligibility for aged and disabled</b></p> <p>◆ <b>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.</b></p> <p>Pursue private grant funding to develop an electronic discharge referral and database system</p> <p>Streamline the State licensing/regulation process</p> <p>Support the national initiative to eliminate the 3-day qualifying stay (Medicare/Federal)</p>	<p align="center"><b><u>WORKFORCE</u></b></p> <p>◆ <b>SCR 212, SD2 follow up: Review report to the 2008 Legislature and consider a follow-on resolution that would be broadened to assess the availability of non-licensed paraprofessional workers</b></p> <p>Support programs and legislation that seek to train and provide monetary support to family caregivers</p>

◆ = LEGISLATIVE PRIORITIES FOR 2008

**Exhibit 5**

THE SENATE  
TWENTY-FOURTH LEGISLATURE, 2008  
STATE OF HAWAII

S.C.R. NO.

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SENATE CONCURRENT  
RESOLUTION

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, recognizing the problem of patients who have been treated in acute care hospitals and whose conditions have improved so that they may be transferred to long term care, but who remain in hospitals because long term care beds in nursing facilities are not available for them; and

WHEREAS, patients in hospitals who are waitlisted for long term care represent a serious problem in Hawaii because it results in a diminished number of valuable acute care beds that are available for those with serious illnesses or injuries and also high costs to hospitals that are avoidable; and

WHEREAS, S.C.R. 198 requested the Healthcare Association of Hawaii to study the waitlist problem and report findings and recommendations prior to the 2008 session; and

WHEREAS, in response, the Healthcare Association of Hawaii created the Waitlist 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 Waitlist 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 Senate of the Twenty-Fourth Legislature of the State of Hawaii, Regular Session of 2008, the House of Representatives concurring, that the Healthcare Association of Hawaii is requested to continue the Waitlist Task Force so that it may 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 findings and recommendations to the Legislature no later than twenty 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, the Director of Health, the Director of Human Services, and the President of the Healthcare Association of Hawaii.

OFFERED BY: \_\_\_\_\_