HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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Statewide Health Coordinating Council – Plan Development Committee

Meeting Minutes

September 1, 2023 | 1:00 PM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS: Melissa Ah Ho-Mauga, Tori Abe-Carapelho, Lance Ching, Adrienne Dillard, Robert Hirokawa, Karen Holt, Paul Roeder, Wesley Sumida
MEMBERS ABSENT: Scott Daniels, Jillian Kelekoma, Jeanette Koijane
GUESTS: Stacy Haumea
SHPDA: John Lewin, Wendy Nihoa

ATTENDANCE RECORD OF APPOINTED MEMBERS

Date	6/19/23	9/1/23	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Melissa Ah Ho-Mauga	/	X								
Tori Abe Carapelho	X	X								
Lance Ching	/	X								
Scott Daniels	X	O								
Adrienne Dillard	/	X								
Robert Hirokawa	/	X								
Karen Holt	X	X								
Jillian Kelekoma	X	O								
Jeanette Koijane	/	O								
Paul Roeder	X	X								
Wesley Sumida*	X	X								

Legend: X=Present; O=Absent; /=No Meeting
*-Chair, **-Vice Chair

TOPIC	DISCUSSION	ACTION
Call to Order	A quorum was established. The meeting was called to order at 1:03 p.m. by W. Sumida, Chairperson, Plan Development Committee (PDC) presiding. W. Sumida noted a correction. Agenda item number 5, "Hawaii the Health State 2024" should read "Hawaii the Health State 2025".	
Roll Call	Member, Guest, and Staff introductions. S. Haumea, Hawaii County Subarea Health Planning Council member, attending meeting on behalf of S. Daniels to assure representation from Hawaii island.	
Welcome	W. Sumida welcomed newly appointed PDC members: M. Ah Ho-Mauga, L. Ching, A. Dillard, R. Hirokawa, and J. Koijane.	
Minutes	Motion to accept the minutes from the meeting on June 19, 2023. Vote: Unanimous. Motion carried. Public testimony – none.	
Hawaii the Health State 2025	J. Lewin, Administrator, provided a briefing on plans for Health Systems Reform and the importance of updating the Health Services and Facilities Plan. A discussion followed. Public testimony – none.	
PDC Subcommittee Development	W. Sumida provided a briefing focusing on subcommittee purpose and structure. The PDC will start with four (4) subcommittees: Keiki, Kupuna, Data, and Universal Coverage. Additional subcommittees may be added in the future. A discussion followed. Members agreed there should be guiding principles and cross cutting topics, such as behavior health, for subcommittees. Subcommittees will be referred to as Advisory Councils. This was followed by an election of Advisory Committee chairs. Motion for K. Holt to serve as chair of the Keiki Advisory Committee. Vote: 7 in favor/0 opposed/1 abstention. Motion carried. Motion for M. Ah Ho-Mauga to serve as chair of the Kupuna Advisory Committee. 7 in favor/0 opposed/1 abstention. Motion carried. Motion for R. Hirokawa to serve as chair of the Data Advisory Committee. Vote: 7 in favor/0 opposed/1 abstention. Motion carried.	

	Motion for P. Roeder to serve as chair of the Universal Coverage Advisory Committee. Vote: 7 in favor/0 opposed/1 abstention. Motion carried. Public testimony – none.	
Statewide and Regional Priorities	After a brief introduction by W. Sumida, T. Abe-Carapelho provided an update on the tool being created to encourage consistency among councils when identifying priorities. T. Abe-Carapelho mentioned she will be working on finalizing the tool and process with the goal of presenting at the next PDC meeting. A discussion followed. Public testimony. W. Nihoa read testimony from PM Azinga. A copy of the testimony is hereby attached to these minutes as Attachment A.	
Recruitment	W. Sumida stressed the need for continued recruitment to the PDC and its Advisory Committees. Members were encouraged to use three documents as recruitment tools. The documents are Hawaii the Health State 2025 White Paper (Attachment B); John "Jack" Lewin, SHPDA Administrator, Biographical sketch (Attachment C) ; and the SHPDA nomination form (Attachment D). Public testimony – none.	
Next Steps	Motion for the PDC to meet monthly. Vote: Unanimous. Motion carried. Unable to decide on a recurring day and time. W. Nihoa to poll members.	W. Nihoa to send poll to determine recurring meeting day/time.
Announcements	None.	
Next Meeting	September 29, 2023 at 1:00 p.m.	
Adjournment	The meeting was adjourned at 2:35 p.m.	

An Ounce of Prevention Equals a Pound of Cure

COVID 19 has given us a wake-up call for the need to have "all hands on desk" to join a team of well-equipped wards to provide a frontline of treatment for highly infectious diseases and bioterrorism attack by building Bio-containment Centers. The objective of biocontainment centers are to confine infectious diseases or toxins thereby reducing the potential exposure in the likelihood of accidental release into the environment.

We can prepare for battle against highly infectious disease by increasing our line of defenses thru gleaning best practices from four (4) of the currently existing Bio-Containment Centers in the United States.

From the National Institute of Health We can model creating core staff trained in strict infection control practices, design specifically to provide high-level isolation capabilities. Equipped with negative airflow, close circuit video & an inside intercom system.

From the Emory University Hospital We can model creating bath rooms with toilets, showers, lockers, where health workers can put on protective clothing, HEPA filters, pressurized steamers, incubators, incinerators, bleached, local water systems.

From the University of Nebraska Medical Center We can model creating biopods or isopods mobile, contained person length bubbles equipped with rubberized extended gloves, ultraviolet light disinfect, dunk tanks, pass through autoclaves.

From the Saint Patrick Hospital We can model creating designed bio-containment isolation safety levels 2, 3, 4 labs. Equipped with portable radiology machines, light detected touchless sinks

The clock is ticking, it is just a matter of time until we experience the next pandemic will we be prepared? Fool me once shame on you. Fool me twice shame on me.

PM Azinga
State Health Planning& Development Agency
Submitted for Public Testimony
Friday, September 1, 2023 1:00pm

‘Hawaii the Health State 2025’; A Vision and Discussion Paper

John C (Jack) Lewin MD
Administrator, Hawaii State Health Planning and Development Agency (SHPDA),

Preface: *this outline is an early phase ‘proposal-in-development’ for discussion purposes only.*

While we as a nation have an outstanding record of global leadership in medical science, health technology and innovation, medical professional training, and clinical research, America has a problematic health care “non-system” as compared to other developed nations, characterized by excessive regulatory, administrative and delivery system complexity; growing unaffordability for families, businesses, and government; unacceptable variation in outcomes despite numerous examples of high quality care; and growing stresses on recruiting and retaining sufficient health care professionals and staff now and for the future. Yet, we are spending nearly twice what other developed nations spend per capita. There are savings to be had, but they are hard to access. Given that health care costs are rapidly increasing beyond current annual spending totaling well over 4 trillion dollars in 2023 (with 50% public dollars), and currently projected to exceed seven trillion by 2030, it is remarkable that more public concern is not generating urgent demand for action. That will surely manifest soon as the rising federal and state costs of Medicare, Medicaid, the VA, the military, Indian Health Services, workers compensation, CHIP, and generous federal tax forgiveness for employer sponsored private coverage coalesce to form a monster that is vampirizing other sectors of the economy.

Hawaii has a remarkable tradition of health system reform innovation. Plantation workers in Hawaii had a tradition of receiving health care long before it became available for US workers after WW II. It was maybe not the best care, although generally adequate, but such care was totally unavailable for agricultural workers anywhere else in the world, including in the mainland USA. The Prepaid Health Care Act (PHCA), passed in 1974, but vacated years later before enactment by the Supreme Court for violating the Employee Retirement Income and Security Act (ERISA) of 1974, has assured good health care for nearly ALL (except part-time) workers and their families in Hawaii after a Hawaii “ERISA exemption” was passed by Congress in the 1980s. The law performs well for Hawaii until today. It is widely felt in Washington that ERISA, which requires an exemption from Congress before states or municipalities can mandate employee health or retirement benefits from businesses, was passed just months after the PHCA in 1974 to prevent other states from copying Hawaii. Then again, in 1989, Hawaii passed the State Health Insurance Program (SHIP), which moved the state very much closer to universal insurance coverage by offering low-cost coverage for part-time workers, mom-and-pop business owners, independent contractors, workers paid by commission like realtors, and for students, and others not covered by the PHCA, Medicare, or Medicaid. These were first-in-the-nation innovations! Hillary and Bill Clinton tried to use the Hawaii innovations as the foundation of their plan, and California passed a version of the PHCA. That would have changed everything in the US. But, unfortunately Arnold Schwarzenegger, at the insistence of his party, led a ballot initiative to narrowly by ½% kill the California bill before implementation. But, all said, Hawaii’s innovation was noticed nationally.

So, from a high point of nearly 97% insured after the above innovations in 1980s and 1990s, Hawaii has slipped somewhat backwards. SHIP got folded into Medicaid-Quest, the premiums became too expensive, and folks dropped out. Many of those are again uninsured today, although Hawaii still has an impressive 94% insured rate. That said, why accept 6% uninsured, many more “underinsured,” and the sharp rises in out-of-pocket costs, even in Medicare? Doctors, hospitals, and patients need “prior authorization” before a necessary test, drug, or procedure can be provided. And there are many other bureaucratic, administrative, and cost frustrations that patients, doctors, hospitals, and even insurers face today.

Unfortunately, Congress is now too divided to tackle these issues. Senator Sanders, in Ted Kennedy’s footsteps, has 30% of America behind his “Medicare for All” concept. But it will not become law. The path toward guaranteeing universal coverage and health system reform must rely now on state leadership.

Principles of Value in the Hawaii the Health State 2025 Strategy: An Incomplete List

1. The collaborative vision must engage all stakeholders, importantly including Native Hawaiians.

2. The strategy must focus on reallocation of unnecessary and wasteful spending for its financing; but Hawaii also deserves its fair share of federal support (Medicare, Medicaid, FMAP[1], GPCI[2]).

3. *Prevention* is the key to achieving a more efficient, effective health care system. Working with DOH, this must include 100% access to proven prevention-related health care services including vaccines and prevention-related disease screening and treatment, without financial disincentives; 100% access to screening for early diagnosis for preventable and serious illness and for effective chronic disease management*;* also, major emphasis with financial clinician *incentives* on prevention of unnecessary ED visits, hospitalizations, and re-hospitalizations.

4. The primary focus of all services must be first on the most disenfranchised populations.

5. Improving access to and quality of care for Keiki and Kūpuna are appropriate initial foci, given these are important bookend populations of Hawaii's society, culture, and future.

6. While excessive profiteering is a growing concern across all of US health care, a critical focus in Hawaii must be on increasing adequate resources and reimbursement for recruiting and retaining the highest quality physicians, nurses, other clinicians, social workers, and caregivers in the face of high housing and costs of living here.

7. Excessive regulatory and administrative costs, waste, and complexity in US health care must be streamlined and eliminated in Hawaii's future. Waste aside, *new* administrative costs should rightly focus on monitoring accurate population-based health outcomes and improvements.

8. New financing models that emphasize value-based reimbursement and incentives for improving outcomes at lower costs must be considered, tested, and implemented.

9. Given the rapidly aging population (Hawaii is the #1 state in longevity), and the fact that there will never be enough caregivers to meet the needs of the population in the future, new technologies must be included to leverage caregivers to effectively reach more patients in a high-tech, but also high-touch future delivery system approach.

10. The state must more effectively partner with the federal government (Medicare and Medicaid, the VA, the Hawaiian Trust, etc.) to maximize federal funding (Medicare benchmark, Medicaid, FMAP) to develop innovative approaches, waivers, and include *social determinants of health!!*

11. The most modern technology, telehealth, and care delivery systems must be cost-effectively available for Hawaii's 1.4 million citizens and 8 million annual visitors. We are not a backwater.

12. For patients, providers, or observers of health care in Hawaii's future, the concepts of Aloha, 'Ohana, Mālama, Laulima, and Ho'ihi (respect) should seem appropriate to their experience.

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[1] FMAP: Center for Medicare/Medicaid Services (CMS) Federal Medical Assistance Percentages, which vary for states. FMAP is also paying 100% reimbursement for Native Americans where Hawaiians can qualify also

[2] GPCI: CMS Geographic Practice Cost Index, which affects payments for rural areas vs. urban areas

Big Seven Potential Short and Long-Term Priorities for the "Hawaii the Health State 2025" Vision -- A Work in Progress

Note: Simplicity is key to a successful health policy strategy proposal. The following outline appears complex but is simply an incomplete list of potential options and reflections to be considered, modified, and prioritized by a Governor-appointed, legislatively confirmed "Hawaii the Health State 2025" Task Force of consumer and health care stakeholders. This is not a plan.

1. **Keiki Care Initiative** (short-term: engage a sub-Committee of SHPDA PDC[3] and DHS to plan)
    - Identify and find financing via MedQuest/CMS to provide universal kid (0-18) health insurance coverage. (a real issue for kids whose parents are not eligible for the Prepaid Health Care Act coverage or haven't applied for MedQuest, but most kids are covered).
    - Note: Keiki care is relatively inexpensive and could be included in Quest waiver update or CHIP. *Modest planning budget may be needed for FY 2024 in DHS.*
    - Research and identification of gaps (consider help of DHS Medicaid/Quest, HAH, HHSC, Kapiolani, pediatricians, FQHCs, etc.) Include SDOH (social determinants of health).
    - Oral care for Keiki is lacking – especially prevention (CHIP and HRSA funding). BUT: we don't have enough dentists. Expanding care in FQHCs, pediatric offices, and *schools* is an option, including use of sealants and fluoride varnishes where dentists are rare.
    - As longer-term possibility, consider possible early child accountable care organization (ACO) federally subsidized MedQuest plan with Kapiolani, Castle, HHSC, pediatricians, NICU docs, and family medicine. Could include expanded prenatal care services, given Hawaii's 50th (worst) ranking in the US for delayed prenatal care until third trimester.
    - Ultimately, the biggest health care boost for keiki in Hawaii would entail getting universal childcare for preschool keiki 3-5 years (cost is significant but huge boost to economy as well).

2. **Kūpuna Care Initiative** (short term < 1 year – sub-Committee of SHPDA PDC to be engaged with participation of DHS-MedQuest, EOA, AARP HI, HAH, HMSA, KP[4], Aloha Care, home care agencies, palliative care (Hui Pohala), hospice, Papa Ola Lokahi, and insurers). *Planning budget needed for 2024*
    - Working with DHS/MedQuest in waiver update, develop new pilot programs and new care delivery models to keep Kūpuna at home vs. nursing homes and LTC placement (factor in social determinants of health – SDOH).
    - Expand use remote patient monitoring (RPM), chronic care management (CCM) existing Medicare funding, and Medicare Advantage plans with SDOH funding options to implement.
    - Involve DHS/MedQuest with dual eligible Medi-Medi patients.
    - Utilize and pay for "well-care" short visits and for individual itemized services to more cost effectively reach more patients.
    - Also implement "Acute care, hospital-at-home" care initiatives as well.

[3] SHPDA PDC: Sate Health Planning and Development Agency Plan Development Committee
[4] Various abbreviations: DHS (HI Department of Human Services); EOA (HI Executive Office on Aging); HAH (Hawaii Hospital Association);HMSA (Hawaii Medic Services Association); KP (Kaiser Permanente Hawaii)

- Reallocate savings from LTC/nursing home Medicaid funding to home care services (current nursing home/LTC costs are > $100K/yr. - and so providing $50K of advanced home care services/yr. would generate $50K of savings. Modified CMS waiver?).
- Employ extensive use of advanced telemedicine services to facilitate physician, nurse, and other clinician care at home. When seniors are not tech savvy, such services and physician visits can be facilitated through onsite health navigators or home health clinicians. These services are also needed for palliative care and post-discharge care.

3. **Training, recruitment and retention of sufficient physicians, nurses, social workers, other clinicians, and caregivers for Hawaii Initiative**: (short- and long-term goal needing the engagement of physician and professional organizations, the Legislature, and others, including SHPDA PDC (Plan Development Committee). *Planning budget needed for 2024.*

- Full utilization of currently funded loan forgiveness funding for recruitment, especially for shortage areas. Reallocate unused loan forgiveness funds to other recruitment/retention options as possible.
- Consider launching new CMS "ACO Reach" CMS plans for Medicare (these offer physicians management of both Part A and Part B funding = 80% of total premium). ACO Reach powerfully incentivizes better preventive care and reduced ED and hospital admission and re-admission costs, and payment incentives for clinicians.
- Renegotiate CMS Medicare Advantage flawed "benchmark" payment level (currently about $12,000/year/beneficiary average in US, but only $9,000/year/beneficiary in Hawaii) to account for Hawaii cost of living (COL) and real estate costs (a longer-term but *essential* strategy). Raising the benchmark would greatly ease payment deficiencies.
- Employ telemedicine services extensively where clinically appropriate (expand use of off-shore clinicians when this is necessary, noting Hawaii successfully used off-shore telemedicine clinicians during COVID-19 efforts).
- Ensure for physicians/clinicians engaged in value-based reimbursement models that real-time access to claims, diagnosis code, HCC (CMS hierarchical condition categories), social determinants of health (SDOH), and equity-related data is available to manage patients effectively (see also the need for a Hawaii "comprehensive statewide clinical health data system" under Item 5 below to accomplish this).
- Establish and expand existing training programs with incentives for Hawaii residents to fill positions across the health care employment spectrum.

4. **Prevention as the 'power' strategy behind outcomes improvement and cost containment:** (Prevention is obviously underfunded, under-emphasized, and under-reimbursed for patients and providers). Prevention education and wellness programs are needed. Hawaii must lead the nation in systematically employing primary and secondary disease screening and prevention strategies in care delivery, including applications of genetic testing for early detection and treatment of inheritable disease. Further, a huge prevention benefit will be realized from reducing health care spending and costs from prevention of unnecessary ED visits, hospitalizations, re-hospitalizations, and disease complications. Non-clinicians and alternate sites can increase access to preventive care where people live, work, and at school-based clinics.

5. **Hawaii Health Status Monitoring and Population Health Initiative**: (short and long-term strategy) *Modest planning budget needed for 2024.*
    - Short term:
        - Add resources as indicated to increase analytics capabilities from Hawaii's existing All Payer Claims Database (APCD) to improve health status and population-based monitoring via SHPDA, DHS, UH, the Hawaii HIE, and other collaborators. Collaborate with HAH discharge and LTC existing data sources as well. Include population-based behavioral health and mental health data.
        - Increase privacy-assured sharing of outcomes, shortcomings, and progress with hospitals, physicians, and other providers to enhance population-based health status improvement, again including behavioral health and substance abuse.
    - Longer-term:
        - Develop a "comprehensive statewide clinical health data system" in Hawaii capable of tracking as close to 100% of comprehensive personal health data, with personal privacy protections in place, for both convenience and clinical benefit of patients (accessing their own data) and of clinicians and health systems granted access by patients to such data. Sources of such data are EHRs, claims data, lab test results and drug prescription data, allergies, radiologic images, health information exchange data, including mainland sources of data. Patients could opt-in to the system through their physician, hospital, or insurer, and could opt-out at any point. But opting out limits access to one's data. From a public health point of view, de-identified data from all such sources can be used to monitor population health and disease outbreaks more effectively.
        - Seek means to include physician and other outpatient data sources including Hawaii's FQHCs to increase awareness of prevention, disease management, behavioral health, and population-based outcomes related to outpatient care.
        - Seek means to integrate clinical data sources from national specialty society registries (such as National Cardiovascular Data Registries, etc.), and CDC, NIH, and other clinical data sources.
        - Finally, integration systems that can access and integrate social services data, behavioral health data and other clinical data are needed to enable SDOH to improve clinical and health outcomes.

6. **Statewide Regulatory and Administrative Simplification and Cost Reform Initiative** (a short- and long-term strategy – *planning budget needed for 2024 Legislature*)
    - Short term:
        - Statewide "prior authorization" (PA) automation reform: this can be a quick win. Cost would be approx. $2-3 M in 2024 ($2M one-time spending and $1M per year ongoing). PA costs physicians, hospitals, and insurers millions per year; it hassles everybody; and delays essential imaging, medication, and procedural care for patients, often endangering outcomes. Hawaii should be first to do this.
        - Statewide Quest formulary simplification reform: also, a potential quick win. Cost is minimal. Each of 5 Quest plans has a different formulary, complicating work for physicians, clinicians, pharmacists, and hospitals. Strategy: convene plans to with DHS/MedQuest to negotiate a common formulary.

  - More extensive formulary integration and simplification should also be undertaken for privately insured, FQHC (HPCA), Prepaid Health Care Act and Medicare/Medicare Advantage patient populations.
- Long Term: Develop a coordinated strategy with CMS (Medicare and Medicaid), DHS/MedQuest, HMSA, Aloha Care, and other payers to simplify and make as consistent as possible regulatory and administrative rules, reporting, payment systems, formularies, quality of care monitoring, and other interfaces and IT systems for physicians, hospitals, and other providers. Planning budget for legislature TBD if needed.
  - The goal is to reduce costs, improve efficiency and collaboration for all participants. The specifics of this goal will need be developed over the next year as more relevant data and high-level conversations lead to workable approaches for all health care participants.
  - HMSA, KP, Aloha Care, other payers (including United, Humana, Centene) and DHS/MedQuest/CMS Medicare and Medicaid are the key payer-side participants in this goal. However, the hospitals (Queens MC, HPH, HHSC, Kuakini, Castle, Maui Memorial) and other physician and provider organizations will also be essential participants in solution crafting.

7. Hawaii Universal Access at Affordable Cost Initiative (short- and long-term strategies)

Health care access, health equity, and health care costs are inextricably entwined. Health care costs are rising rapidly as a percent of US GDP, and are also becoming increasingly unaffordable for individuals, families, businesses, unions, and government. Universal access and equity require affordability to be realized. Focusing on prevention, team-based primary care, reduction of administrative and regulatory waste and costs, making behavioral health a more effective aspect of primary care, and systematically reducing unnecessary ED visits and hospitalizations, and rigorous data analytics as previously stated, will be essential to achieving affordability. Include Papa Ola Lokahi early in the brainstorming. But in addition:

- Short-term:
  - Beginning with Keiki universal access, and Kūpuna expanded access to advanced home care services, consider how to expand Medicaid (or CHIP) access to cover all keiki 0-18 as a first step. Work with MedQUEST/CMS to get this done.
  - Explore access to additional benefits for special populations, such as an ACO or special coverage plan for high-risk prenatal care and high-risk children 0-3 --- more to be discussed later but *include school health services!* Include DOE's "community care" concept of accessing family health services at schools!
- Long-term:
  - Develop over next 2 years a strategy for achieving full universal access to defined benefits per age from birth to end-of-life by 2025 for all citizens in Hawaii, working with the aforementioned multiple stakeholders, but importantly including CMS (Medicare and Medicaid), DHS/MedQuest, the FQHCs, all payers, the provider community, and consumer stakeholders, with financing options for possible implementation in 2025 – much more to be discussed after significant data analysis, actuarial research and other background work can first be conducted. *Planning budget needs to be developed for 2024 legislature.*

- Strictly monitor against any further "tiering" of health care based on income.
- Keep clear in mind that universal access will be fully dependent on achieving in parallel a robust prevention focus, regulatory and administrative costs containment and simplification, behavioral health services enhancement, and federal partnerships. Assure that Hawaii receives its fair share of federal resources; and that we include new value-based payment and reimbursement models (better outcomes at lower costs). Much more discussion and deliberation on this topic will be needed. SDOH must be centrally factored in!
- Primary care services must be based on a foundation of team-based primary care that includes physicians, nurses, social workers, and health navigators; and it must be community-sensitive and community-based to succeed.
- Also carefully consider lessons to be learned from other state experiments in progress, such as Maryland's *all-payer* and *global budgeting* models, Colorado's new public option, and New York's similar plan for one. Noting that CMS has declared as their goal that all federally funded Medicaid and Medicare services will be "value-based" by 2030, we should evaluate performance of potential new "value-based care" financing options. Some of the options being discussed by states and policymakers across the country to be considered here are:

    - A possible CMS-Hawaii *Medicare Advantage (MA) for All* model (A MA-like public option with age-related benefits (birth to end of life) with consistent admin rules to allow uninsured individuals to buy in, make the option a choice for PHCA beneficiaries, and assure that Medicaid is also somehow folded in). Insurers could then compete on cost.

    - A statewide Accountable Care Organization model. ACOs were created as part of the Affordable Care Act to allow teams physicians and hospitals to form insurance-like care models organized to provide value-based care funded by federal Medicaid and Medicare, and they can also be funded by employer and union coverage as well. There could be a new value-based option for MedQuest, and another one for the Prepaid Health Act participants financed by employers and unions, and value-based Medicare Advantage-like offering for retired persons over 65 and the disabled. There can also be specialized disease focused ACOs.

    - A Hawaii version of a "public option" model. Finally, many stakeholders here believe it is possible to create a unique, seamless integration of MedQuest, the Prepaid Health Care Act employer/union-based coverage, and Medicare Advantage as a Hawaii 'public option' to achieve universal access to equitable high-quality affordable care. This model must begin as a patient *choice* of care, incentivized by lower premiums and co-pay costs to individuals, families, businesses, unions, and government, and with very likely some additional federal support. The only mandate required would be that employers and unions would need to offer the plan as one of the choices available to their beneficiaries. The beauty of a value-based payment structure (with capitated payment) would encourage funding social determinants of health (SDOH), and would reward physicians, nurses, and care team

providers with higher reimbursement opportunities when savings from improved chronic disease management and reduced unnecessary hospitalizations, re-hospitalizations, and ED visits are achieved. Some details to be considered in this approach would need to include:

1. Given that MedQuest and the employer-union plans in the Prepaid Health Care Act (PHCA) coverage have different benefits and payment levels and different sources of funding, these differences would need to be "smoothed." This means provider reimbursements under Quest would need to increase to parity with PHCA coverage, and patient premiums, co-pays, and deductibles would need to be decreased for workers in PHCA coverage (similar to MedQuest) to make it attractive.

2. These changes would increase costs, but the value-based reimbursement strategies, increased prevention emphasis, reduced unnecessary ED visits and hospitalizations employed in the model, along with other sources of savings (see item 8 below for more options) would create new resources to cover payment increases and premium/deductible/copay reductions.

3. This model would continue to utilize state and federal funding for MedQuest beneficiaries, and employer-union-employee contributions for the parallel privately funded Prepaid Health Care Act (PHCA) beneficiaries. It is important to note here that the PHCA funding requires no federal or state support – instead it is funded by an increase in the costs of goods and services that supports the contributions employers-unions and employees make together. When we buy some food, or dry-clean a shirt, or receive any other service from businesses here, we pay a little bit more for the product or service to cover the costs of health care for the employees. So, we pay maybe 25 cents more for a burger in Hawaii so that all the fast-food employees can also have health insurance. This is a very efficient means of financing health care. Abandoning this for funding employee coverage by tax increases, as Senator Sanders recommends, is a politically much more difficult stretch.

4. FQHCs and AlohaCare could continue using (enhanced) MedQuest/Medicaid funding to cover their existing beneficiaries, but they could also benefit from increased numbers of employer-union PHCA beneficiaries who find their services more convenient in rural and underserved communities, and among local retirees as well.

5. Then, seamlessly integrating federally funded Medicare Advantage coverage for retirees and the disabled would

complete the various aspects ("pieces") of the model.

6. Rather than a "single-payer" concept, this would be a multi-payer one, where beneficiaries choose from competitively priced identical coverage offered by HMSA, Kaiser-Permanente, AlohaCare, and other payers. The insurers could offer additional non-essential "amenity" benefits at optional additional cost. Also, medical savings accounts might be included to pay for any remaining co-pays/deductibles and drug costs, if desired, but the model should minimize out-of-pocket (OOP) costs. However, the entire model would be designed with simplified administrative and regulatory oversight, and a guarantee of high-quality, equitable, affordable universal coverage for all.

7. Finally, the model would be available as a *choice* for all beneficiaries. The existing MedQuest program and choices of various HMSA, KP, and other insurance plans, and traditional Medicare would still be available, but hopefully less desirable.

8. The model therefore will only succeed when it is a superior option which beneficiaries *choose* in order to experience lower premiums, co-pays, and deductibles; better outcomes; and more modern and convenient services. To succeed, the model will also need to bring the reimbursement of clinicians and hospitals in publicly funded MedQuest and Medicare Advantage portions to parity with the PHCA reimbursement levels. To accomplish that, viable and achievable priorities for cost savings would need at minimum to include:

- **a.** Improved prevention services performance, including incentive-based health and wellness education and nutrition/exercise/lifestyle programs.
- **b.** Team based primary care, including social workers and SDOH evaluation, monitoring, and intervention.
- **c.** Increased access to mental and behavioral health services as essential primary care.
- **d.** Recruitment of sufficient health professionals to assure access to care for underserved communities and populations.
- **e.** Increased telemedicine services between patients and clinicians, especially for established patients, for chronic disease management, and for triage of non-emergent patient questions and symptoms.

f. Increased school-based clinical services in underserved communities, including behavioral health services and prevention.

g. Improved home care services for patients for palliative care, post-discharge care, and potentially for acute-care-at-home pilot projects.

h. Advanced home care with remote patient monitoring (RPM), chronic care management (CCM), which are eligible for new federal reimbursement, for patients eligible for nursing home and LTC placement who can continue to be cared for at home and in the community.

i. Automated prior authorization.

j. Formulary simplification and pharmacist engagement in chronic disease care coordination.

k. Advanced health monitoring, outreach, and care coordination for very high-cost patients.

l. Advanced patient health status monitoring data systems, with provision of 'real-time' data needed for clinicians to improve value-based outcomes.

m. Population-based data surveillance systems to monitor overall program performance.

9. <u>How we get to such a new model</u>: Use the Task Force and a monumental stakeholder collaboration with sophisticated planning, data analytics, and actuarial expertise to seek consensus on a comprehensive strategy to achieve universal access to equitable, high-quality, and affordable care for all citizens in Hawaii, and do so over the next 12 months, anticipating the evolution of a plan of action before the 2025 Legislature. Under the leadership of Governor Josh Green, we must begin now therefore to engage Hawaii government agencies, Legislative leaders, insurers, hospitals, healthcare associations, physicians, and health professionals, FQHCs, consumer groups, Papa Ola Lokahi and Native Hawaiian/Pacific Islander representatives, federal agencies, the Hawaii Congressional delegation, and other stakeholders to assure that the plan developed is representative of the people and diverse culture of Hawaii. SHPDA will also require significant use of planning, data analytics, actuarial, and strategist consultation, in addition to visitation of national policy experts and federal officials who can facilitate meaningful policy discussions.

John C. (Jack) Lewin, MD

John C. (Jack) Lewin, MD was appointed in April 2023 by Hawaii Governor Josh Green MD as Administrator of the State Health Planning and Development Agency (SHPDA) in Honolulu. He is charged with coordinating the development of a comprehensive health care reform strategy and implementation plan for Hawaii that guarantees universal access, equity, affordability, an adequate and exemplary health workforce, and high-tech and data-supported improvement in personal health outcomes and population health. On behalf of the Governor and the Legislature, he is charged to bring health sector stakeholders and consumer leaders together in the state to envision a health future emphasizing prevention, information technology and other innovation, including personalized medicine; advanced home, elder, and community care; value-based reimbursement strategies; and streamlined and more efficient regulatory and administrative systems. But the challenge is making the resulting plan and legislation an elegantly simple framework, with flexibility to address the aforementioned priorities innovatively, and with respect to differences and preferences of local communities, health systems and island cultures.

Widely published, Lewin brings extensive experience to this challenge as former Hawaii Director of Health (1986-1994), Chairman of the National Coalition on Health Care in Washington DC from 1995-2023. He is also Founder/CEO of Lewin and Associates LLC of Manhattan, New York, a health policy and health care innovation consulting firm focused on advising Congress, federal agencies, and the health sector. He has been a frequent testifier to the Congress, and a collaborator with the US Department of Health and Human Services, FDA, and other federal agencies. Other previous professional roles include being President and CEO of the NYC-based Cardiovascular Research Foundation, CEO of the DC-based American College of Cardiology, CEO of the California Medical Association, Chairman and founder of the Physicians Foundation, and a Commissioned Officer of the US Public Health Service working with Native Americans in Arizona, New Mexico, and Utah.

He was Hawaii's Director of Health when the Prepaid Health Care Act (PHAC) landmark health legislation had been granted an ERISA exemption from Congress and was finally able to be fully implemented after the Supreme Court vacated it. He proposed and succeeded in getting legislative support for the State Health insurance Program (SHIP), which offered affordable insurance to people not eligible for the PHAC -- unemployed and part time workers, realtors and those paid by commissions, self-employed people, students and others -- allowing Hawaii to become the first state to achieve near universal coverage. As a result, the Clinton Administration and California's Governor and legislature used Hawaii as a model for their reform proposals.

Through Lewin and Associates, Lewin has been a senior medical advisor, chief medical officer, or board member to various innovative health start-up companies including MDPortals Inc, GATC Health, Amedisys, Privis Health, Wellth Inc., Clartet, Quiron Health, Webshield, Safe Health, and Empowered Home. He was formerly Chairman of the Patient Safety Institute.

In summary, Lewin is an internationally recognized expert in promoting healthy populations and is a strong proponent of a more efficient, effective, affordable, and sustainable healthcare system that provides access to high-quality care for all. He has advised two Presidents of the United States as part of a rewarding career in health care, public health, and public policy. He was named as one of *Modern Healthcare's* "100 Most Influential People in Healthcare," and is a recipient of the AMA's Nathan Davis Award, the American Hospital Association's Justin Ford Kimball Award, and USPHS Commissioned Officers Association's "Health Leader of the Year" award. Dr. Lewin received his BA in Biological Sciences from the University of California, Irvine, and his MD and medical training from the University of Southern California. He and his wife Sandra raised their 3 children in Hawaii, and he has somehow found time to run 27 marathons.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
Council/Committee/Sub-Committee/Task Force Nomination Form

Date: _____

Nominator's Name: _____

Nominee Information:
Name: _____

Title (if applicable): _____

Affiliation (if applicable) _____

Email Address: _____

Phone Number(s): _____

Other Contact Info: _____

Indicate the Council(s)/Committee(s) for which you are making this nomination:

☐ Statewide Health Coordinating Council (SHCC)*
☐ Tri-Isle Subarea Health Planning Council*
☐ Windward Subarea Health Planning Council*
☐ Hawaii County Subarea Health Planning Council*
☐ Kauai County Subareas Health Planning Council*
☐ West Oahu Subarea Health Planning Council*
☐ Honolulu Subarea Health Planning Council*

☐ Statewide Health Coordinating Council Plan Development Committee (PDC)**

☐ PDC Subcommittees:
- ☐ Acute Care Service Technology***
- ☐ Long Term Care Services***
- ☐ Primary Care Services***
- ☐ Health Disparities***
- ☐ Data and Service Gap Areas***
- ☐ Behavior Health***
- ☐ Substance Use Disorder***
- ☐ Workforce***
- ☐ Other: _____

**Governor Appointed Position*
***SHCC Appointed Position*
****PDC Appointed Position*

Why the nominee would be a good candidate for the position(s) indicated above (use space on back if needed):

_____

_____

_____

_____

Is the nominee aware of this nomination? ☐ Yes ☐ No
Has the nominee expressed interest? ☐ Yes ☐ No

Thank you

For office use:
Date Received: _____
☐ Confirmed Interest _____
☐ Info on Application Process Provided _____
☐Not interested at this time.
☐Application Submitted on _____
Notes: