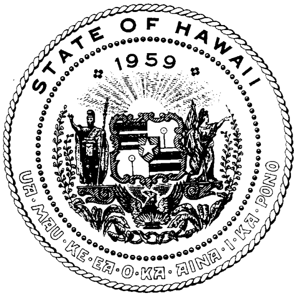

HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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West Oahu Subarea Health Planning Council

DRAFT

Meeting Minutes

November 15, 2023 | 12:30 PM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS: Eric Barsatan, Mae Patricia La Chica, Paul Roeder, Frederick Shaw

MEMBERS ABSENT: Camonia Graham-Tutt, Beverly Inocencio, Jay Raymundo

GUESTS: None

SHPDA: Jack Lewin, Wendy Nihoa

ATTENDANCE RECORD OF APPOINTED MEMBERS

Date	03/16/22	6/15/22	9/21/22	11/30/22	1/25/23	3/15/23	5/24/23	7/18/23	11/15/23
Eric Barsatan	O	X	O	O	X	X	O	X	X
*Camonia Graham-Tutt	X	X	X	X	X	X	X	X	O
Beverly Inocencio	O	O	X	X	X	X	X	X	O
**Mae Patricia La Chica	X	O	X	X	O	O	X	O	X
Jay Raymundo	O	X	O	O	X	O	O	O	O
Paul Roeder	X	O	X	X	X	X	X	X	X
Frederick Shaw	X	X	X	X	X	X	X	X	X

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

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 12:33 p.m. with T. LaChica, Vice Chair, WOSAC presiding.	
Roll Call/Introductions	Members and staff introduced themselves.	
Meeting Minutes	Motion to accept the minutes from the meeting on July 19, 2023. Vote: Unanimous. Motion carried. Call for public testimony – None.	
Administrator's Report	The Administrator's Report was distributed and reviewed.	
State Health System Reform Planning Update and 2023-2024 Key Priorities	J. Lewin, Administrator, SHPDA reported after 400+ interviews and discussion with key stakeholders and providers the "Hawaii the Health State 2025" document has been updated. Changes made to areas on Universal Access and Affordable Care for All. A copy of the updated document is hereby attached to these minutes as Attachment A. SHPDA Plans to apply for the AHEAD (All-Payer Health Equity Approaches and Development Model) Grant. The AHEAD grant is highly competitive awarding eight (8) states $12M over 6 years. SHPDA anticipates the Centers for Medicare & Medicaid Services to release its Notice of Funding Opportunity sometime this week. The following link to the AHEAD grant was shared in the chat https://www.cms.gov/priorities/innovation/innovation-models/ahead J. Lewin presented the 2024 legislative requests as summarized on the September 20, 2023 SHPDA Key Priorities 2023-2024 Summary Listing document. A copy of the document is hereby attached to these minutes as Attachment B. Call for public testimony – None.	
Statewide Health Coordinating Council – Plan Development Committee (PDC)	P. Roeder, WOSAC Liaison to the PDC and Chair of the Universal Access Advisory Council (UACC) , reported the UACC inaugural meeting tomorrow. Meeting will focus on SHPDA priorities, the AHEAD grant, and next steps. W. Nihoa added, the Priority Selection Process was approved by the PDC. Phase I of the process will initiate with the subarea health planning councils next month, December 2023. Call for public testimony – None.	

Project: Health Care Job Fair	C. Graham-Tutt was not in attendance, item deferred to the next meeting. W. Nihoa mentioned C. Graham-Tuff suggested moving the Health Care Job Fair to Summer 2024. Call for public testimony – None.	
Announcements	SHPDA. Reminder of Act 125 (GM 1226, 2023), recording of public meetings went into effect on October 1, 2023. Ethics Training. Reminder the deadline to complete the mandatory ethics training for board members is December 31, 2023. The self-directed training is accessible via Hawaiʻi State Ethics Commission | Ethics Training (hawaii.gov). 2024 WOSAC Meeting Schedule. Members agreed to keep recurring meetings to the 3rd Wednesday of every other month at 12:30 p.m.	
Next Meeting/Agenda	January 17, 2024 at 12:30 p.m. via Zoom.	
Adjournment	The meeting was adjourned at 1:16 p.m.	

'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.

[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.

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[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 Hawaii HIE and with HAH discharge database, "Laulima", 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. Mainland data for Hawaii patients and citizens is also needed. 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. This needs to be a collaboration of HI HIE, Laulima, and the SHPDA/MedQUEST/UH All-Payer Claims Database (APCD) if we want to accelerate progress in these regards.
        - 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 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 health care is 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, with rigorous data analytics as previously stated, will all be essential to achieving affordability.

- 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. We are working with MedQUEST/CMS to get this done, and the request is included in the MedQUEST 1115 Waiver update proposal already.
  - Explore access to additional benefits for special populations, such as a 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. A legislatively sanctioned multi-stakeholder Task Force has been proposed to seek consensus on what an ideal health care future for Hawaii should include.*

- 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, behavioral health clinicians, 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 and Vermont's *all-payer* and *global budgeting* models, Colorado's public option, and New York and California's similar plans 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.

- Considerations of Hawaii's health care strengths and shortcomings toward developing new models of innovation here:

  Our impressive strengths include:
  - The highest longevity of the 50 states.
  - The lowest health care costs per capita of all states.
  - CDC-estimated state population health statistics that are among the best of the 50 states.
  - The Prepaid Health Care Act (PHCA) is a very efficient private workforce insurance coverage program requiring no tax subsidies (the PHCA is the nation's *only* statewide employer health coverage mandate).
  - MedQUEST is arguably the most innovative Medicaid program in the country, with reimbursement for providers approaching parity with Medicare.
  - Hawaii's 92 Federally Qualified Health Centers (FQHCs) and their AlohaCare insurance partner provide one of the nation's best safety net care systems.
  - Hawaii's majority insurers and hospital systems remain non-for-profit, and all profess to be committed to Aloha, and to the health of the people and our diverse communities and multi-ethnic society. This is a key advantage over the mainland health care, which is increasingly comprised of for-profit shareholder-directed corporations.
  - A new $30 million loan forgiveness program for physicians, nurses, and other professionals to recruit and retain health workers in short supply.

Our shortcomings include:

- Major workforce deficiencies exacerbated by extremely high costs of living and housing costs. We are having huge difficulties recruiting and retaining doctors, nurses, and other health professionals (estimated 1000 physicians and 3000 nurses short).
- Major federal funding deficiencies in Medicare benchmark and geographic (GPCI) levels compared to comparable states.
- Rising health care costs > inflation.
- Persistent uninsured persons, albeit lower levels than a majority of states.
- Persistent health inequities, particularly among Native Hawaiians and Pacific Islanders.
- High administrative costs and unnecessary regulatory complexity.
- Lack of effective data-supported health status monitoring and population/public health systems to track progress and shortcomings in health care and public health.
- Lack of effective prevention, wellness promotion, and care coordination strategies across the populations in need.
- Significant problems in addressing rural health needs. The Health Resources and Services Administration and Census Bureau have documented that Hawaii ranks worst of all states in the share of state population living in primary care shortage areas: 35.64% (513,312 people).
- Despite Hawaii's history of health system innovation, there is an ongoing perception that medical quality and health care innovation lag the mainland, and therefore that travel to the mainland for care is clinically advantageous for treatment of cancer and other serious illnesses; and similarly that neighbor island patients need to travel to O'ahu for routine care. While such perceptions are most often wrong, their persistence relates to some basis in truth.

- **Four Considerations on Possible Innovation Models for Achieving Universal Access, Equity, Improved Outcomes and Affordability in Hawaii:**

1. **A possible CMS-Hawaii *Medicare Advantage (MA) for All* model.** Medicare for All, the rallying cause of Senator Bernie Sanders and 35% of Americans including many people in Hawaii, would eliminate insurance companies and expand the role of government funded health care. A Medicare-Advantage-for-All concept continues to include competing insurance companies, but in an administratively simplified model that would include a mix of private/employer-based and significant ongoing federal funding. At a state level, an MA-for-All model could provide defined 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 employed (PHCA) beneficiaries, and assure that Medicaid is also somehow folded in. Insurers could then compete on cost and quality. This approach has many health policy fans on the mainland. But

the political hurdles associated with it, while nonetheless daunting, are less so than achieving Medicare for all. Nonetheless, this would be a major challenge.

2. **A statewide Accountable Care Organization (ACO) 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. Again, there are many mainland policy-wonk fans of a statewide ACO model for achieving our access and affordability. Even Saudi Arabia is considering this approach. But the political hurdles associated with achieving it here would be again daunting.

3. **A Hawaii version of a "public option" model.** The "public option" was perhaps the most controversial part of the Affordable Care Act, where it failed to be included; but many policy makers and stakeholders here believe it is possible to create a unique, seamless integration of insurance coverages across a state using this approach. If that were to be proposed here, we would have to imagine increased integration of MedQuest, private insurance, and Medicare – presumably with additional federal funding to make it feasible, since this is consistent with CMS/federal goals. Several US states are creating public options, including Colorado, California, and others. That said, while we are having healthy discussions, I already perceive pushback on considering a public option from HMSA, Kaiser Permanente, our private hospital systems, and others here, fearing that it would be underfunded and possibly worse than the status quo. For the moment, I suspect that some of the baggage that caused the concept to fail in the Affordable Care Act makes it a poor choice as the mechanism for moving forward here. We would be better advised to think about a new, Hawaii-friendly concept for modernizing health care.

4. **A possible new Hawaii health system innovation model**: Let's envision a *new model* for health care that builds on the strengths of Hawaii's current health care situation and moves beyond our perceived shortcomings by "piloting" changes aimed at improving health outcomes, reducing inequities, reducing variation in care, and lowering the growth of costs at the same time.

   This could occur by working with the key stakeholders to envision the best way to accomplish this, and by using federal planning and implementation funding through the new CMS/CMMI "AHEAD" grant, which will give 8 successful state grantees $12 million over 8-9 years in planning, actuarial, and implementation funding, and with potentially hundreds of millions of dollars in direct federal assistance to primary care and to acute and critical access hospitals to achieve better outcomes at lower costs. This grant will assure such improvements in private insurance and Medicare are aligned with MedQUEST (Medicaid) and with behavioral health integration.

   This model will involve 2 years of planning and 8-10 years of implementation. It can be thought of as a "rolling, evolving pilot project" that would offer advanced

primary care (including social services and behavioral health), new models of home and community care, and improved prevention and care coordination. It could be offered as a new patient *choice* of care, incentivized by lower premiums and co-pay costs to individuals, families, businesses, unions, and government. The clear advantage is the additional federal support to help hospitals and clinicians achieve the ambitious goals. HMSA, Kaiser Permanente, AlohaCare all need to be participants along in this 'multi-payer' concept, with hospitals and clinicians as key providers. The only mandate possibly to be included might be that employers should offer the pilot model as one of the choices available to their beneficiaries. A value-based payment structure which could be included would incentivize addressing social determinants of health (SDOH), and could reward physicians, nurses, and care team providers and hospitals with higher reimbursement opportunities when savings from improved chronic disease management and reduced unnecessary hospitalizations, re-hospitalizations, and ED visits are achieved. The increased primary care funding support could greatly alleviate our physician, nurse, and health care workforce shortages. Our statewide FQHCs will also be key to success here. Critical access hospitals could also benefit.

To accomplish the cost-containment goals, all health care participants would need to be partners in creating and implementing viable and achievable priorities for cost savings. Such priorities would need at minimum to include:

a. Improved prevention services performance, including Improved incentive-based health and wellness education and targeted nutrition/exercise/lifestyle programs.

b. Team-based advanced primary care, with physicians, advanced practice nurses and Pas, but also including psychologists, clinical pharmacists, and social workers, and addressing social determinants of health. Mental and behavioral health services are essential primary care.

c. Increased access to care in rural communities with recruitment of sufficient health professionals and use of technology to improve outcomes in underserved communities and populations.

d. 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.

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

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

g. Advanced home care with remote patient monitoring (RPM), chronic care management (CCM), and new high-tech, high-touch care models to allow nursing home/LTC-eligible patients to instead age in their home and community when desired, with significant cost savings.

h. Special focus and consideration on Native Hawaiian and Pacific Islander populations in Hawaii to address glaring inequities and high morbidity and mortality rates in these important populations here.

i. Automated prior authorization and streamlined professional credentialling.

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 clinical data surveillance systems and health costs tracking to monitor overall program performance.

How we could get consensus on such a new model: The Legislature will propose a new Health Care Task Force that will offer insights about a better future. That's very good. But we will also need a monumental multi-stakeholder collaboration, with sophisticated planning, data analytics, and actuarial expertise to seek consensus on a comprehensive strategy. Every single one of more than 300 stakeholder meetings we have informally held at SHPDA to ask about the current status and future of health care in Hawaii has made clear that all feel without exception that we are far from perfect, and that the status quo is not a future option. We have work to do. Partly this is because we are still part of the wasteful US healthcare 'non-system.' But in large part it is also because we haven't resolved as a state to work together to craft a path toward a better multi-payer model that consistently produces better outcomes at lower costs, with higher patient *and* provider satisfaction. We can do this. And we can do it without the stigmata of Medicare Advantage for all, an ACO model for all, or a public option approach. Let's create a Hawaii-centric multi-stakeholder approach to the better future. And MedQuest, the Prepaid Health Act, and Medicare are all essential parts of that better approach when better integrated.

We need to be one of the 8 successful states in becoming "AHEAD" grantees. We are preparing for that in partnership with MedQUEST, UH faculty, and all the SHPDA advisory bodies.

Under the leadership of Governor Josh Green MD, 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.

"Change is difficult, risky, sometimes painful, and unavoidable.
But fear of change leads inevitably to obsolescence." -- *J. Lewin MD*

ATTACHMENT B

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
DEPARTMENT OF HEALTH - *KA 'OIHANA OLAKINO*

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

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September 20, 2023

SHPDA Key Priorities 2023-2024 Summary Listing

SHPDA was created by the Legislature in 1975 to fulfill a large and critically missing state capacity and responsibility for health care and services planning and development in Hawaii. SHPDA was enacted through HRS Chapter 323. The agency originally had 65 staff to serve as the de facto "health authority" for the Governor, the Legislature, and the Hawaii health sector. The staff was whittled down over the Agency's 48-year history during deficit budget years from 65 to 6 positions, and the mission narrowed as a result to only being capable of managing the state's Certificate of Need (CON) process. The CON process has been a beneficial means of cost containment, but it represents only small fraction of what the state requires to be able to monitor, track, and improve the health status of the Hawaii population, as well as too monitor and report on the state's return on investment in terms of population health status and comparative outcomes, quality, and cost effectiveness of health care services. Hawaii Act 139 of 2016 further authorized SHPDA in 2016 to obtain health data from all Hawaii insurers to fulfill its mission through an All-Payers Claims Database (APCD), which has been created and will soon be generating statewide comprehensive health status monitoring and population health reports. Once operational, Hawaii will be the first state to accomplish this national critically important goal. Priorities 1-3 will move the agency toward a proactive ability to achieve our original mission, but the very modest staff and infrastructure investments in Priorities 1 & 2 are necessary for those steps in Priorities 3-7 to be realizable. The full explanations and justification for the SHPDA Key Priorities for 2023-2024 follows this summary page.

SHPDA Key Priorities 2023-2024 Summary List

1. SHPDA Essential Modernization*	**$244,266 Legislative ask***
2. State of Hawaii Health Services and Facilities Plan*	**$102,355 Legislative ask***
3. Hawaii the Health State Universal Access/Affordable Care*	**$745,000 Legislative ask***
4. Health Status Monitoring and Population Health Reporting Grant	$250,000 part of AHEAD
5. Keiki and Kupuna Initiatives Phase One	Part of MedQuest Waiver
6. Secure "Specialist Telemedicine Access" grant for Maui	$200,000 one-year Foundation Grant
7. Secure CMS/CMMI "AHEAD" Grant for Hawaii	$325,000 Foundation Grant
*Total Legislative ask through Administration/Legislative Package	$1,091,621
Total Foundation, other philanthropy, or federal grant requests	$525,000

(AHEAD Grant funding if successful: $12,000,000 over 6 years)

September 20, 2023

SHPDA Key Priorities 2023-2024

1. **SHPDA Essential Modernization**. This priority for us at the agency, along with priorities 2 and 3 are SHPDA's most important priorities. Without these necessary steps and funding to improve SHPDA's staff and infrastructure, we cannot fulfill the important mission we are charged to achieve. SHPDA was created by the Legislature to fulfill a large and critically missing state capacity and responsibility for health care and services planning and development in Hawaii with its enactment through HRS Chapter 323 in 1975. The agency originally had 65 staff to serve as the de facto "health authority" for the Governor, the Legislature, and the Hawaii health sector. The staff was whittled down over the years during deficit budget years to 6 positions, and the mission narrowed as a result to basically only being capable of managing the state's Certificate of Need (CON) process. The CON process has been a beneficial means of cost containment and prevention of frivolous or unnecessary investment in health care, but it represents only small fraction of what the state needs to be able to monitor, track, and improve the health status of the Hawaii population, as well as to monitor and report on the state's return on investment in health care in terms of population health status and comparative outcomes, quality, and cost effectiveness of health care services. Priorities 4-6 will all move the agency toward a proactive ability to achieve our mission, but the following very modest staff and infrastructure investments in Priorities 1, 2, and 3 are necessary for those steps to be realizable. These specific funding requests are:

   - The addition of one PHAO staff position (Public Health Administrative Officer IV SR22) to assist with fiscal, contracts, and personnel management services.
     Cost is $71,016

   - Office redesign, construction, and disposal: Redesign and construction to accommodate one (1) new staff person, three (3) consultant spaces, two (2) UH student intern workspaces, and a conference room. Also includes disposal of 50 years of unusable equipment and unnecessary old files to make room for new staff space without expansion of office itself.
     Cost is $135,000

   - Electronic filing of all CON records and other data from 1975 to the present, to free up physical space and make public access to CON and SHPDA documents more convenient and accessible. (First year $38,250; and $8000/yr. thereafter)
     Cost is $38,250

   a. The ASK**: $244, 266** (for 2024 only; recurring costs/yr. will be $79,016).
   b. Status: These requests are all in the Admin. package for the 2024 Legislature

2. **State of Hawaii Health Services and Facilities Plan**. SHPDA was mandated to develop and periodically revise a State Health Service and Facilities Plan for the Legislature, Governor, and the health sector in Hawaii. When SHPDA had 65 staff this was more realistically achievable, but the staff has been over time reduced to 6 positions which are now devoted exclusively to the Certificate of Need (CON) process, which itself depends on the plan. The last comprehensive revision of the plan was produced in 2009. It is very much needed still, and so we will produce one for 2024 using a short-term consultant research-writer, with help from our staff to produce and circulate. From here on, the plan should be updated at least every other year. For now, we need a consultant, until we can staff up later.

   a. The ASK: **$102,355 for a consultant writer/researcher**.
   b. Status: this is in the 2024 Administrative budget request.

3. **Hawaii the Health State 2025** – **Strategy for Universal Access to High-quality, Equitable, and Affordable health Care for All.**
Hawaii has perhaps more than any other state the potential to design and implement a **"**public option" insurance *choice* for health care consumers across the entire population. It has to focus on prevention to improve outcomes and equity, and systematically reduce costs. This will be require streamlining the regulatory, administration, and access mechanisms, increasing the interfaces between competing insurance participants, and using "value-based" payment models. Despite being provided by multiple payers (HMSA, Kaiser Permanente, Aloha Care (with Federally Qualified Health Centers) and multiple funding sources (Medicaid, employers and employee-union private contributions, and Medicare), the model could require use of advanced primary care models (including physicians, nurses, social workers, psychologists, pharmacists, and care coordinators working in teams, and with telemedicine). It could also employ, high-tech, high-touch home and community care models, and real-time advanced clinical data support and health status monitoring, new technology, and consideration of social determinants. The goal is to include all the latest 'bells and whistles' to improve outcomes and equity, and to lower costs of care. The model will only succeed in attracting consumers if it achieves its better outcomes, lower costs, and higher patient *and* provider satisfaction. It will need to be piloted and have full cooperation of all key players above.

   a. The ASK: **$745,000 for 2024 actuarial, data analytics, and health planning consulting**.
   b. Status: In SHPDA Legislative proposal for funding (also in Administration package).

4. **Health Status Monitoring and Population Health Reporting.** Hawaii, like all states in the US, an effective means of tracking progress and health outcomes, and in identifying gaps and problems in health care and in clinical aspects of public health (primary and secondary prevention and chronic disease outcomes). Under the authority of SHPDA, the legislature amended our authorizing HRS Chapter 323 of 1975 with Act 139 of 2016 to require collection and use for these purposes all insurance data for EUTF (mostly HMSA and Kaiser Permanente), MedQuest, and Medicare beneficiaries, covering well almost 1.2 million Hawaii citizens. That data, collected in the All-Payer Claims Database (APCD) already has more than 1 million residents included, but is still an early phase in mining the data and reporting on it for the aforementioned purposes. The APCD is being managed MedQuest and UH. This priority adds new resources to hire a physician informaticist (probably at UH estimated at $160,000 per year) and funds ($90,000) for accelerating the mining of the APCD data.

   a. The ASK: **$250,000 (not in the 2024 legislative package as of now).**
   b. Status: This will be funded via our federal grant proposal "AHEAD".

5. **Keiki and Kupuna Initiatives Phase One**. Working with MedQuest on their 1115 Waiver renewal for 2024, Hawaii will request that all uninsured Keiki (birth to 18) be presumptively and automatically insured by MedQuest. SHPDA's Keiki Advisory Group will develop additional priorities for legislative consideration in 2024 and 2025. Similarly, we will seek a new provision in the 1115 MedQuest Waiver 2024 renewal for a pilot project that allows Hawaii to recoup 50% of savings achieved by diverting Kupuna who are fully eligible for nursing home (LTC) placement and who desire to age at home, to receive home advanced services equal to at least half of current nursing home annual costs (currently averaging $169,000/year). If successful, the pilot could be expanded broadly, generating millions of savings for additional unfunded health care priorities. Meanwhile, the SHPDA Kupuna Advisory Group will develop additional priorities for advanced Kupuna home care for legislative consideration in 2024-2025.

   a. The ASK**: in negotiations with CMS and MedQuest.**
   b. Status: Kupuna pilots might be funded via privately with HMSA, Queens, or HPH.

6. **<u>Secure "MD Specialist Telemedicine Access" grant for Maui</u>**. Hawaii missed the deadline for the Making Care Primary grant program from CMS to improve primary care by increasing access to specialty care and improving access to behavioral health and social determinants of health. We have been invited to piggyback on Colorado's program through their Netchemistry vendor to allow virtual and immediate telemedicine specialist visits for primary care doctors and their patients to receive immediate consults when specialist access is weeks or months away due to shortages of specialists. This could be critically important for Maui right now, but also for all rural parts of Hawaii. FQHC clinic clinicians and primary doctor practices could access the service. If successful on Maui, we can expand in mid-2024. While valuable statewide, we need start-up $$$ for Maui now, rather than waiting until after the 2024 legislature.

    a. The ASK: $200,000 in grant/foundation funds to participate ASAP.
    b. Status: we are seeking emergency state matching or philanthropy funds.

7. **<u>Secure CMS/CMMI[i] AHEAD[ii] Grant for Hawaii</u>**. CMS will select up to 8 states to receive up to $12 Million each over about 6 years with AHEAD grants. The grants are to improve primary care, chronic disease management, behavioral health, community-based and home care, including social determinants of health like housing, food security, and substance abuse treatment. Because of Hawaii's PHCA[iii] employer insurance mandate, our MedQuest program, and our statewide FQHC system, we believe we have a head start on winning a grant. The first round of proposals is due by December 2023 – very soon! This could help in Maui fire health recovery efforts; but this is also critical for planning and achieving Hawaii's ideal health care future and our goal for being first state to achieve universal access to high quality, equitable, affordable health care for all.

    a. The ASK: $315,000 in planning money ASAP (900 consultant hours @ $350/hr.)
    b. Status: We are seeking emergency state or philanthropy funding to apply soon.

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[i] CMS: Centers for Medicare and Medicaid Services; CMMI: Center for Medicare and Medicaid Innovation Division of CMS. CMMI gives out $30-100 million in health care grants each year.

[ii] AHEAD: All-Payer Health Equity Approaches and Development Model (AHEAD Model). The AHEAD Model aims to shift health care to more community-based approaches to better address chronic disease, behavioral health and other medical conditions, according to CMS. The agency hopes that participating states will be better "equipped" to promote health equity, greater primary care utilization and more sustainable health care spending, with seamless interfaces between insurance coverages.

[iii] PHCA: Hawaii's unique-in-the-nation Prepaid Health Care Act, which guarantees quality health insurance to nearly all workers and their families.