THE SENATE
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

S.B. NO. 1468 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 PART I

2 SECTION 1. The legislature finds that improving the
3 medicaid health care system of Hawaii will require a
4 comprehensive and coordinated approach. Dr. Donald Berwick,
5 Administrator of the Centers for Medicare and Medicaid Services,
6 has long supported broad system change with linked goals through
7 the "Triple Aim" approach. The Triple Aim focuses on improving
8 the individual experience of care, improving the health of
9 populations, and reducing per capita costs of care for
10 populations. Achieving these interdependent goals in health
11 care requires balance, collaboration, data, and innovation. The
12 legislature finds that one such innovation and opportunity
13 endorsed by the Patient Protection and Affordable Care Act
14 (Public Law 111-148) as amended by the Health Care and Education
15 Reconciliation Act of 2010 (Public Law 111-152), together known
16 as the Affordable Care Act, is the patient-centered medical home
17 model, also known as the patient-centered health home.

1 A patient-centered health home is a model of delivering
2 comprehensive, integrated, and holistic health care services to
3 patients, including preventive and lifestyle health services.
4 It is not necessarily a physical structure, but rather a
5 collection of health care providers and community organizations
6 that work collectively to provide and manage patient health.
7 The primary provider within a health home works with a health
8 care team to provide comprehensive and integrated services to
9 patients. The health home team may include a primary care
10 provider, behavioral health provider, care manager or patient
11 care coordinator, and allied health professionals.
12 The collaborative nature of the patient-centered health
13 home systematically works to reduce health disparities for
14 patients with multiple chronic diseases like diabetes,
15 hypertension, and depression, which are aggressive drivers of
16 cost. Patient-centered health care homes improve patient
17 outcomes by integrating and coordinating care across the entire
18 continuum of care, providing holistic health care services, and
19 transforming the delivery of health care by moving patient
20 treatment away from acute, incident-based care, toward a more
21 proactive, wellness-oriented, and healthy patient behavior
22 paradigm.

A 1999 study of standard doctor visits published in the "Journal of the American Medical Association" revealed that doctors interrupted patients after twenty-three seconds of problem explanation, and spent just 1.3 minutes giving information. Fifty per cent of patients left without understanding what the doctor said, and ninety-one per cent of patients had no active involvement in their own decision-making process. By having patients take an active and informed role in their own health, and partnering them with a proactive health care team that works collectively to encourage healthy lifestyles, the patient-centered health care home reduces long-term costs by focusing on wellness, education, and preventive services, which not only reduce general health care costs but also more costly emergency room and inpatient facility use.

To facilitate the most efficient use of resources and to enhance patient care through extensive care coordination, a patient-centered health home and the health care team must employ health information technology that enables sharing of patient and treatment data and collection and reporting at the patient and provider level. Health homes should have electronic health record systems that meet the Centers for Medicare and Medicaid Services' federal meaningful use guidelines.

1 Transformation of health care delivery must simultaneously
2 be accompanied by a reassessment of reimbursement. Given the
3 enhanced level of services provided by patient-centered health
4 care homes, it is essential that organizations operating under
5 this model be reimbursed for the array of services that
6 ultimately contribute to long-term cost savings. The
7 reimbursement model should pay for services provided and
8 outcomes produced. A comprehensive reimbursement strategy for a
9 medicaid health home model includes consistent fee-for-service
10 reimbursement based on existing prospective payment system
11 guidelines, reimbursement for enhanced health care home
12 services, based on a per member per month formula, and
13 organizational incentive payments for improving total population
14 health in the chronic diseases areas identified.
15 The legislature finds that the Affordable Care Act grants
16 states the option to provide health homes to medicaid enrollees
17 with chronic conditions and receive a ninety per cent federal
18 medical assistance percentage for those enrollees for the first
19 eight fiscal quarters. The legislature further finds that the
20 Affordable Care Act also provides financial support and
21 incentives for health systems that move toward team-based,
22 collaborative methods of care and wellness.

1 The purpose of part I of this Act is to authorize the
2 establishment of a Hawaii medicaid modernization and innovation
3 task force that may establish a patient-centered health home
4 pilot program within the medicaid program.
5 SECTION 2. (a) No later than July 1, 2011, there may be
6 established within the department of human services for
7 administrative purposes the Hawaii medicaid modernization and
8 innovation task force to be appointed by the governor as
9 provided in section 26-34. The task force shall be comprised of
10 thirty-five members with geographic representation from across
11 the State as follows:
12 (1) The chairpersons of the committees with jurisdiction
13 over human services of the respective houses of the
14 legislature, or the chairpersons' designees;
15 (2) The chairpersons of the committees with jurisdiction
16 over health of the respective houses of the
17 legislature, or the chairpersons' designees;
18 (3) The director of human services, or the director's
19 designee;
20 (4) The director of health, or the director's designee;
21 (5) The state insurance commissioner;
22 (6) The lieutenant governor;

1 (7) One representative of a not-for-profit health plan
2 offered as a plan in any state health care program;
3 (8) One representative of a nonprofit health provider
4 association;
5 (9) One representative of a local behavioral health
6 professional association;
7 (10) Six patient-consumer representatives, at least three
8 of whom serve on the board of a federally qualified
9 health center;
10 (11) One oral health provider;
11 (12) One representative of the business sector;
12 (13) One licensed advanced practice registered nurse;
13 (14) One non-physician mental health provider;
14 (15) One licensed primary care physician practicing family
15 medicine to be appointed from a list of nominees
16 submitted by the speaker of the house of
17 representatives;
18 (16) One licensed primary care physician practicing
19 geriatric medicine to be appointed from a list of
20 nominees submitted by the speaker of the house of
21 representatives;

1 (17) One representative of a health plan offered as a plan
2 in any state health care program to be appointed from
3 a list of nominees submitted by the speaker of the
4 house of representatives;
5 (18) One representative of any allied or complimentary
6 health profession that provides support to primary
7 care physicians and medical home teams to be appointed
8 from a list of nominees submitted by the speaker of
9 the house of representatives;
10 (19) One licensed primary care physician practicing
11 pediatric medicine to be appointed from a list of
12 nominees submitted by the president of the senate;
13 (20) One representative of a local medical professional
14 association to be appointed from a list of nominees
15 submitted by the president of the senate;
16 (21) One representative of a health plan offered as a plan
17 in any state health care program to be appointed from
18 a list of nominees submitted by the president of the
19 senate;
20 (22) One representative of any allied or complimentary
21 health profession that provides support to primary
22 care physicians and medical home teams to be appointed

1 from a list of nominees submitted by the president of
2 the senate;
3 (23) One representative from a hospital;
4 (24) One representative from a physician's group;
5 (25) One representative from the health care provider
6 industry;
7 (26) A physician assistant;
8 (27) An individual with a finance background; and
9 (28) A social worker.
10 (b) To the extent permissible by law and in addition to
11 any other duties prescribed by law, the task force may develop
12 and implement the Hawaii patient-centered health home pilot
13 program. The task force may develop a program that is consumer-
14 driven, culturally appropriate, and family-centered and that
15 optimizes access and provides team-based, integrated, and
16 holistic care delivery. The task force shall:
17 (1) Adopt a definition, criteria, and standards for health
18 homes that take into consideration the recommendations
19 of the Patient-Centered Primary Care Collaborative
20 Joint Principles of the Patient-Centered Medical Home
21 and the National Committee for Quality Assurance
22 Patient-Centered Medical Home Certification Standards,

1 and is consistent with the definition of "health home
2 services" contained in Title 42 United States Code
3 Section 1396w-4;
4 (2) Consult with any local health plan or provider that
5 has implemented a medical home or health home model of
6 care in Hawaii, consider the criteria and standards
7 used by the health plan or provider, and determine
8 whether the criteria and standards are appropriate for
9 inclusion in the task force's criteria and standards
10 for the Hawaii patient-centered health home pilot
11 program;
12 (3) Certify health homes that meet the standards
13 established by the task force;
14 (4) Adopt a definition of the medical home team that
15 includes providers within the medical home, including:
16 (A) A primary care provider;
17 (B) Behavioral health provider;
18 (C) Care manager or patient care coordinator;
19 (D) Nursing staff;
20 (E) Nutritionists and dieticians;
21 (F) Oral health care provider;
22 (G) Pharmaceutical provider;

1 (H) Ambulatory care providers; and
2 (I) Other specialty care providers;
3 (5) Develop quality and performance measures that
4 certified health homes in the pilot program must
5 report to the task force, health plans, and department
6 of human services;
7 (6) Develop a payment methodology for certified health
8 homes that shall include a per member per month care
9 coordination fee, consistent fee-for-service
10 reimbursement, payment for any services not reimbursed
11 under current medicaid or prospective payment system
12 guidelines but that are recommended as a covered
13 service in the health home pilot program developed by
14 the task force, and organizational incentive payments
15 for improving total health among chronic disease
16 populations, and other metrics as adopted by the task
17 force; provided that for federally qualified community
18 health centers, the payment methodology is in addition
19 to, and no less than, existing prospective payment
20 system rates; and
21 (7) Develop annual reporting requirements for certified
22 health homes and health plans to report to the task

1 force, department of human services, and legislature
2 on:
3 (A) The number of members in the program and
4 characteristics of members including income,
5 ethnicity, language, complex or chronic
6 condition, age, and sex;
7 (B) The number and geographic distribution of health
8 home providers;
9 (C) The performance and quality of health homes in
10 treating complex chronic condition patient
11 populations;
12 (D) Measures of preventive care;
13 (E) Health home payment methodology arrangements
14 compared with costs related to implementation and
15 payment of care coordination fees; and
16 (F) Estimated and actual impact of health homes on
17 health disparities.
18 (c) The task force shall select a chairperson by a
19 majority vote of its members. A majority of the members serving
20 on the task force shall constitute a quorum to do business. The
21 task force may form workgroups and subcommittees, including
22 individuals who are not task force members, to:

1 (1) Obtain resource information from medical
2 professionals, insurers, health care providers,
3 community advocates, and other individuals as deemed
4 necessary by the task force;
5 (2) Make recommendations to the task force; and
6 (3) Perform other functions as deemed necessary by the
7 task force to fulfill its duties and responsibilities.
8 (d) Members of the task force shall serve without
9 compensation and shall receive no reimbursement for expenses.
10 (e) The task force may solicit monetary gifts and
11 donations to offset the costs and expenses of the task force.
12 (f) The task force may require reports as necessary in the
13 form specified by the task force from state agencies and program
14 and service providers of any state health care program.
15 (g) No later than twenty days prior to the convening of
16 the regular session of 2012, the task force shall submit to the
17 legislature, the governor, the director of health, and the
18 director of human services a report relating to the development
19 of the program containing:
20 (1) The progress of the task force; and
21 (2) Any and all criteria, standards, measurements, payment
22 methodology, and other requirements of the Hawaii

1 patient-centered health home pilot program adopted by
2 the task force pursuant to this section.
3 (h) No later than twenty days prior to the convening of
4 the regular session of 2013 the task force shall submit to the
5 legislature, the governor, the director of health, and the
6 director of human services a report relating to the
7 implementation of the program containing information and data
8 regarding the problems experienced with the program, benefits of
9 the program, and the practical application of the program. The
10 report shall also contain an opinion as to whether the program
11 is a practical approach to modernizing medicaid-centered health
12 care and recommendations as to whether the program should be
13 continued.
14 Based on the task force's recommendation, the legislature
15 and the governor may determine whether to continue the Hawaii
16 patient-centered health home pilot program.
17 (i) The task force shall cease to exist on June 30, 2013.
18 PART II
19 SECTION 3. Chapter 327E, Hawaii Revised Statutes, is
20 amended by adding a new section to be appropriately designated
21 and to read as follows:

1 "**§327E- Advance health-care directive program.** There
2 may be established a program within the appropriate agency to
3 encourage Hawaii residents with advance health-care directives
4 to maintain a copy of that advance health-care directive on
5 their person."
6 PART III
7 SECTION 4. Chapter 346, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately designated
9 and to read as follows:
10 "**§346- QUEST reimbursement modifications.** No managed
11 care plan or provider offering services under any QUEST program
12 should modify reimbursement policies, guidelines,
13 interpretation, or positions adopted by medicaid or any agent,
14 whether formally or informally, in writing or orally, without
15 providing a ninety day prior written notice of such change to
16 any affected health care provider. No such modification may be
17 applied retroactively if it would have the effect of reducing
18 reimbursements previously made to such health care providers if
19 prior approval for reimbursement was obtained through medicaid."
20 PART IV
21 SECTION 5. New statutory material is underscored.
22 SECTION 6. This Act shall take effect on July 1, 2050.

Report Title:
Hawaii Patient-Centered Health Home Pilot Program; Hawaii Medicaid Modernization and Innovation Task Force

Description:
Authorizes the Hawaii Medicaid Modernization and Innovation Task Force that may design and implement the Hawaii Patient-Centered Health Home Pilot Program. Authorizes the establishment of an advance health care-directive program. Provides that managed care plans or providers offering services under QUEST programs may not modify reimbursement policies, guidelines, interpretation, or positions adopted by Medicaid or any agent without providing prior written notice to any affected health care provider. Effective July 1, 2050. (SB1468 HD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.