Hawai'i Medicaid Vision and Waiver Renewal

The Affordable Health Insurance Working Group
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Med-QUEST DIVISION

VISION

The people of Hawai’i embrace health and wellness

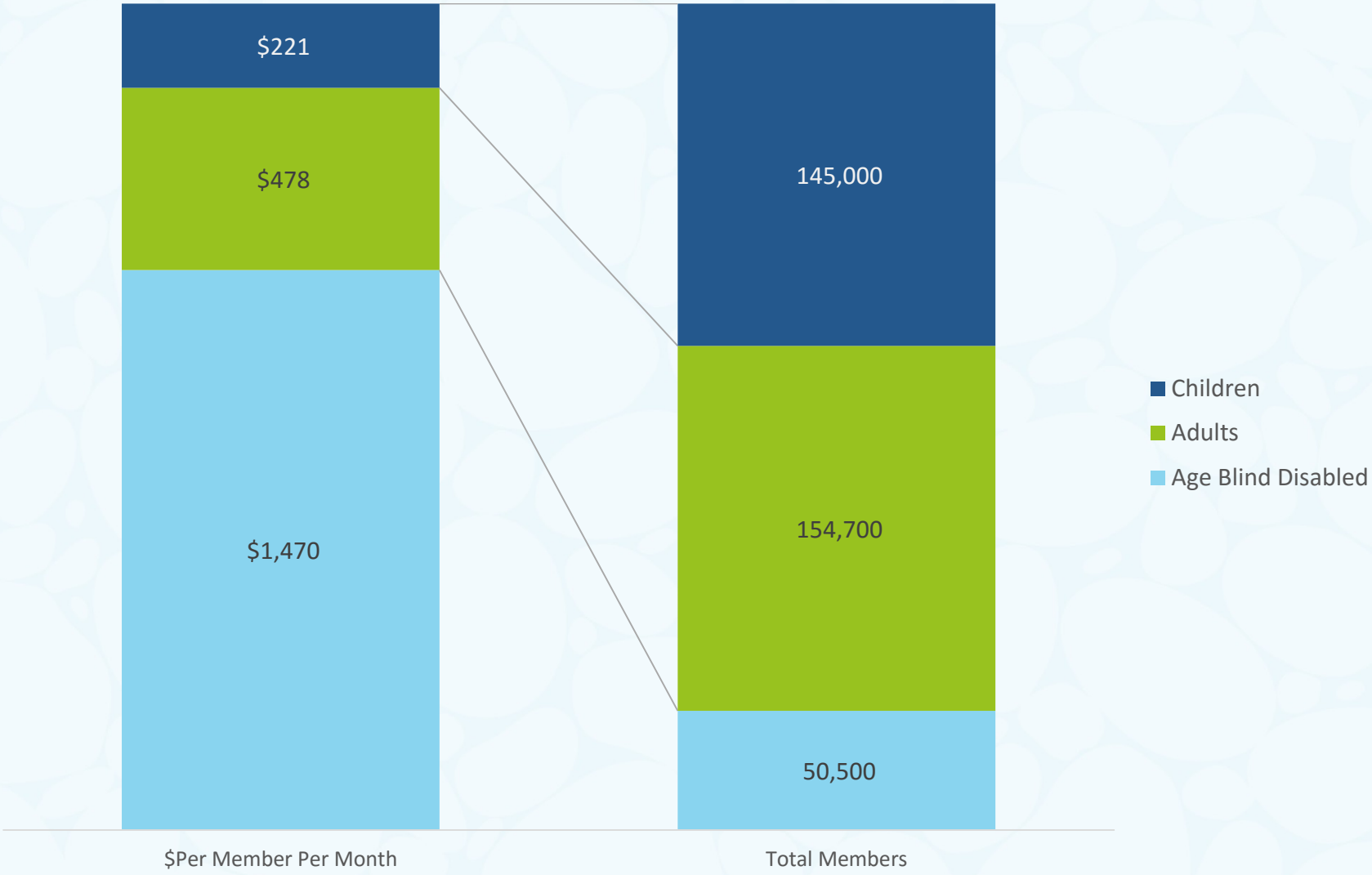
MISSION

Empower Hawai'i’s residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha.

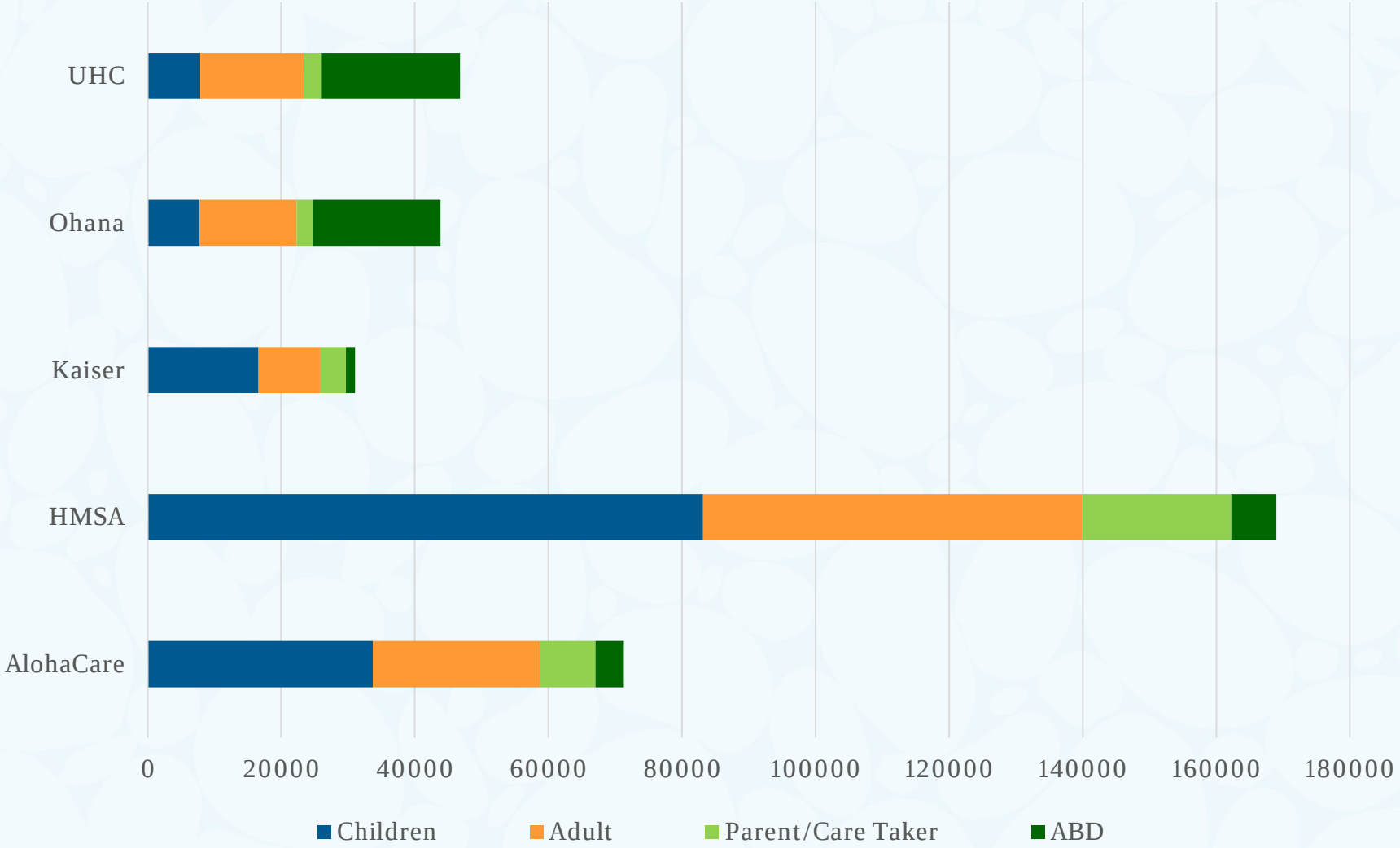
Fast Facts:

- Hawaii has ranked the healthiest state in the country for years
- Most efficient/effective health care (Bloomberg News Sept. 25, 2017)
- Medicaid:
  - Serve about 357k or ¼ of state population (1.4M) and 45% of all children
  - 1115 waiver Demo waiver since 1994; up for renewal 12/31/2018
  - Medicaid expansion state (including prior to ACA)
  - CHIP is a Medicaid expansion (308% FPL)
  - Delivery system is nearly 100% managed care including Long Term supports & services
  - Mental Health managed care carve-out
  - Dental is FFS. Very limited Adult dental benefit
  - Federal base match rate is currently about 53.4%

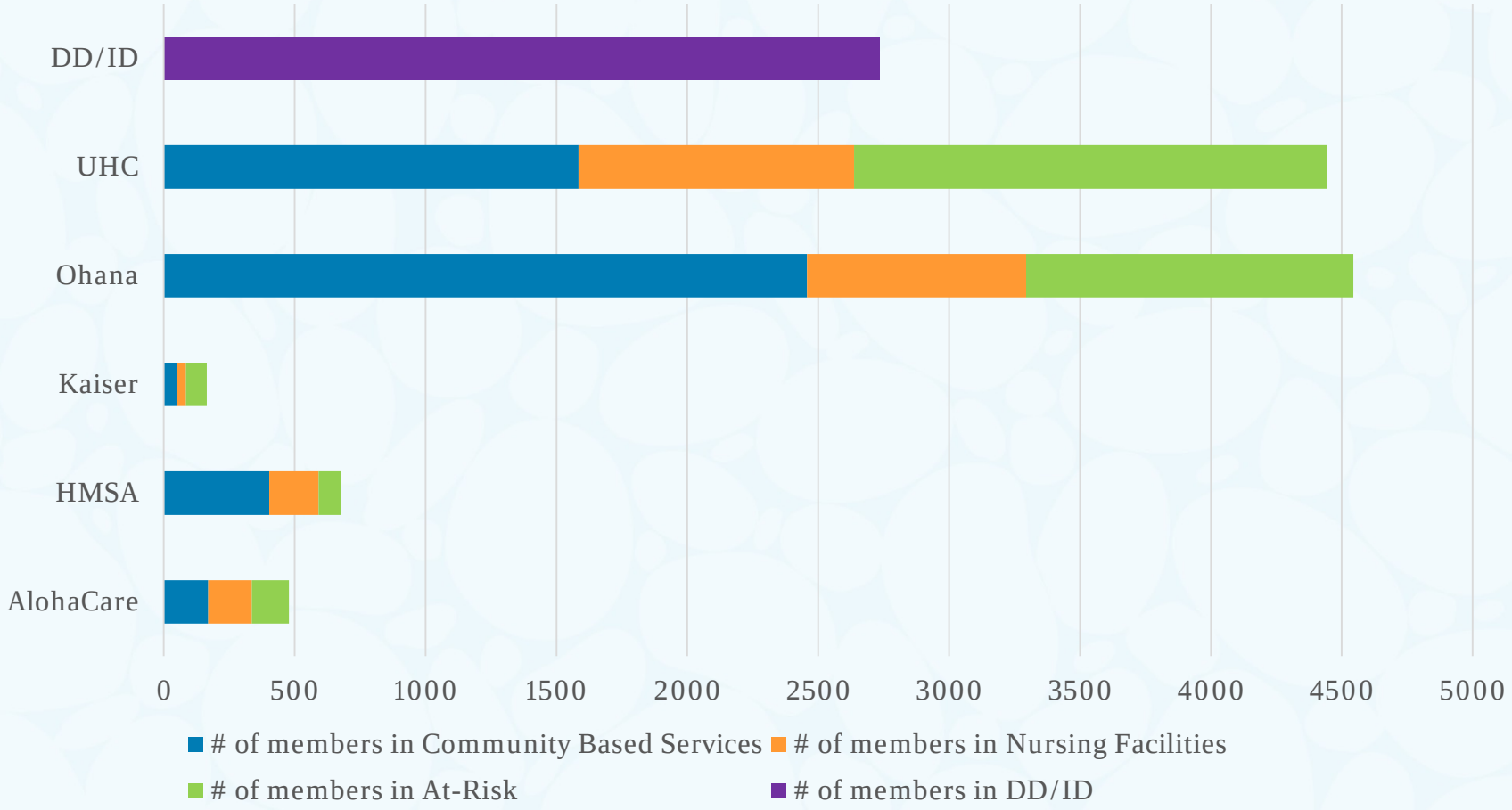
QUEST Integration 2017



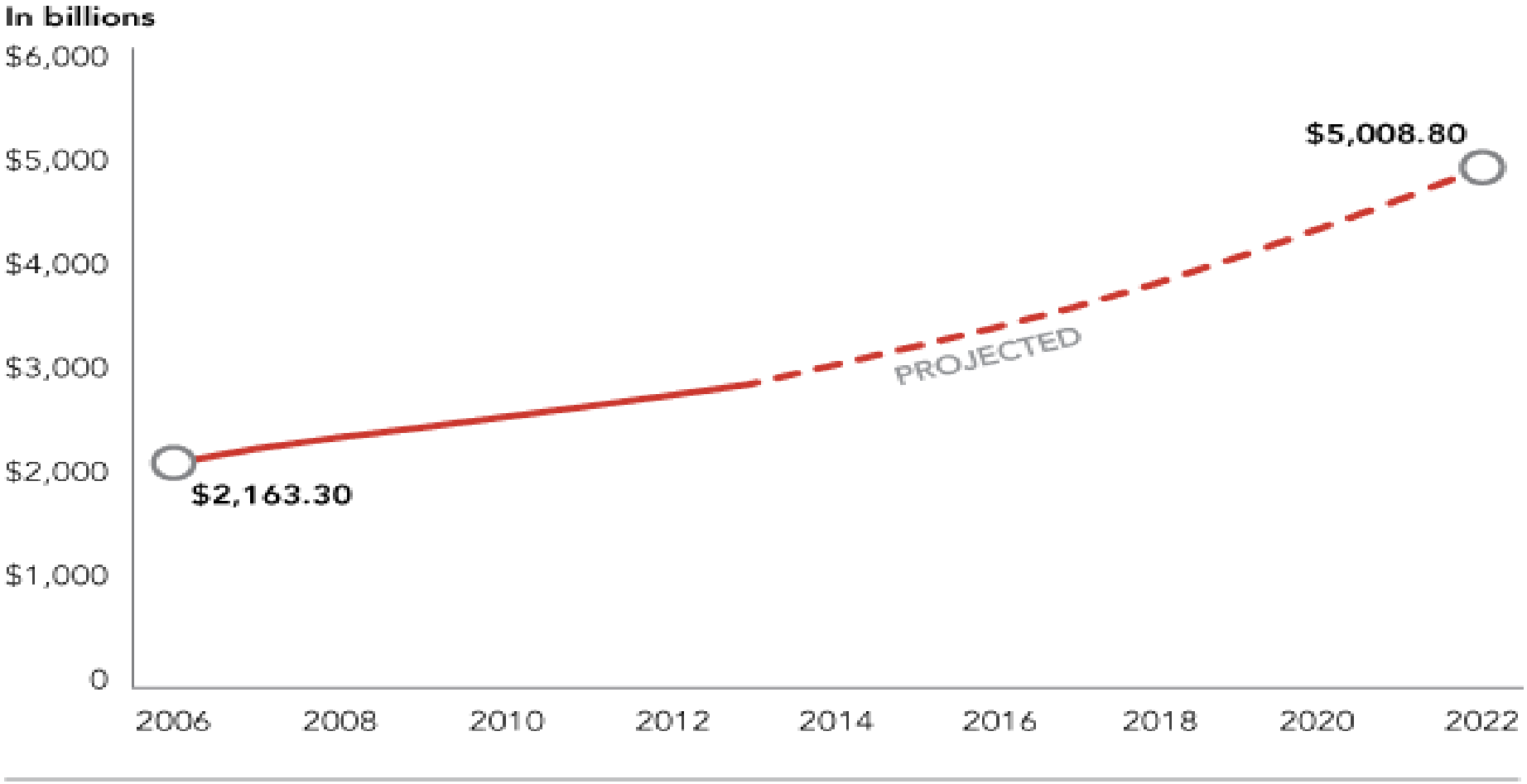
Managed Care Enrollment



of Members using Long Term Care or in Developmental/Intellectual Disabilities programs



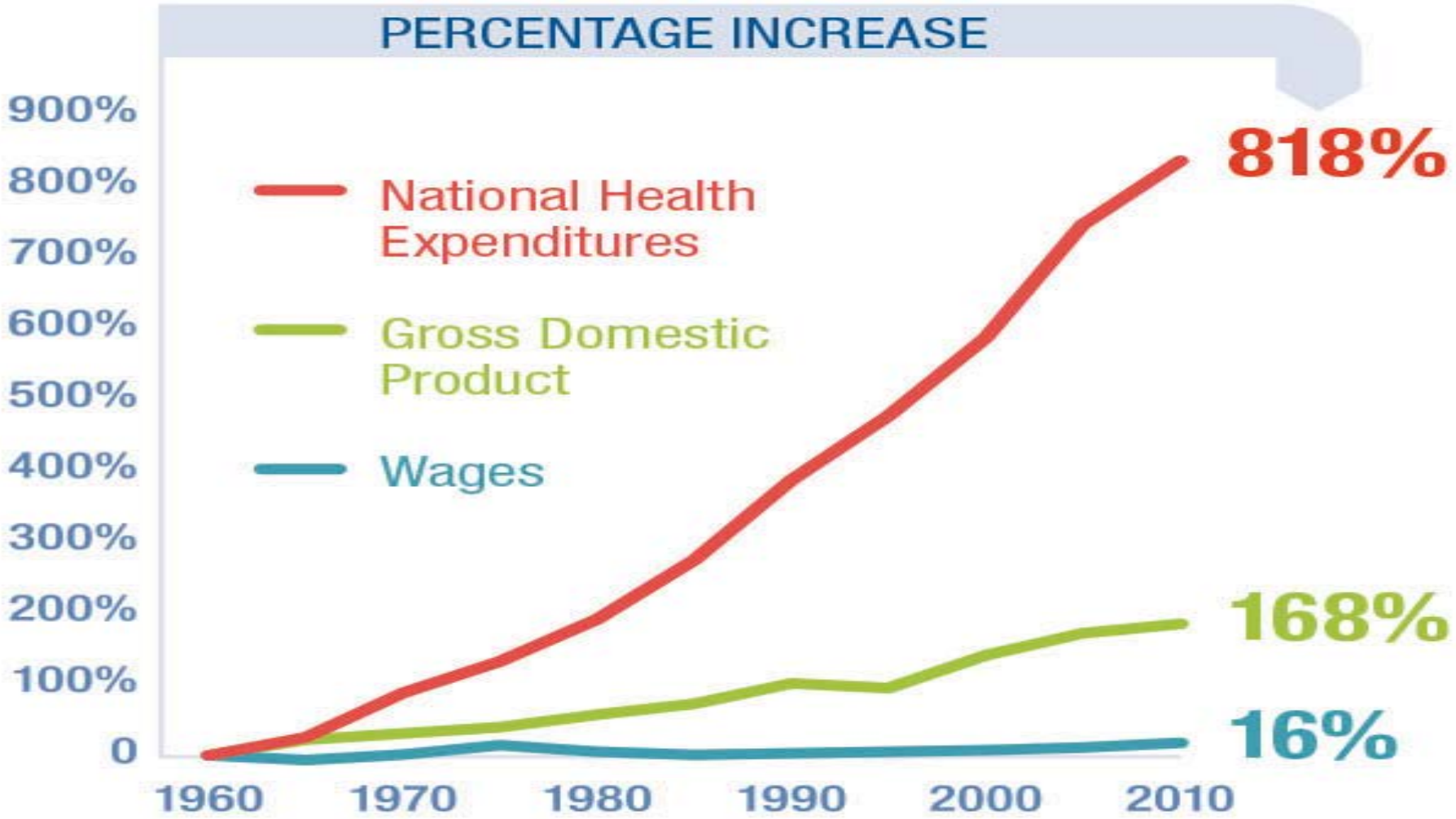
Health care spending is projected to nearly double in the next decade.



Notes: The health spending projections were based on the National Health Expenditures released in January 2013. The projections include impacts from the Affordable Care Act. Numbers may not add to totals because of rounding.
Source: Centers for Medicare & Medicaid Services, Office of the Actuary

THE HUFFINGTON POST

Health care spending has grown much faster than the rest of the economy in recent decades.



Source: McKinney, "Accounting for the Cost of U.S. Health Care" (2011), Center for American Progress

Commonwealth Fund: Select Population Health Outcomes and Risk Factors

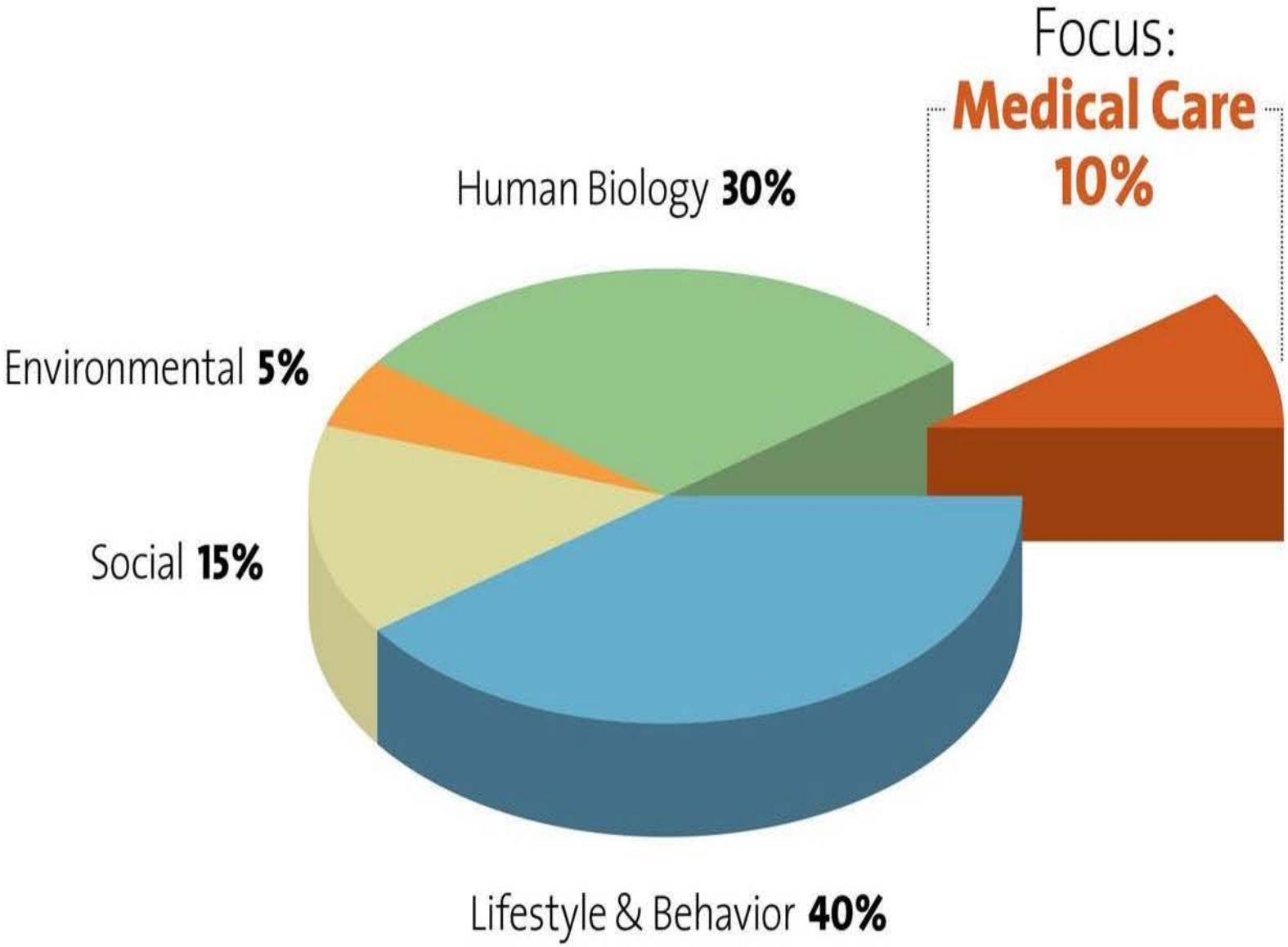
	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.

[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis.
Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.

[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.

[d] 2012. [e] 2011.


Focus:
Medical Care
10%
Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%

Health is everyone's "kuleana"!

As a community, we need to ask:

- **What do we want our communities and our health care delivery system to look like?**
- **What do we want to invest in?**
- **What do we value?**

Hawaii Medicaid Health Innovation Project (HIP)

- HIP is a five-year plan to develop and implement a roadmap to achieve the vision of **"healthy families, healthy communities."**
- The overall goals are to:
  - Achieve the **Triple Aim** (better care, better health, lower cost); and
  - To align state programs and funding around a common framework: A multigenerational, culturally appropriate approach that invests in children and families over the life-cycle to nurture well-being and **improve individual and population health outcomes.**

Opportunity:
Transitioning the System

- Providing health care differently.
- Promoting workforce development and capacity.
- Paying for health care differently – Re-aligning incentives.
- Section 1115 demonstrations and waiver authorities are **vehicles states use to test new or existing ways to deliver and pay for health care services.** Waivers have to be budget neutral.

Waiver Renewal Timeline

Qtr 4 2017

- Continue to develop waiver concepts
- Hold public hearings for feedback

Qtrs 1-2 2018

- Submit concept paper to CMS & Intent to renew
- Consultants start
- Continue to seek input from stakeholders and community

Qtrs 3-4 2018

- Negotiate waiver renewal
- Negotiate Special Terms and Conditions

Qtr 1 2019

- New waiver period starts on January 1, 2019
- Start implementation of initiatives approved in waiver

Approach to Innovation

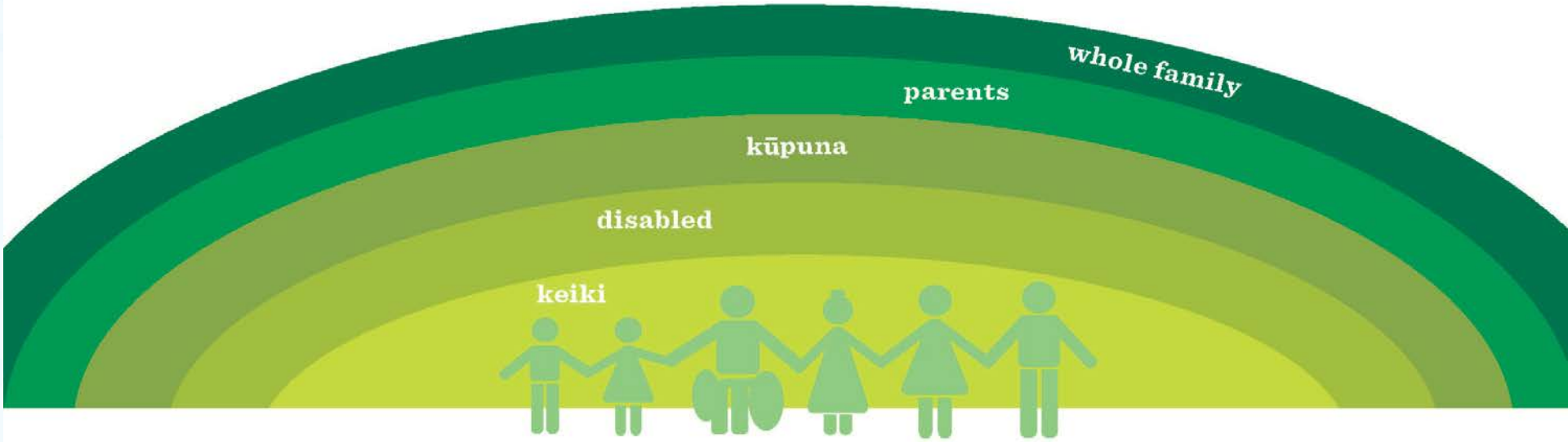
Emphasis on:

- Health promotion, prevention and primary care
- ‘Ohana Nui - Children, especially young children
- Focus on the whole person
- All health care is local and community-based
- Where we live, work, learn and play - Social determinants of health (SDOH)

When we support **children,** the whole family benefits
When we support **families**, children thrive

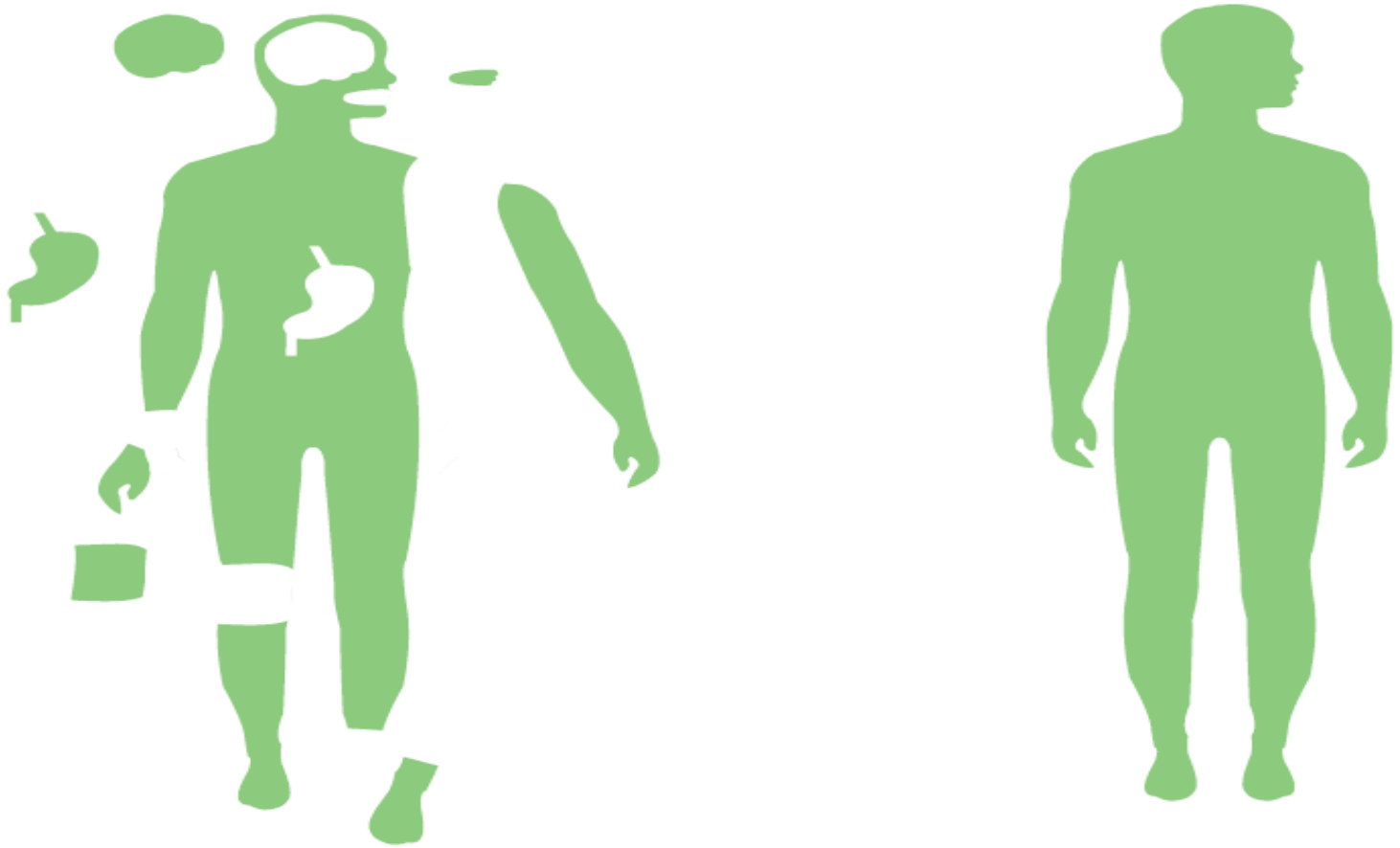
Hawai‘i multi-generational approach:

‘Ohana Nui



Whole Person Health

OPERATES ON THE UNDERSTANDING THAT ALL PARTS OF THE BODY ARE INTERCONNECTED.
ONE PART AFFECTS THE WHOLE, AND ALL PARTS OF THE BODY AFFECT OVERALL HEALTH



The Approach Extends Beyond the Clinic Walls

Source: Public Health Institute

Health Improvement Plan
Four Strategies

- Improve health overall through health promotion, prevention, and early mitigation of disease throughout the life course.
- Improve care provided to high-needs and high-cost (HNHC) individuals.
- Promote population health by strengthening capacity and linkages between health delivery systems and community resources.
- Promote quality and financial alignment to transition to an outcomes-based payment systems that achieve the Triple Aim.

Invest in Primary Care

Strategy #1: Improve health overall through health promotion, prevention, and early mitigation of disease throughout the life course.

- One of the best places to focus on health promotion and prevention is in the primary care setting.
  - Greater use of primary care has been associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency departments visit, and lower mortality.
  - Underinvestment in primary care is one of four fundamental reasons that the U.S. health system ranks last among high-income countries.

Source: Christopher F. Koller, M.P.P.M., M.A.R., and Dhruv Khullar, M.D., M.P.P. N Engl J Med 2017; 377:1709-1711 November 2, 2017 DOI: 10.1056/NEJMp1709538

Invest in Primary Care

Proposed Priority Projects:

- Track the Managed Care Organizations (MCO) primary care spending rate, which is the proportion of all medical spending devoted to primary care, as a measure for assessing the MCO's orientation toward high-value care;
- Focus on promoting best practice, evidence-based education such as diabetes education, and Dr. Ornish's Program for Reversing Heart Disease;
- Reimbursement for behavioral health integration: Payment to PCPs and members of the multidisciplinary team for providing integrated services using the Collaborative Care Model and other evidence-based integration models;

Invest in Primary Care

- Support PCPs by promoting psychiatric hotline services (aka “curbside consults”), and continuing education opportunities such as Project Extension for Community Healthcare Outcomes (ECHO);
- Promoting value-based payments that promote preventive health and health homes; and
- Promotion of Screening, Brief Intervention, and Referral to Treatment (SBIRT) at the primary care level to address substance misuse and abuse, promote Motivational interviewing, and transitions of care models.

Invest in Primary Care

Focus on Children

- Promote the importance of screening young children for developmental and behavioral health conditions, including social-emotional development.

- Promote and pilot home-visiting for vulnerable families and children in collaboration with other state and community based entities.

Address Care for High Needs/High Cost Members

Strategy #2: Improve care provided to individuals with High-Needs and High-Costs (HNHC), particularly for individuals with physical and behavioral health co-morbidities.

Rationale for Focusing on this Population:

- The top one percent of patients account for more than 20 percent of health care expenditures, and the top five percent account for nearly half of the nation's spending on health care. These trends are evident in HI also.
- They are a vulnerable population.
- The potential for return on investment.

Source: The National Academy of Medicine. https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Executive-Summary.pdf

HNHC Members

Priority Initiatives:

- Promote the importance of implementing evidence-based practices that specifically target HNHC members including
  - the Chronic Care Model, Collaborative Care Model (behavioral health integration), Dr. Ornish's Program for Reversing Heart Disease
  - Promote other evidence-based practices and coordinated care models that improve outcomes and decrease costs;
- Provide tenancy supports, MH and substance use treatment focus on chronically homeless;
- Incentivize quality, whole-person care, including intensive care management that include health related social needs;
- Incentivize quality, whole-person care, and implement health homes and value-based purchasing strategies;

HNHC Members

Priority Initiatives:

- Further developing the Managed Long Term Services and Supports program
  - improving transitions of care
  - identifying specific metrics and outcomes in managed care contracts;
- Implementing programs that support palliative care and quality of life at the end of life; and
- Revising health plan requirements so they can better target HNHC members and identify and meet their medical, behavioral, social, and functional needs.

Promote Population Health

Strategy #3: Promote population health by strengthening capacity and linkages between health systems and community resources.

- Research shows that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes.
- HOWEVER, it is difficult for providers and communities to achieve this because there isn't an entity that directly supports clinical-community linkages, and there are limited resources.

As a result, MQD is exploring:

- The Hawaii Accountable Communities of Health (ACH) model that will serve regional communities and link three objectives:
  - Improving health outcomes for vulnerable populations;
  - Supporting regional and local capacity to improve community features that shape the health and well-being of Medicaid beneficiaries; and
  - Use investment funding to incentivize and jumpstart high value collaborative care initiatives.

Source: The Center for Medicare and Medicaid Services. https://innovation.cms.gov/initiatives/ahcm [Accessed 11/08/17]

Promote Population Health

The ACHs will receiving funding based on achievement of milestones for:

- **Phase I: Pay for Planning –** Initial planning activities and partnerships that establish structure and capacity for achieving HIP goals. The plan is called the Regional Health Improvement Plan (RHIP).
- **Phase II: Pay for Reporting and Process Improvements –** Completing actions specified in the RHIP.
- **Phase III: Pay for Outcomes –** Demonstrable progress toward outcomes due to implementation of the RHIP.

Quality & Outcome-Based Payment Systems

Strategy #4: Incentivizing quality, whole-person care, and implementing health homes and value-based purchasing strategies;

The goal is to align value-based payment methodologies to support integrated patient-centered health care at all levels (health plan and provider levels). To achieve this, MQD is exploring:

- Developing alternative payment methodologies for promising practices in primary care;
- Supporting accountable care organizations, value-based payments, and other payment models;
- Incorporating social determinants of health into provider and insurance payments;
- Implementing multi-payer models for services such acute and outpatient care;
- Alternative payment models for Federally Qualified Health Centers (voluntary participation); and
- Adopting payment models that decrease cost variation by including total cost of care.

Foundational Building Block: HIT

Foundational Building Block #1: Use data and analytics to drive transformation and improve clinical care.

Access to data and analytics is critical to providing and measuring quality care, and implementing payment reform. MQD is exploring the following:

- Support health information exchange and the All Payer Claims Database (APCD);
- Develop capacity to collect, analyze and use clinical and cost data to support patient-centered system development and to track trends;
- Address the governance, legal, policy and technical issues that impede the adoption of exchanging health information among providers;
- Promote common performance measurement; and
- Support Data integration across systems where feasible (homeless systems).

Foundational Building Block 2: Workforce Capacity

Hawaii faces significant shortages and distribution challenges in its health care workforce that impact access to care, delivery of care, and ultimately health outcomes. MQD is exploring the following:

- Promote and support residency programs that train new generations of health professionals in whole person, whole family care, team based models, and behavior health care;
- Promote the inclusion of community health workers and peer-support specialists in multidisciplinary team based care; and
- Help promote and build primary care capacity for behavioral health by supporting the Collaborative Care Model, Project ECHO, and other care/capacity building models.

Foundational Building Block #3: Performance Measurement and Evaluation

- MQD will work with stakeholders to develop a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivered through the HIP.
- The goal is to create a core set of industry-standard metrics that will serve as a common basis for measuring progress and impact of the HIP and facilitate continuous improvement throughout the initiative.
- MQD will develop a dashboard that will include a set of metrics that measure the impact of HIP.
- MQD will have an evaluation completed on HIP activities.

HAWAII MEDICAID HEALTH INNOVATION PROJECT				
Goals	Healthy Communities, Healthy Families and Achieving the Triple Aim – Better Health, Better Care, Lower Costs			
Strategies	Improve health overall by building healthy communities and individuals through health promotion, prevention, and early mitigation of disease throughout the life course.	Improve care provided to individuals with high-needs and high-costs, particularly for individuals with physical and behavioral co-morbidities.	Promote population health by strengthening community capacity and improving linkages between health delivery systems and community resources.	Transition to quality & outcome-based payment systems that achieve the Triple Aim.
Foundational Building Blocks	**Health Information Technology:** Use data analytics to drive transformation and drive clinical care			
	Workforce Strategy: Increase workforce capacity and flexibility			
	Continuous Improvement: Performance measurement and evaluation			

QUESTIONS?

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Changes at Federal Level

Challenges	Opportunities
• Uncertainty	• More flexibility in some areas