HOUSE OF REPRESENTATIVES
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

H.B. NO. 326 H.D. 1 S.D. 2

A BILL FOR AN ACT

RELATING TO HEALTH.

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

PART I

SECTION 1. The purpose of this part is to improve access to the full range of health care services to medicaid and QUEST members accessing services through a mobile medical van, by ensuring that medicaid and QUEST health plans have the flexibility to provide appropriate health services via technological means such as telehealth. This is especially important with a new mobile medical van to begin providing services to the more remote areas on the island of Hawaii. Allowing QUEST and medicaid members to access services through the mobile medical van will assist in improving the health of those with chronic conditions as well as improving the overall health of area residents.

SECTION 2. Chapter 346, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§346- Telehealth services; medicaid and QUEST.** (a) The department shall not require:

(1) The department's approval for a health plan under the department's medicaid or QUEST program to deliver services using a telehealth service; or

(2) In-person visits to qualify any teleheath service for coverage under the department's medicaid or QUEST program.

This section shall apply only to a mobile medical van program operating in a county with a population of less than two hundred fifty thousand and to include a program operated by Kona community hospital through a partnership with a non-profit mutual benefit society operating in the State that provides health care coverage to at least six hundred thousand members.

(b) An eligible mobile medical van program shall be operated by a qualified provider.

(c) For the purposes of this section, "telehealth" means the use of telecommunications services, as defined in section 269-1, including real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering

enhanced health care services and information to parties separated by distance. A standard telephone contact, facsimile transmission, or an email text, in combination or by itself, does not constitute a telehealth service for the purposes of this section."

PART II

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

A patient centered health home is a model of delivering comprehensive, integrated, and holistic health care services to patients, including preventive and lifestyle health services. It is not necessarily a physical structure, but rather a collection of health care providers and community organizations that work collectively to provide and manage patient health. The primary provider within a health home works with a health care team to provide comprehensive and integrated services to patients. The health home team may include a primary care provider, behavioral health provider, care manager or patient care coordinator, and allied health professionals.

The collaborative nature of the patient centered health home systematically works to reduce health disparities for patients with multiple chronic diseases like diabetes, hypertension, and depression, which are aggressive drivers of cost. Patient centered health care homes improve patient outcomes by integrating and coordinating care across the entire continuum of care, providing holistic health care services, and transforming the delivery of health care by moving patient treatment away from acute, incident-based care, toward a more proactive, wellness-oriented, and healthy patient behavior 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.

Transformation of health care delivery must simultaneously be accompanied by a reassessment of reimbursement. Given the enhanced level of services provided by patient-centered health care homes, it is essential that organizations operating under this model be reimbursed for the array of services that ultimately contribute to long-term cost savings. The reimbursement model should pay for services provided and outcomes produced. A comprehensive reimbursement strategy for a medicaid health home model includes consistent fee-for-service reimbursement based on existing prospective payment system guidelines, reimbursement for enhanced health care home services, based on a per member per month formula, and organizational incentive payments for improving total population health in the chronic diseases areas identified.

The legislature finds that the Affordable Care Act grants states the option to provide health homes to medicaid enrollees with chronic conditions and receive a ninety per cent federal medical assistance percentage for those enrollees for the first eight fiscal quarters. The legislature further finds that the Affordable Care Act also provides financial support and incentives for health systems that move toward team based, collaborative methods of care and wellness.

The purpose of this part is to establish a Hawaii medicaid modernization and innovation council to establish a patient centered health home pilot program within the medicaid program, and to address other priorities as identified by the legislature.

SECTION 4. (a) No later than January 1, 2012, the department of human services shall establish and implement the Hawaii patient centered health home pilot program within the medicaid program in accordance with the provisions determined by the Hawaii medicaid modernization and innovation council established in section 5 of this part. The Hawaii patient centered health home pilot program shall provide comprehensive, person-centered, and integrated primary care services to state health care program members using a health home model of care delivery. Beginning January 1, 2012, members of state health care programs shall receive care through certified health homes provided by medical home teams. The pilot program shall terminate no later than June 30, 2013; provided that the Hawaii patient centered health home pilot program, upon the council's recommendation and approval by the legislature and the governor, may be continued as a permanent program at that time.

(b) Definitions. As used in this part:

"Commissioner" means the state insurance commissioner of the department of commerce and consumer affairs.

"Council" means the Hawaii medicaid modernization and innovation council established in section 5 of this part.

"Health home" means a provider of primary care services that meets the requirements for participation in the Hawaii patient centered health home pilot program established by this part.

"Member" means any qualified enrollee of a state health care program.

"Primary care services" means health care that includes primary medical, behavioral, mental, and dental services.

"State health care program" means any medicaid funded health care program administered by the department of human services including QUEST, QUEST-ACE, QUEST-Net, QUEST-Expanded Access, Basic Health Hawaii, and Hawaii Premium Plus.

SECTION 5. (a) No later than July 1, 2011, there shall be established within the department of human services for administrative purposes the Hawaii medicaid modernization and innovation council to be appointed by the governor as provided in section 26-34. The council shall be comprised of thirty-one

voting members with geographic representation from across the State as follows:

(1) The director of human services, or the director's designee, as an ex officio voting member;

(2) The director of health, or the director's designee, as an ex officio voting member;

(3) The state insurance commissioner, as an ex officio voting member;

(4) The lieutenant governor;

(5) One representative of a not-for-profit health plan offered as a plan in any state health care program;

(6) One representative of a nonprofit health provider association;

(7) One representative of a local behavioral health professional association;

(8) Six patient-consumer representatives, at least three of whom serve on the board of a federally qualified health center;

(9) One oral health provider;

(10) One representative of the business sector;

(11) One licensed advanced practice registered nurse;

(12) One non-physician mental health provider;

(13) One licensed primary care physician practicing family medicine to be appointed from a list of nominees submitted by the speaker of the house of representatives;

(14) One licensed primary care physician practicing geriatric medicine to be appointed from a list of nominees submitted by the speaker of the house of representatives;

(15) One representative of a health plan offered as a plan in any state health care program to be appointed from a list of nominees submitted by the speaker of the house of representatives;

(16) One representative of any allied or complimentary health profession that provides support to primary care physicians and medical home teams to be appointed from a list of nominees submitted by the speaker of the house of representatives;

(17) One licensed primary care physician practicing pediatric medicine to be appointed from a list of nominees submitted by the president of the senate;

(18) One representative of a local medical professional association to be appointed from a list of nominees submitted by the president of the senate;

(19) One representative of a health plan offered as a plan in any state health care program to be appointed from a list of nominees submitted by the president of the senate;

(20) One representative of any allied or complimentary health profession that provides support to primary care physicians and medical home teams to be appointed from a list of nominees submitted by the president of the senate;

(21) One representative from a hospital;

(22) One representative from a physician's group;

(23) One representative from the health care provider industry;

(24) A physician assistant;

(25) An individual with a finance background; and

(26) A social worker.

(b) To the extent permissible by law and in addition to any other duties prescribed by law, the council shall develop and implement the Hawaii patient centered health home pilot

program established in section 4 of this part. The council shall develop a program that is consumer-driven, culturally appropriate, and family centered and that optimizes access and provides team based, integrated, and holistic care delivery. The council shall:

(1) Adopt a definition, criteria, and standards for health homes that take into consideration the recommendations of the Patient-Centered Primary Care Collaborative Joint Principles of the Patient-Centered Medical Home and the National Committee for Quality Assurance Patient-Centered Medical Home Certification Standards, and are consistent with the definition of "health home services" contained in Title 42 United States Code Section 1396w-4;

(2) Consult with any local health plan or provider that has implemented a medical home or health home model of care in Hawaii, consider the criteria and standards utilized by the health plan or provider, and determine whether the criteria and standards are appropriate for inclusion in the council's criteria and standards for the Hawaii patient centered health home pilot program;

(3) Certify health homes that meet the standards established by the council;

(4) Adopt a definition of the medical home team that includes providers within the medical home, including:

(A) A primary care provider;

(B) Behavioral health provider;

(C) Care manager or patient care coordinator;

(D) Nursing staff;

(E) Nutritionists and dieticians;

(F) Oral health care provider;

(G) Pharmaceutical provider;

(H) Ambulatory care providers; and

(I) Other specialty care providers.

(5) Develop quality and performance measures that certified health homes in the pilot program must report to the council, health plans, and department of human services;

(6) Develop a payment methodology for certified health homes that shall include a per member per month care coordination fee, consistent fee-for-service reimbursement, payment for any services not reimbursed under current medicaid or prospective payment system

guidelines but that are recommended as a covered service in the health home pilot program developed by the council, and organizational incentive payments for improving total health among chronic disease populations and other metrics as adopted by the council; provided that for federally qualified community health centers, the payment methodology is in addition to, and no less than, existing prospective payment system rates; and

(7) Develop annual reporting requirements for certified health homes and health plans to report to the council, department of human services, and legislature on:

(A) The number of members in the program and characteristics of members including income, ethnicity, language, complex or chronic condition, age, and sex;

(B) The number and geographic distribution of health home providers;

(C) The performance and quality of health homes in treating complex chronic condition patient populations;

(D) Measures of preventive care;

(E) Health home payment methodology arrangements compared with costs related to implementation and payment of care coordination fees; and

(F) Estimated and actual impact of health homes on health disparities.

(c) The council shall select a chairperson by a majority vote of its members. A majority of the members serving on the council shall constitute a quorum to do business. The council may form workgroups and subcommittees, including individuals who are not council members, to:

(1) Obtain resource information from medical professionals, insurers, health care providers, community advocates, and other individuals as deemed necessary by the council;

(2) Make recommendations to the council; and

(3) Perform other functions as deemed necessary by the council to fulfill its duties and responsibilities.

(d) Members of the council shall serve without compensation but shall be reimbursed for expenses, including travel expenses, necessary for the performance of their duties.

(e) The council may appoint, without regard to chapters 76 and 89, an executive director who shall serve at the pleasure of the council and whose duties shall be set by the council. The salary of the executive director shall be set by the council; provided that the salary shall not exceed the salary of the deputy director of the department of human services. The executive director may also appoint other personnel, without regard to chapters 76 and 89, to work directly for the executive director.

(f) The council may require reports as necessary in the form specified by the council from state agencies and program and service providers of any state health care program.

(g) No later than twenty days prior to the convening of the regular session of 2012, the council shall submit to the legislature, the governor, the director of health, and the director of human services a report relating to the development of the program containing:

(1) The progress of the council; and

(2) Any and all criteria, standards, measurements, payment methodology, and other requirements of the Hawaii patient centered health home pilot program adopted by the council pursuant to this section.

(h) No later than twenty days prior to the convening of the regular session of 2013 the council shall submit to the legislature, the governor, the director of health, and the director of human services a report relating to the implementation of the program containing information and data regarding the problems experienced with the program, benefits of the program, and the practical application of the program. The report shall also contain an opinion as to whether the program is a practical approach to modernizing medicaid-centered health care and recommendations as to whether the program should be continued.

Based on the council's recommendation, the legislature and the governor may determine whether to continue the Hawaii patient centered health home pilot program.

(i) The council shall cease to exist on June 30, 2013.

PART III

SECTION 6. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 7. New statutory material is underscored.

SECTION 8. This Act shall take effect upon its approval; provided that part I of this Act shall take effect on July 1, 2117, and shall be repealed on June 30, 2013.

Report Title:
QUEST Telehealth Services; Hawaii Patient Centered Health Home Pilot Program; Hawaii Medicaid Modernization and Innovation Council

Description:
Provides for telehealth services coverage for medicaid and QUEST patients using Kona hospital's medical van program. Establishes the Hawaii patient centered health home pilot program. Establishes the Hawaii medicaid modernization and innovation council to design and implement the program. Council ceases to exist on 6/30/13. Effective 07/01/2117 and repeals 06/30/2013. (SD2)

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