NEIL ABERCROMBIE
GOVERNOR

PATRICIA McMANAMAN
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

April 6, 2011

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 1468, S.D. 2, H.D. 1 - RELATING TO HEALTH**

Hearing: Wednesday, April 6, 2011; 5:00 p.m.
Conference Room 308, State Capitol

PURPOSE: The purpose of the bill is to: 1) establish a Hawaii Medicaid modernization and innovation task force authorize the design and implement a patient centered health home pilot program within the Medicaid program; 2) establish an advanced health care directive program; and 3) prescribe how QUEST managed care plan providers may effect changes in reimbursement policies.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) opposes Part 1 of this bill because it gives an external entity, the Hawaii Medicaid Modernization and Innovation Task Force, the authority for Medicaid programs. DHS is recognized by the federal Centers for Medicare and Medicaid Services as the single state agency for Medicaid that is responsible for administering the State's Medicaid programs.

The council should have no authority to set criteria and have the power to certify and therefore supersede federal regulations on the definition, composition, and certification of a medical/health home. An independent council with the authority to

dictate direction to DHS as proposed by the bill is likely to conflict with guidance from the Centers for Medicare and Medicaid Services (CMS). Additionally, the bill does not acknowledge that implementation of council recommendations are subject to CMS approval or would be state-only funded.

Additionally, this bill would establish the 35 member task force in DHS with no identified funding. DHS does not have any funding to administer this task force and is looking at reduced funding for its Medicaid programs in the coming biennium.

This bill would allow the task force, the members who will be appointed by the Governor, to solicit monetary gifts and donations to offset the costs and expenses of the task force, Part I, Section 2(e). This would seem to contravene Section 84-11, HRS which prohibits solicitation of gifts including monetary.

DHS is already pursuing health home pilot programs. Although the notion of the medical/health home has existed for a long period of time and proudly begins in Hawaii, the original model was for children with special health care needs. The medical/health home concept has reached a tipping point, but its understanding continues to evolve as applied to different populations. While similar concepts exist in the numerous medical/health home definitions, much remains to be learned.

The real potential of the health/medical home is shifting from a reactive individual-based model to a proactive population-based one. Currently providers do not get reimbursed to provide routine preventive care and disease management outside of the examination room. The financial incentive is based on quantity of care. Changing reimbursement methodology to instead incentivize quality of care is already being pursued.

Our Medicaid program is diverse with different health plans relying on somewhat differing provider networks. For example, the majority of AlohaCare members receive

their care through FQHCs, but the majority of HMSA members receive their care from other providers, many of whom are solo practitioners. DHS strongly opposes a one-size fits all approach and instead recognizes the need to be sensitive to the differences of all the providers who serve our Medicaid recipients.

DHS welcomes stakeholder input as we pursue the medical/health home. DHS has not in any way prohibited its health plans from pursuing the medical/health home, and some plans have chosen to do so. DHS intends to take a more proactive approach by requiring health plans to have medical/health home pilots. This will allow us to better understand what works in Hawaii and with different providers.

DHS also opposes Part III of this bill because it infringes on the contracting between two private parties, namely the health plan and contracted providers. These contracts contain terms regarding modifications to the contracts, including reimbursement changes. Reimbursement reductions do not occur retroactively; however, the state has a responsibility to provide program oversight and identify fraud, waste, and abuse. Making adjustments in response to such identified practices is a federal requirement of the Medicaid program.

Thank you for the opportunity to provide testimony on this bill.

TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-SIXTH LEGISLATURE, 2011

ON THE FOLLOWING MEASURE:
S.B. NO. 1468, S.D. 2, H.D. 1, RELATING TO HEALTH.

BEFORE THE:
HOUSE COMMITTEE ON FINANCE

DATE: Wednesday, April 6, 2011 **TIME:** 5:00 p.m.

LOCATION: State Capitol, Room 308

TESTIFIER(S): David M. Louie, Attorney General, or
Lili A. Funakoshi, Deputy Attorney General

Chair Oshiro and Members of the Committee:

The Department of the Attorney General provides the following comments on this measure.

First, section 2 of this bill, beginning on page 5, authorizes establishment of a thirty-five member Hawaii Medicaid modernization and innovation task force with geographic representation from across the State. On page 8, the bill provides that the task force may develop and implement a patient-centered health home pilot program within the Medicaid program of the Department of Human Services (DHS). Section 2(d) on page 12 of the bill provides that members of the task force are to serve without compensation and are not to be reimbursed for expenses. Section 2(e) of the bill, on page 12, provides that: "The task force may solicit monetary gifts and donations to offset the costs and expenses of the task force."

This section as worded may conflict with section 84-11, Hawaii Revised Statutes (HRS), which prohibits any legislator or employee from soliciting or accepting gifts which include, but are not limited to, money, and which can reasonably be inferred to have been given to influence the legislator's or employee's performance of official duties. Section 84-3, HRS, defines

"employee" as any "nominated, appointed, or elected officer or employee of the State," including members of boards, commissions, and committees, and employees under contract to the State. With no funding for the task force or for reimbursement of members' expenses, allowing members to solicit funds could be seen as opening the door to influencing the performance of their official duties, in conflict with section 84-11. The bill also does not establish a fund into which any monetary donations would be deposited.

Second, section 2(b) of the bill charges the task force with a number of responsibilities, which include: (1) adopting definitions, criteria and standards for health homes; (2) certifying health homes that meet the standards established by the task force; (3) developing quality and performance measures for a certified health home in the pilot program to report on; (4) developing a payment methodology; and (5) annual reporting requirements for the certified health homes. The specifics of these responsibilities may require adoption of rules to set forth the rights and responsibilities of the certified health homes participating in this program.

Third, section 3 of this measure, on pages 13-14, amends chapter 327E, HRS, by authorizing the establishment of an advanced health-care directive program to "encourage Hawaii residents with advance health-care directives to maintain a copy of that advance health-care directive on their person." The measure does not specify the responsible department nor does it provide any appropriation to fund the program.

Finally, section 4 of this measure, on page 14, amends chapter 346, HRS, by adding a section to address QUEST reimbursement modifications. The amendment prohibits any managed care plan or provider, who has contracted services under

a QUEST program, from modifying reimbursement policies, guidelines, interpretation, or positions adopted by Medicaid or any agent, unless the plan or provider has provided a ninety-day prior written notice of such a change to any affected health-care provider. This measure may violate the constitutional proscription against impairment of contracts. U.S. Const., art. I, sec. 10. It is a fundamental principle that obligations of a contract cannot be impaired by subsequent passage of any law. Taylor v. Taylor, 537 P.2d 483, 486 (Mont. 1975); Pulos v. James, 302 N.E.2d 768, 775 (Ind. 1973). The obligation of a contract is impaired by a law that alters the contract's terms by creating new rights or imposing new conditions or different liabilities. Northern Pacific Railway v. Duluth, 208 U.S. 583, 590 (1908). "Any law which changes the . . . legal effect of the original parties, giving to one greater or the other a less interest or benefit in the contract, impairs its obligation." Kentucky Utilities Co. v. Carlisle Ice Co., 131 S.W.2d 499, 504 (1939). See also Anthony v. Kualoa Ranch, Inc., 69 Haw. 112 (1987).

If this measure passes, it may effectively amend the terms of the QUEST contracts between DHS and the Hawaii Medical Service Association, AlohaCare, and Kaiser ("health plans"). This is because it imposes the requirement on these health plans to provide a ninety-day written notice to any affected health-care provider before the health plans can modify reimbursement policies, guidelines, interpretation, or positions adopted by Medicaid or any agent.

As such, this measure may impermissibly alter the QUEST contracts by creating new rights or imposing new conditions or different liabilities on the health plans.

If the Committee approves this measure, we recommend deletion of section 2(e) and section 4. The potential need for rulemaking in section 2(b) of the bill may be addressed by authorizing the task force to recommend definitions, criteria, and standards, rather than adopting them. We also suggest that section 3 specify the responsible department and address the need for an appropriation.

HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
April 6, 2011 at 5:00 p.m. (Agenda #4)

Supporting Parts I and III of SB 1468 SD 2 HD 1, and proposing an amendment to Part II.

The Healthcare Association of Hawaii advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. Our members employ more than 40,000 people statewide, delivering quality care to the people of Hawaii. Thank you for this opportunity to testify in support of Parts I and III of SB 1468 SD 2 HD 1 and to propose an amendment to Part II of the bill.

Part I of the bill creates the Hawaii Medicaid Modernization and Innovation Task Force to develop and implement the Hawaii patient-centered health home pilot program. This consumer-driven, culturally appropriate, family-centered program is intended to optimize access to care by providing team-based, integrated, and holistic care delivery.

Nearly 40 states have implemented a form of the patient-centered health home, and all of them have shown improvement in care, cost, or both. In Hawaii, a numer of organizations are involved in some form of patient-centered health home, such as Kaiser Permanente, HMSA, Aloha Care, Hawaii Pacific Health, the Hawaii Independent Physicians Association, and several community health centers.

The federal Affordable Care Act (ACA) provides financial resources for programs and states to implement patient-centered models of care that Hawaii can take advantage of. The ACA will also create a center to facilitate innovations in Medicare and Medicaid. This innovation center would be able to assist the Council created by the bill to guide the creation of the patient-centered health home.

Part III of the bill requires managed care plans and the providers in their networks to be informed 90 days in advance of any changes to Medicaid reimbursements. In many cases, plans and providers have not been notified in advance, resulting in disruptions in their operations in order to accommodate the reimburesement changes. Part II of the bill would ensure plans and providers that they would have enough time to anticipate the changes, plan for them, and implement the necessary operational changes.

Part II of the bill establishes a program to encourage residents with advance health care directives to keep a copy of it on their person. This is a well- intentioned proposal to enable individuals to direct the kind of care they want to receive at the end of life. However, advance health care directives may not direct the efforts of EMS personnel. Instead, physicians orders for life-sustaining treatment (POLST) is the appropriate document. We propose that Part III of the bill be amended to encourage the development of an electronic POLST registry that can be easily accessed by EMS personnel.

For the foregoing reasons, the Healthcare Association supports Part I and III of SB 1468 SD 2 HD 1 and proposes an amendment to Part II.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

Wednesday, April 6, 2011, 5:00 pm, Conference Room 308

To: COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair
Rep. Marilyn B. Lee, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 1468, SD 2, HD 1 Relating to Health

In Support

Chairs & Committee Members:

Hawaii Medical Association supports SB 1468, SD2, HD1.

While we realize that this bill has been watered down substantially we still support its function.

Health Care Providers should be given the opportunity to create a well functioning medical home model and then the ability to move beyond that. This bill allows for greater provider input than would likely be allowed by the individual and separate endeavors at patient centered health homes attempted by insurance companies.

When North Carolina produced a patient centered medical home – their savings were minimal until physicians, nurses and hospitals got together and took the medical home model to the next level of collaboration and integration. The results of North Carolina's experiment were large savings and increased provider willingness to take Medicaid patients.

Background:

* In 1991, NC started Carolina Access, a program that established the groundwork for Community Care by requiring Medicaid recipients to choose a primary care provider (PCP) in order to avoid unnecessary care.

* Carolina Access was only **moderately effective in reducing inappropriate emergency department use; this program could not achieve significant improvements in the quality and cost-effectiveness** of care without creating a community-based infrastructure that could support the physicians and the Medicaid patients they served.
* NC's Medicaid agency partnered with providers in the creation of North Carolina Physician Advisory Group.
* **During severe budget pressures in the mid-1990s NC's administration chose to transform the plan by retaining Carolina Access' "medical home" as the foundation and including enhancement that could further address quality and cost.**

Overview:

* Based in part on the idea that each patient should have a "medical home," the Community Care program assigns each Medicaid patient to one of **14 community health networks.**
* **Each network in turn is organized and operated by physicians, nurses, hospitals, health departments and departments of social services.**
* State Medicaid administrators and health care providers manage the program exclusively and **then funnel profits directly back into patient care.**
* Under federal Medicaid regulations, CCNC is structured as an enhanced primary care case management model, with designated medical homes receiving a fee-for-service payment and a set amount per member/ per month (pmpm) to compensate for key access and population management (including acute and preventative care and disease and care management) activities. The Community Care networks also receive a set amount pmpm.

Development:

* Four main components were designed to **strengthen the ability of the PCP to manage patient care and improve patient outcomes:**

  1. Formation of community networks: **To strengthen the ability of physicians to manage care, PCPs are encouraged to work together and with other community health providers in community networks to cooperatively plan for meeting the care needs of recipients, particularly those with chronic conditions.**

2. Population management tools: To provide physicians and other network partners with the tools needed to improve care, the program includes such population management approaches as evidence-based programs and protocols, disease management, pharmacy management, care management, and practice-based improvements.

3. Case management and clinical support: To provide the support and coordination needed by physicians to care for complex chronic care patients who see many providers.

4. Data and feedback: To provide physicians and network partners with relevant information on how their patients are faring and to illustrate opportunities for improvement in quality, utilization, cost, and core processes by collecting, analyzing and regularly reporting performance metrics back to physicians and networks.

Results:

* Through private, not-for-profit provider networks, NC is putting in place the local systems that are needed to achieve long-term quality, cost, access, and utilization objectives in the management of care for the entire Medicaid population.
* This public-private partnership has changed the relationship of the state payer from a regulatory model to that of an active manager of a health program utilizing a shared accountability model with local Community Care networks for the cost and quality of services provided.

The program has not only offered high-quality, patient-centered care for the state's neediest children and adults, but has also saved millions of dollars in health care costs

The important of provider-centric organization cannot be stressed enough. Insurer-driven initiatives will have other ancillary goals specific to their own interests. For instance, when an insurer's patient centered medical home project proposes to pay PCPs $3 per member per month to cover the costs of care coordination, when case management companies receive $200-300 per involved patient per month for their services. We don't want to allow systems that are aimed at offering incentives for providers to cheery pick healthy patients and deny care.

Hawai'i Primary Care Association

345 Queen Street | Suite 601 | Honolulu, HI 96813-4718 | Tel: 808.536.8442 | Fax: 808.524.0347
www.hawaiipca.net

House Committee on Finance
The Hon. Marcus Oshiro, Chair
The Hon. Marilyn Lee, Vice Chair

Testimony in Support of Senate Bill 1468, SD2 HD1

Relating to Health

Submitted by Nani Medeiros, Policy and Public Affairs Director
April 6, 2011, 5:00 p.m., Room 308

The Hawai'i Primary Care Association represents all community health centers of Hawai'i. We strongly support Part 1 of Senate Bill 1468, SD2 HD1 with amendments. This **establishes a Medicaid Modernization and Innovation Council to create a health care home pilot program *within existing state Medicaid programs* and perform other duties as directed by the Legislature.**

The purpose of this council is to address long term systemic changes in Medicaid to ensure a sustainable health care program for Hawai'i.

With its current focus only on cutting benefits, and developing administrative strategies without expert stakeholder input, the Department of Human Services will lead Hawai'i down a road that may present an even greater budget crisis by 2014, when significant changes in Medicaid must be implemented under the Affordable Care Act.

More than two dozen organizations in Hawai'i are committed to the Medicaid Modernization and Innovation Council contained in this bill and have requested to be members. While the Department of Human Services contends that the council as proposed in this measure is unmanageable, ineffective, and usurps its authority, the number of supporters/members actually speaks to the fact that many organizations in Hawai'i dealing with Medicaid issues believe their voices are *not* heard by the Department of Human Services, and have not been for many years, thus warranting the creation of a formal council recognized by the Legislature and Executive Branch.

Further, in an economic climate where resources are vanishing and we have heard for over a year that the Medicaid division in the Department "does not have the resources" to get anything done, it is disappointing that the Department would downplay and ultimately reject a diverse group of healthcare experts willing to volunteer their time and resources to modernize Medicaid. Given that this comprehensive effort would transform Medicaid into a program that would save hundreds of millions of dollars, improve the patient experience, and improve the health of Hawai'i's people, the Department's conflicting and inadequate response to this effort is extremely troubling and raises serious questions.

A patient-centered health care home is not an actual structure, but a linked approach to providing health care that **improves the patient experience, improves health outcomes**, and **reduces per capita costs.** This model will transform the health care system from one that is reactive and costly to one that is proactive and efficient.

According to the Patient Centered Primary Care Collaborative, "Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization."

Nearly 40 states have implemented some form of patient-centered health care home model (also known as medical home). All of these showed a level of improvement in care, cost, or both. Some of the notable examples include:

- Group Health Cooperative of Puget Sound reduced costs by $10 per person per month. **Potential Hawai'i savings for Medicaid: $32 million per year.**
- Intermountain Healthcare Medical Group Care Management reduced costs by $640 per patient per year. **Potential Hawai'i savings for Medicaid: $169 million per year.**
- Colorado Medicaid and SCHIP reduced costs by $215 per child per year. **Potential savings in Hawai'i Medicaid/SCHIP: $28 million per year.**

In Hawai'i, the following organizations are involved in some form of patient-centered health care/medical home program:

- Kaiser Permanente
- HMSA
- Hawai'i Pacific Health
- Hawai'i Independent Physicians Association
- Bay Clinic
- Hāmākua Health Center
- Wai'anae Coast Comprehensive Community Health Center
- Kalihi-Pālama Health Center
- Waimānalo Community Health Center
- West Hawai'i Community Health Center
- AlohaCare

As private physicians and health plans transform their health care delivery systems into health/medical homes, it makes sense for the State to work with consumers, providers, and plans to explore the same path for Medicaid. **Physicians and health care professionals will not want to implement multiple versions of health/medical homes for their patients**: one model for privately insured patients, another for Medicaid enrollees. In addition to the significant cost savings in Medicaid that could be achieved with the implementation of a health home model, the timing to look at the model now is sensible.

The Affordable Care Act of 2010 provides financial resources for programs and states to implement patient-centered models of care:

- Eight state demonstration projects coordinating care and payment from Medicare, Medicaid, and private health plans;
- The Advanced Primary Care Practice Demonstration for Medicare patients at community health centers;
- State demonstrations to integrate care for dual eligible (Medicare and Medicaid) individuals;
- A health home option for Medicaid enrollees that provides a 90% FMAP (federal match) for covered services during the first 8 fiscal quarters of the program.

Under the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) were directed to formally establish a new Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation

Center will explore innovations in health care delivery and payment that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through quality improvement.

Creating a Hawai'i council to focus on innovation in our local Medicaid issues is a natural complement to the national efforts of the Innovation Center, and key to transformation of the Medicaid system. Modernization of our Medicaid program cannot be done in a vacuum by government: **consumer, insurer, community and provider input must be incorporated**, and the Council provides a comprehensive, fact-based forum for that input.

The Council could also function as a multipurpose entity, addressing numerous Medicaid modernization issues and innovation concepts including: patient centered health home, information technology, eligibility systems, the Hawai'i health insurance exchange role in Medicaid eligibility and enrollment, and health care for COFA migrants.

In closing, we stress the need for a comprehensive transformation of Hawai'i's Medicaid system that improves quality health care, supports living well, and is cost effective. This kind of innovation does not come easy. In many respects, it is easier to cut benefits, reduce eligibility, and require the use of generic drugs for Medicaid enrollees. However, unless we fundamentally reform the direction of Medicaid, program costs will still rage out of control and, more importantly, the health of people could be negatively affected, driving costs higher still.

We ask you to pass Senate Bill 1468 SD2 HD1 with our proposed amendments. Thank you for the opportunity to testify.

94-450 Mokuola Street, Suite 106, Waipahu, HI 96767
808.675.7300 | www.ohanahealthplan.com

Wednesday, April 6, 2011

To: The Honorable Marcus R. Oshiro
Chair, House Committee on Finance

From: 'Ohana Health Plan

Re: Senate Bill 1468, Senate Draft 2, House Draft 1 - Relating to Health

Hearing: Wednesday, April 6, 2011, 5:00 p.m.
Hawai'i State Capitol, Room 308

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to submit these comments on Senate Bill 1468, Senate Draft 2, House Draft 1 – Relating to Health.

We appreciate the intent of this measure to start a process that will develop a system of delivering comprehensive, integrated, and holistic health care services to patients, including preventative and lifestyle health services, and look forward to the opportunity to participate on this council so that we may contribute to the meaningful dialogue on how we can make this concept a meaningful reality.

The establishment of a Hawai'i Medicaid Modernization and Innovational Council to further discuss how to best develop and implement a quality-driven health care delivery system using cost-effective mechanisms is certainly the first and perhaps most important step we can take at this time to move heath care in Hawai'i in the right direction.

Thank you for the opportunity to provide these comments on this measure.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

April 6, 2011

The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair
House Committee on Finance

Re: SB 1468 SD2, HD1 – Relating to Health

Dear Chair Oshiro, Vice Chair Lee, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1468 SD2, HD1. HMSA has no comments on Parts I and II of the Bill, but we oppose Part III of the Bill.

As currently drafted, Part I of the Bill would create a Medicaid Modernization and Innovation Task Force that would consider establishing a patient centered medical home (PCMH) pilot program. Part II authorizes the establishment of a program to encourage Hawaii residents with advance health care directives to maintain a copy on their person. And, Part III of the Bill (1) requires a managed care plan or provider that offers services under QUEST to provide 90-day written notification to any affected provider of any change to Medicaid reimbursement policies, guidelines, interpretation, or positions; and (2) prohibits the retroactive application of such a modification if it reduces reimbursements previously made to affected providers if prior approval for the reimbursement was obtained through Medicaid.

With respect to Part III of this Bill, HMSA concurs that advance notice of changes regarding Medicaid reimbursements is appropriate and desirable. Consequently, our contracts with providers generally specify that we provide 60-day notice of such changes. However, we are bound by Med-QUEST rules, even if they are changed retroactively. The provisions of Part III of this Bill prevent us from adjusting previously paid reimbursements because of retroactive rules changes, and this unfairly penalizes our QUEST program and our QUEST members. Funding for QUEST is limited, and this provision would require us to unfairly pay more than is allowed or covered.

We respectfully request that Part III of SB 1468, SD2, HD1, be deleted from the Bill. Thank you for the opportunity to testify on this measure.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

AlohaCare
For a healthy Hawaii.

April 6, 2011
5:00pm
Conference Room 308

To: The Honorable Rep. Marcus R. Oshiro, Chair
The Honorable Rep. Marilyn B. Lee, Vice Chair
House Committee on Finance

From: Paula Arcena, Director of Public Policy
Robert Toyofuku, Government Affairs

Re: SB1468, SD2, HD1 Relating to Health

Thank you for the opportunity to testify on SB1468, SD2, HD1 which establishes the Hawaii patient centered health home pilot program and the Hawaii Medicaid modernization and innovation task force to design and implement the program.

AlohaCare **supports** SB1468.

The establishment of a task force is a step toward a more collaborative effort toward reforming Hawaii's Medicaid program in light of opportunities offered by the U.S. Patient Protection and Affordable Care Act (ACA) and constraints imposed by the State of Hawaii's budget crisis. To date, Medicaid stakeholders have no formal forum for discussions with the Hawaii MedQUEST Division of the Department of Human Services (DHS). The establishment of a task force will provide a means for dialogue for all stakeholders, including DHS.

The patient centered medical home (PCMH) is a concept that maximizes the benefits of coordinated primary and preventive care to meet patient needs. Like other Hawaii health care organizations, AlohaCare has initiated a PCMH pilot project. AlohaCare's pilot project involves four community health centers, three on Oahu and one in West Hawaii. The PCMH concept is flexible and adaptable to different patient populations and regions, therefore we believe multiple efforts are necessary. Thus, we support the creation of a task force specifically to address the future needs of Hawaii's Medicaid population, including but not limited to the PCMH concept.

AlohaCare is a non-profit, Hawaii based health plan founded in 1994 by Hawaii's community health centers to serve low-income families and medically vulnerable members of our community through government sponsored health insurance programs. We serve beneficiaries of Medicaid and Medicare on all islands.

AlohaCare has been contracted by the Hawaii Department of Human Services since the QUEST program started in 1994 to provide insurance coverage for Medicaid eligible beneficiaries through the QUEST program. We serve approximately 75,000 QUEST enrollees statewide.

Thank you for this opportunity to testify.

1357 Kapiolani Blvd, Suite 1250, Honolulu, Hawaii 96814
www.AlohaCare.org

FINTestimony

From: Marc Gannon [MGannon@waikikihc.org]
Sent: Tuesday, April 05, 2011 8:54 AM
To: FINTestimony
Subject: SB 1468 S.D. 2 H.D. 1 (related to health), hearing April 6, 5:00 PM

Members of the House Finance Committee,

I am writing to express my support of SB 1468 S.D. 2 H.D. 1 related to Health, which would establish a Patient-Centered Health Care Home Council; and I respectfully ask for your support.

Thank you for your consideration.

With aloha,
Marc

Marc Gannon, LSW
Chief Administrative Officer
Waikiki Health Center
277 Ohua Avenue
Honolulu, HI 96815
(808) 791-9351
(808) 697-6848 fax
mgannon@waikikihc.org

FINTestimony

From: Deborah Smith [fotsismith@gmail.com]
Sent: Tuesday, April 05, 2011 1:43 PM
To: FINTestimony
Subject: SB 1468 SD 2 HD 1

I wish to submit this testimony strongly SUPPORTING SB 1468 S.D.2 H.D. 1

The proposed bill would create a Medicaid Modernization and Innovation Council that would be empowered to develop a patient-centered health care home pilot project for Medicaid enrollees. This comes at a time when our state DHS intends to slash assistance to Medicaid enrollees; a group that represents a vulnerable portion of our population.

The proposed bill is collaborative; it brings together insurance plans, health care providers, consumers and community groups. This helps ensure that all players have access to the process and input into the design and implementation.

As has been proven elsewhere, the patient-centered health care home is a linked approach that provides health care that **improves patient experience, improves health outcomes and reduces per capita costs.** This is the direction that our state needs to take to ensure that we continue to provide health care to those most in need and in a manner that results in more positive health outcomes.

Please support SB 1468 S.D.2 H.D.1 Mahalo, Deborah Smith

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, April 05, 2011 4:00 PM
To: FINTestimony
Cc: syamamoto2@dhs.hawaii.gov
Subject: Testimony for SB1468 on 4/6/2011 5:00:00 PM
Attachments: SB1468SD2HD1_HMS_04-06-11_FIN.pdf

Testimony for FIN 4/6/2011 5:00:00 PM SB1468

Conference room: 308
Testifier position: oppose
Testifier will be present: Yes
Submitted by: Patricia McManaman
Organization: Department of Human Services
Address:
Phone:
E-mail: syamamoto2@dhs.hawaii.gov
Submitted on: 4/5/2011

Comments: