Model Design Project Narrative

The State of Hawai‘i seeks a Model Design cooperative agreement to build upon the momentum created from its $937,000 Round One Model Design award in 2012, which resulted in a comprehensive State Healthcare Innovation Plan (SHIP). The plan described **six catalysts** for system change to support population health, including: 1) primary care practice support; 2) enhanced care coordination; 3) value-based payment reform; 4) workforce enhancements; 5) health IT connectivity and data; and 6) strategic use of policy levers.

The first Model Design and SHIP planning process revealed two troubling gaps in Hawai‘i’s healthcare system: effective awareness, diagnosis, and treatment of **behavioral health** conditions at all levels, and poor **oral health.** While transformation of Hawai‘i‘s healthcare system is progressing well according to the SHIP in many respects, behavioral and oral health have largely been left out of these innovations.

Addressing behavioral and oral health care at the same level as primary and specialty care is a significant need in Hawai‘i for a variety of reasons. First, behavioral and oral health conditions disproportionately affect the most vulnerable populations. Second, behavioral health was identified as the number one preventable cause of hospitalization in the statewide 2012 Community Health Needs Assessment. Further, a recent actuarial analysis found that the average total healthcare cost for individuals with a behavioral health diagnosis was three times the average total healthcare cost for those without a BH diagnosis (see *Financial Analysis*).

Oral health care is another important problem in Hawai‘i, and has also fallen outside of innovation initiatives. Hawai‘i has no public water fluoridation and lags in preventive care. With inadequate surveillance, reliable current data on Hawai‘i’s oral health status is lacking; however, nothing has been done since the last time data was collected in 1999 that would lift Hawai‘i from

among the states with the worst rates of decay[1] and unaddressed dental needs, particularly for children. Access to care is limited and, in addition to clinical costs, Hawai'i continues to spend $1 million per year flying Medicaid children from neighbor islands to Honolulu to get otherwise unobtainable dental care. Oral healthcare for adults is also considerably lacking as dental benefits are not included in the State's adult Medicaid coverage (other than emergency care) or in Medicare or Affordable Care Act Essential Health Benefits.

1. Plan for Improving Population Health

Hawai'i's healthcare system is in transition between "Acute Care System 1.0" and "Coordinated Seamless Healthcare System 2.0." Its intent is to move significantly toward "Community Integrated Healthcare System 3.0"[2] where the system takes responsibility for population health and includes integration of community resources to address non-clinical supports for health and well-being, stratifies payment to encourage attention to disparities, supports a "learning health system," and fully embraces new opportunities to improve health, access, and care with HIT. Significant progress has been made over the past two years. Accountable care systems are being built by major nonprofit hospitals, which are also leaders in health information technology (HIT) integration. The statewide health information exchange network is expanding services to enable providers to share information. The patient-centered medical home (PCMH) model, which provides the necessary platform for developing behavioral care enhancements, has become Hawai'i's dominant model for primary care practices. Another key element – availability and transparency of health performance outcomes data – is

[1] Hawai'i State Dept. of Health, *2004 Hawai'i Oral Health Profile*, 1989 vs 1999 prevalence.

[2] Neal Halfon, UCLA Center for Healthier Children, Families & Communities.

progressing in the Governor's office, which is implementing a CCIIO-funded grant to develop an all-payer claims database (APCD). This database is intended to collect claims information and link it to public health, quality, and outcomes data to produce meaningful information for rate review, policy making, and consumers and healthcare system use. With the exception of the first accountable care organization in Hawai'i that started in 2014 and Kaiser-Permanente's integrated model, which account for 20% of Hawai'i's market, payment strategies that involve integrated systems and financial risk-sharing are not yet widespread, nor is benefit design being employed to improve compliance or health status.

To address the remaining system gaps, Hawai'i's Health Care Transformation Office (HCTO) will lead the effort to develop and implement a Population Health Plan (PHP). The process to complete the PHP will be similar to the successful process Hawai'i used to complete the SHIP in Round One; HCTO will work with the all SIM committees to develop the content, and the Steering Committee will be responsible for the oversight of the plan (*see Section 6*). The data will come from the APCD, the State Department of Health (DOH), Medicaid, and other resources. Hawai'i will work closely with the DOH to ensure the plan assesses the overall health burden at the population level including CMMI/CDC measures related to tobacco, obesity, and diabetes. The PHP will also include the payment and delivery model interventions and goals identified during the second Model Design process related to behavioral health and begin to address health disparities and the underlying social determinants of health, and the Triple Aim.

Strategies to address oral health needs will also be included in the PHP. To address this challenge, the HCTO will collaborate with the DOH to conduct a statewide oral health survey of public school children, and identify and collect other sources of oral health data (e.g., emergency dental visits for Medicaid adults and commercial dental insurer data). The information will be

included in the population health dashboard and used for policy and program development. In addition, HCTO will describe efforts to collaborate with the DOH and the Department of Education to pilot a tele-dentistry project in which dentists complete examinations via tele-dentistry and approve plans for execution by dental hygienists. For adults, HCTO will work with DOH and Medicaid to propose an array of adult dental benefits that provides the greatest health benefits with limited resources. The HCTO will also convene an ad hoc OH committee to advise the team on oral health plans and priorities.

2. Health Care Delivery System Transformation Plan

The elements included in the initial SHIP are guiding system transformation in Hawai`i. The process that produced the SHIP also identified glaring holes in the system's ability to deliver timely, effective behavioral health (BH) care and pointed out the neglect of oral health in overall health status. This proposal, therefore, will apply the same six catalysts as in the SHIP to improve those services to ensure a complete system of care for population health.

The target populations for BH service integration and improvement are: (1) Patients in primary care settings with mild to moderate BH conditions; (2) Patients with chronic conditions in combination with BH conditions, which provide the most considerable potential for cost savings; and (3) Patients with Severe and Persistent Mental Illness (SPMI). Plans for addressing each of these populations are described within the six catalysts below.

A. Primary Care Practice Support: Stakeholders from the previous planning round codified their consensus around two main points for primary care practice support. First, as expressed in every committee, the state's move towards supporting practices achieving PCMH criteria was appropriate, and, to this end, insurance company data shows considerable progress: As of June 2014, Hawai'i Medical Service Association (HMSA), the largest health insurer in the

state, has 73% of 736,807 members in a PCMH; Kaiser, the second largest health insurer in the state, has 100% of their 230,000 members in a PCMH. Additionally, all Medicaid health plans are contractually required to have 80% of their members in a PCMH by 2017. Taken together, this means that more than 80% of the state's total residents will be in a PCMH by 2017. Second, even among practices that achieved PCMH, primary care providers (PCPs) felt that BH services needed to be strengthened. Indeed, PCPs interviewed in focus groups during the planning process identified the lack of BH training and resources as an obstacle to offering those services at the primary care level.

In response, a second Model Design cooperative agreement will build on the widespread uptake of the PCMH model to integrate screening and treatment of BH with primary care and improve care coordination for physical and behavioral health. This round of planning will develop strategies that support PCPs to screen, diagnose, and treat patients with BH conditions in the primary care setting. Specific objectives are to: (1) Create a permanent technical assistance/education resource center for PCPs in the state that disseminates evidence-based best practices; (2) Improve access to BH specialty care and support for PCPs through provider-to-provider telehealth consults; (3) Develop a plan for BH staff resources to support PCPs with BH integration via group practices and independent practice associations; and (4) Agree on pilots and payment innovations for PCPs for screening, diagnosis, treatment, and referrals.

B. Enhanced Care Coordination: The care coordination catalyst will focus on the strategies outlined in the 2013 SHIP in order to improve BH services. The HCTO's ultimate goal is to build robust community care networks (CCNs) that include new healthcare team members (e.g., community health workers (CHWs) and clinical pharmacists) and foster integration of community resources to address patients' psychosocial and economic needs.

Two pilots will provide insight to develop larger-scale CCNs and targeted, intensive interventions, and provide a platform of discussion regarding selection of a unified care coordination tool *(see HIT Section)*: (1) Medicaid Health Home pilot: Hawai‘i’s Medicaid Health Home will be a two-year pilot that will include a robust evaluation to determine if it will be continued beyond the demonstration period. The Health Home team will include a PCP, a Health Home coordinator, a nurse care manager, a BH consultant, and other ancillary supports (e.g., CHW, peer specialist). This model will not only address chronic care medical and BH needs but will also provide assistance with housing, food, child care, employment, and other social service supports that address the social determinants of health. The legislature approved a funding mechanism for the first Health Home to be facilitated by Federally Qualified Health Centers. The first Health Home project will be implemented in early 2015. In the upcoming model design phase, a second Medicaid Health Home will be developed to support a broader array of primary care providers who care for patients with SPMI and other chronic conditions. (2) Department of Public Safety “Transition Clinics” Initiative: Compared to the general population, individuals in jails and prisons across the country suffer significantly higher rates of serious mental illness, substance abuse disorders, and other health conditions. To address these statistics and improve the rate of successful re-entry, Hawai‘i plans to pilot a “Transition Clinics” initiative to assist justice-involved misdemeanants with SPMI and other BH conditions.

C. Payment Reform: *See Section 3.*

D. Health Information Technology (HIT): *See Section 5.*

E. Workforce Enhancements: Hawai‘i suffers from both shortages and maldistribution of healthcare providers in many key professions, including BH providers. Psychiatrists,

particularly, are in short supply in rural areas and for Medicaid patients. These shortages add impetus to a team-based healthcare workforce model. Model Design Round 2 strategies include:

- Developing “emerging roles” that support the delivery of patient-centered and coordinated care for individuals with BH conditions, in particular by: (1) Developing CHW capacity, including adopting best practices from more experienced states; (2) Pursuing strategies to include and sustain CHWs and clinical pharmacists in BH teams; and, (3) Identifying scope of practice barriers for both BH and OH providers and developing a plan to address them.
- Developing an interprofessional workforce center to serve as a data repository and neutral authority on workforce data with BH provider data as its first priority.
- Supporting state-owned academic institutions and rural hospitals to expand interprofessional medical education residency programs that integrate BH with primary care practice.

F. Policy Levers: Hawai‘i’s current siloed agency model fails to support public-private partnership necessary to impel innovation across the system and achieve population health. The state plans to strategically leverage policy and public investments to help achieve the goals of greater BH integration including: 1) payment levers such as the state’s Medicaid program and Employer Union Trust Fund (EUTF); 2) HIT levers such as the Hawai‘i Health Information Exchange (HHIE), CMS’ Implementation Advanced Planning Document (IAPD) requirements, and Office of National Coordinator (ONC) directives (*see HIT Section*); and 3) state policy levers such as the state legislature.

Additionally, there is no permanent agency responsible for the priorities and catalysts identified by the SHIP. (The HCTO in the Governor’s Office may only be temporary according to the state constitution.) During Round Two, the HCTO will work with stakeholders and the

legislature to establish a structure with legal and executive authority and resources to implement healthcare transformation initiatives on an ongoing basis. S*ee Sections 4 and 9.*

3. Payment and/or Service Delivery Model

Payers in the state have been actively working on transitioning from a fee-for-service payment system to a model based on outcomes. The Medicaid program, with an enrollment of 320,000, already includes value-based purchasing incentives in its managed care contracts. The Employer-Union Health Benefit Trust Fund (EUTF), which insures public employees and retirees, does not include such provisions in their contracts at present but the board is seeking additional information for future proposals. (The HCT Coordinator has recently been appointed to the EUTF board.) Together, Medicaid and EUTF cover nearly 40% of Hawai'i's population and have contractual leverage with five of Hawai'i's seven insurers so have tremendous potential influence on plan behavior. Much of the state's momentum for payment reform arises from the unique level of collaboration across payers and plans. For example, all payers have already agreed on a common definition of PCMH and have agreed to reimburse PCMH providers at a higher rate, which is driving rapid PCMH expansion, as noted above.

The focus of Round Two will be to explore multi-payer BH integration payment innovation for Medicaid, Medicare, EUTF and commercial insurance. These include exploring incentives to identify and treat BH conditions in the primary care setting, requiring payers to effectively manage and coordinate care, paying for services and/or providers not currently covered such as clinical pharmacists and CHWs, and exploring risk adjustment strategies for more complex patients. In addition, the HCTO plans to work with stakeholders and consultants on three key payment innovations: identify appropriate benefit design changes to incentivize patient compliance and improve health status; identify payment innovations that incentivize

behavioral and oral health care integration; and develop actionable strategies to move the market toward shared-risk contracting. *See Sections 2.A-F for strategies to address the six catalysts.*

4. Leveraging Regulatory Authority

During Round Two, the HCTO will work with stakeholders and the legislature to establish a permanent structure with legal and executive authority, and resources to implement healthcare transformation initiatives. HCTO will also work to increase alignment across state agencies to highlight and address population health priorities, especially Medicaid and EUTF, public health, professional licensing, insurance regulation, and education. The HCTO and the agency responsible for certificates of need are working together to join these functions in the HCTO. The HCTO plans to engage a consultant to help assess current structures, consider options that would better support current and future needs, and develop a phased approach to achieving changes in structures, responsibilities, and relationships. The HCTO will convene a state agency council chaired by the Governor's Chief of Staff to collectively identify healthcare policy, program, and funding priorities necessary to advance healthcare transformation plans.

A new policy lever for Round Two is Hawai'i's plan to pursue an Affordable Care Act (ACA) Waiver. The ACA, which allowed Hawai'i to expand Medicaid coverage, gives Hawai'i an opportunity to have virtually universal coverage. Act 158 was signed into law to create a taskforce to develop an ACA innovation waiver for implementation in 2017. The taskforce will explore coverage innovations that support the SHIP, such as: (1) Identification of possible gap group strategies for coverage; (2) Increased uniformity and/or alignment among health plans to better support innovations for workforce, HIT, benefit design, and risk-sharing; and (3) Increasing quality and cost transparency for consumers and purchasers. The HCTO Coordinator will chair the ACA Innovation Taskforce. *See Sections 2.F and 9 for more policy levers.*

5. Health Information Technology (HIT)

The first Model Design process produced stakeholder consensus on key issues related to HIT. All stakeholders agreed that HIT is essential to achieving the goals of health reform. In particular, the state, in concert with current efforts in the private sector, must actively utilize all policy levers available to promote the ideals of data collection, interoperability, data exchange standards, and information exchange solutions in the state's healthcare ecosystem, leveraging the Hawai'i Health Information Exchange (HHIE) and Medicaid's IAPD.

During Round One, providers reported they are required to use different population health management and care coordination tools by plans and large health systems, and expressed frustration due to limited interoperability, and an inability to manage their entire practice population in a single system. In Round Two, the state will work with providers, health plans, and large health systems to explore using common population management and care coordination tools to support the SIM initiatives discussed above. Further, the state needs to improve data collection, analysis, and targeted dissemination efforts to help policy makers and providers address population health and engage consumers at the state level and the delivery system level. The state will play a crucial role in this effort by leveraging Medicaid and EUTF to provide common population management tools at the delivery system level for primary care providers, and developing state-level dashboards containing the health status of the identified populations, cost, and population system savings.

Hawai'i seeks funding in Round Two to align HIT policies and needs with population health both generally and for behavioral and oral health care in particular. Discussions and planning will focus on how the state can leverage and possibly mandate connection to the HHIE to promote increased information exchange broadly for these functional areas, developing HIE

interfaces and delivery system tools such as ADT notifications, and developing other functionality that will help providers manage population health and coordinate care. Specific goals include developing a comprehensive HIT plan which includes a sustainability plan to finance and ensure congruence of all HIT initiatives.

The state also plans to build data planning, aggregation, and dissemination capabilities to help public and private stakeholders assess and improve population health. These critical state efforts including the development of the APCD, the state-level policy dashboard, and a reporting database, which will integrate claims, public health, clinical and quality data. A state-level reporting database is one of the major macro goals of the HIT planning process; that is, to help integrate the state's development of the APCD into the long-term health information technology goals of the state. The HCTO will convene a quarterly data committee to help public and private payers and providers identify and address trends cooperatively.

The HCTO also plans to promulgate data standards and governance to bolster the exchange of data related to behavioral health for the three identified populations in collaboration with the HHIE and its clinical and data committees. Planning will center on the creation of strategies and governance to increase standardized information exchange that will expedite electronic sharing of information.

6. Stakeholder Engagement

Hawai‘i's healthcare transformation leaders experienced unprecedented engagement in healthcare transformation planning and pilot initiatives throughout the State Innovation Model Design Round One process. More than 250 individuals from across the healthcare spectrum participated in the "Hawai‘i Healthcare Project" during Round One, including Native Hawaiian organizations, FQHCs, hospitals, academic healthcare, BH providers, and health plans. The

Round One planning process was co-chaired by Dr. Virginia Pressler, Vice President for Innovation at one of Hawai'i's largest hospital systems, who is also a population health expert and former deputy director at the state Department of Health. The stakeholder engagement process in Round One included establishing the goals, options, and agreements for a comprehensive innovation plan.

Hawai'i will continue to support a process that is transparent and inclusive in Round Two by featuring intensive stakeholder engagement through SIM committee meetings, targeted efforts to engage providers including hospitals and independent physician associations through community meetings, facilitated retreats, and access to the HCT website. The committee structure includes public and private sector participants and legislators on three standing committees: 1) The Steering Committee to oversee the SIM process and deliverables; 2) The Delivery and Payment System Reform Committee to develop an actionable plan; and 3) The Quality, Data, and Evaluation Committee to ensure measure alignment and development of the evaluation plan. Ad hoc committees will be created as needed to address specific issues.

The process will support ten provider focus groups with at least one on each island that include all provider types. In addition, the HCTO Coordinator will meet with the major independent physician associations, the hospital association, and the primary care association regularly to solicit feedback. Small and large public events will be scheduled to solicit feedback on the planning efforts. Specifically, there will be 16 "community conversations" across all islands, at least three large stakeholder "check-in" events, and a healthcare transformation summit to which more than 1,000 people will be invited. These events will be attended by a cross-section of community leaders in healthcare, education, business, government, labor, nonprofit, and faith-based organizations. Knowing the transformation process can be

challenging, Hawai‘i will contract with professional facilitators to convene at least one state-only retreat and at least one private and public stakeholder retreat to work on particularly challenging issues. All stakeholders and the public will continue to have access to the Hawai‘i Healthcare Project website which posts meeting and other information, and allows for public input. At the end of Round Two, key stakeholders—including payers, providers, and purchasers—will be asked to sign letters of commitment in support of a detailed, actionable PHP.

7. Quality Measure Alignment

The Quality, Data, and Evaluation Committee is charged with developing strategies to align quality measures across public and private payers, across federal and state programs (e.g., the state’s Healthy People 2020 plan, the National Quality Strategy and National Prevention Strategy, CMMI Core Measures, and SAMHSA initiatives), initiatives identified in the Hawai‘i SHIP, and other programs and initiatives. The Hawai‘i Association of Health Plans has already agreed to provide relevant behavioral health HEDIS measures. The committee will work with all other SIM committees, the APCD Council (chaired by the HCTO Coordinator), and the HHIE. *See Section 6 for more information.*

8. Monitoring and Evaluation Plan

The monitoring process will ensure that all milestones and requirements outlined in the cooperative agreement are met. The HCTO will develop a detailed, time-specific project plan that includes assumptions, risks, and mitigation strategies (see also the timeline, potential risks, and mitigation strategies in the Operational Plan). The Plan will be subject to approval by the Steering and the Quality, Data, and Evaluation Committees, and will be monitored (along with progress updates) on a weekly basis. The committees will also review and approve an evaluation

plan to assess whether there was adequate stakeholder representation and engagement, and if the HCTO identified the key issues and interventions that will address the established goals.

9. Alignment with State and Federal Innovation

The HCTO is pursuing a State Plan Amendment (SPA) and IAPD to submit to CMS to approve changes to the Medicaid program and/or to draw down federal dollars for HIT initiatives. The Health Home SPA is a key component of the ACA's emphasis on: a) expansion of more robust services for Medicaid; and, b) care coordination services as expounded under Section 2703 of ACA. The HIT catalysts will be aligned with the following federal initiatives: ONC: Improving adoption of existing data standards and governance and increasing interoperability; NCQA, HRSA, SAMHSA: choosing quality metrics that catalyze BH integration; and CMS: the combination of quality and claims metrics.

Further, community health workers (CHWs) are recognized in the ACA as important members of the healthcare workforce, and CHWs support the new and emerging payment and delivery models (patient-centered, team-based care) that are being adopted in Hawai'i.

The HCTO will fully leverage CCIIO-supported initiatives, both via the previously mentioned CCIIO-funded APCD and the Hawai'i Health Connector (HHC), the state's insurance marketplace. HHC is vital to promoting population health in the state, not only through ACA-compliant healthcare plans, but by working with marketplace assisters and community-based non-profit organizations who can give newly insured individuals information about population health initiatives and programs that exist in their area while advising on plan choice.

Other innovation demonstration projects with which the HCTO is aligning include the following: (1) Pharm-to-Pharm, funded by a Round One Health Care Innovation Awards agreement to the University of Hawai'i at Hilo, to leverage pharmacists to help with medication

reconciliation. The state will build upon the model created by this project as a key driver to help promote the use of clinical pharmacists, where appropriate, in primary care teams. (2) Castle Medical Center Bundled Payment Initiative**:** this Hawai‘i-based hospital system has entered the Bundled Payments for Care Improvement initiative, which aims to help medical providers develop effective bundled payments for inpatient stays in the hospital. The state will use Castle's experience to help educate the provider community on the merits of bundled payment. FQHC Primary Practice Demonstration**:** Two FQHCs, Bay Clinic and West Hawai‘i Comprehensive Center, are working towards Level 3 PCMH certification. These efforts are accretive to greater state efforts to help PCPs improve their ability to screen and treat a range of patients with complex behavioral health and medical conditions. *See Sections 2.F. and 4 for more policy levers.*

In conclusion, Hawai‘i has a unique record of good health status, cost-effective care, and high level of coverage. These achievements mask the fact that behavioral and oral health have been left out of health system excellence. With the plans described in our application the state of Hawai‘i, through its Healthcare Transformation Office (HCTO), is poised to achieve universal coverage and a high level of health, quality, and cost-effectiveness throughout its health care system. The Round One Model Design award prepared the way for Hawai‘i to effectively address behavioral and oral health care through the same six catalysts that have been driving the existing transformation efforts. As with the Round One award, the HCTO is well-positioned to begin hiring staff and planning stakeholder engagement events immediately upon notice of award.