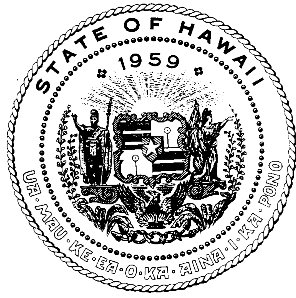

HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
1177 Alakea Street, Suite 402 • Honolulu, HI 96813 • Phone: (808) 587-0788 • www.shpda.org
Honolulu Subarea Health Planning Council

Meeting Minutes
August 8, 2024 | 12:00 Noon Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS: Katherine Finn Davis, Trisha Kajimura, Wesley Sumida, Charlene Takeno, Colette Kon

MEMBERS ABSENT: Tori Abe Carapelho

GUESTS: Tosa Lobendahn

SHPDA: John Lewin, Wendy Nihoa

ATTENDANCE RECORD OF APPOINTED MEMBERS

Date	8/10/2023	9/14/2023	10/12/2023	11/9/2023	12/14/2023	1/11/2024	2/8/2024	3/14/2024	4/11/2024	8/8/2024
Tori Abe Carapelho**	X	X	O	O	X	X	X	O	X	0
Katherine Finn Davis*	X	O	X	X	X	X	X	X	X	X
Trisha Kajimura	/	/	X	X	O	O	O	O	X	X
Colette Kon	/	X	X	X	O	X	O	O	X	X
Wesley Sumida	O	X	O	X	X	O	O	O	X	X
Charlene Takeno	O	X	O	O	X	X	X	O	X	X

Legend: X=Present; O=Absent; /=No Meeting, *-Chair, **-Vice Chair

Meeting Recording: https://www.zoomgov.com/rec/share/buGEF1Ubfsufop2EEVZ--_NNL_CJ4iJJCR6pPXyDyD8rvk3tSqKFBaccyzZZN4rn.JPOKayZeGspt9amS?startTime=1723154427000
Passcode: 0@4U!8@+

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 12:02 p.m. by K. Finn Davis, Chairperson, presiding.	
Minutes	Motion to accept the minutes from the April 11, 2024, meetings. Vote: Unanimous. Motion Carried. Public testimony – None.	
Administrator's Report	The Administrator's Report was distributed and reviewed. There were no questions.	
Honolulu Subarea Health Planning Council (HONSAC) Membership	There are currently six members on the HONSAC. Current membership terms were discussed. W. Nihoa, Comprehensive Health Planning Coordinator will work with members individually to determine next steps. A short discussion followed. Public testimony – none.	
State Health Planning and Development Agency (SHPDA) Updates	J. Lewin, SHPDA Administrator, provided the following updates: Shared SHPDA's priorities (Attachment A); Priorities include trying to calculate how many people are not insured and or underinsured, medical debt and shortage of health care workforce. Hawaii was the recipient of the All-Payer Health Equity Approaches and Development Model (AHEAD) grant. The other states are Connecticut, Maryland, and Vermont. Approximately up to 12 million Dollars to the State of Hawaii. This will become active and go live in 2025. A discussion followed. Public testimony – none.	

HONSAC Chair/Vice Chair and SHCC Liaison Position	K. Finn-Davis presented the vacancies and elected to defer nomination and selection to our next meeting. A discussion followed. Public testimony – none.	W. Sumida/W. Nihoa-meeting.
HONSAC Priorities	K. Finn-Davis summarized HONSAC's big bucket priorities was in Workforce Shortage, Mental Health, Kupuna/Long Term Care, Access, and Preventative Care. The document "HONSAC Priorities" was screen shared.	
Standing Committee/Other Committee Reports and Updates	Membership Committee. C. Takeno, Chair reported no updates. Discussion followed. C. Takeno will present a grid resulting from the member survey administered last year. The information on the grid will help to inform a more targeted recruitment strategy. All agreed to keep this item on the agenda. Statewide Health Coordinating Council (SHCC). The HONSAC liaison to the SHCC, H. Okumura, resigned from HONSAC and SHCC effective February 29, 2024. W. Nihoa mentioned a new SHCC liaison will need to be identified. There was a brief discussion. This item will be added to the next meeting agenda.	C. Takeno-prepare to present grid at next meeting. Members consider SHCC position.
Announcements	None	
Next Meeting	September 12, 2024, 12 noon.	
Adjournment	The meeting was adjourned at 12:59 p.m.	

Attachment A

DRAFT August 2024

SHPDA *Draft* 2025 Top 8 Priorities

Note: The following draft priorities will be reviewed with Hawaiʽi's major insurers, hospitals, physicians, nurses, dentists, long-term care and other providers, consumer groups and government agencies for their feedback and suggestions before finalizing.

1. **The uninsured:** While the uninsured problem in Hawaiʽi seems to some to be less serious than for other states, we still have 5-6% of citizens who lack coverage. There are disputes about the accurate numbers. Nonetheless, this needs to be addressed to guarantee access for all citizens.

2. **Medical debt**: The problem of medical debt relates to both financial vulnerability of both uninsured and underinsured persons. While this has historically not been much of an identified problem in Hawaiʽi, it has become one, and needs to be addressed. It basically relates to insurance coverage gaps and needs for better consumer education about health coverage.

3. **The Healthcare Workforce**: Hawaiʽi has an excellent health care system for a rural and small state overall. But primary care and specialty care access, across a wide array of professional categories including behavioral health and social services, is a growing and serious shortfall. The workforce gaps in long-term care and home and community-based services must also be addressed as a top priority. The growing primary care gap, which is exacerbated in rural health care shortage areas, also in part relates to financial disparities between primary care and specialty incomes. FQHCs are helping to address this gap, but it needs to be a state focus for SHPDA, the Governor, the Legislature, UH, HAH, EOA, and us all until it is resolved. We do not want, nor can we afford, to have emergency departments fill this gap. The Governor's HELP loan forgiveness program will help with recruitment, but retention is another matter to be addressed; and funding for training of new healthcare professionals needs to be ramped up. In the interim, new models of care using AI and technology, remote monitoring systems, advanced home and community-based care innovation, community health workers (CHWs) and other approaches also need to be explored.

4. **Rising health care costs and affordability of health coverage**. The US expects to be spending $7 *trillion* annually on health care by 2030 (the country spent $4.6 trillion in 2023). Hawaiʽi is part of the US health care "non-system." We need to chart our own unique path to maintaining affordability of and access to care for all here. Working with other agencies, SHPDA is charged with estimating and monitoring total annual health care spending, with comparison to other states and the nation. We need to work with key health sector participants to slow avoidable rises in cost and assure ongoing affordability. We also need to focus on increasing primary care access to reduce avoidable inpatient and ED use. Finally, re-balancing spending for institutional long-term care toward increased home and community-based services is also a key priority and opportunity for SHPDA, Med-QUEST, EOA, and palliative care providers.

5. **The AHEAD grant**: CMS announced in early July that Vermont, Maryland, Connecticut and Hawaiʻi are the first four states to be awarded the ambitious AHEAD Collaborative Agreement (grant). Funding and pre-implementation planning will commence immediately. SHPDA and Med-QUEST, as the co-applicants for the state, will receive about $12 million over the initial 5 years of AHEAD for administration; planning; actuarial services; data acquisition, analytics, and innovation; and other contractual services. AHEAD will also provide up to $50 million a year beginning in January 2027 for grant implementation. This funding will be paid directly to participating hospitals and providers from 2027 through 2035 for Hawai'i to improve primary

care access, including addressing -- as part of "advanced" primary care -- more of the behavioral health and social determinants of health factors adversely impacting health outcomes and population health. For the state to receive these benefits, which has broad local support, CMS requires that a majority hospitals must begin the task of shifting their reimbursement to value based approaches, including in addition to providing high quality acute and emergency care, to increasing their responsibility *with new incentives* to improve the health of their communities served, and to do so in ways that reduce avoidable ED use and inpatient care. CMS intends to establish this kind of value-based future nationally by their goal of 2030 for all of Medicare and Medicaid. AHEAD gives us a head start. We need to use the state-directed resources to collaborate with insurers, hospitals, and other providers on a Hawai'i-specific approach to helping the nation find a viable path to ongoing affordability and improvement of health care in terms of modernizing hospital and provider reimbursement and advanced data tracking methodologies. The overall goal is to foster a systematic approach to population health improvement and sustainable affordability.

6. **<u>The Federal funding equity gap</u>**: Hawaiʻi deserves and sorely needs to be funded equitably with other states by the federal government in per capita Medicare and Medicaid payment, and in geographic (GPCI) professional reimbursement. This is critical to the viability of our hospitals, providers, and insurers. SHPDA plans to organize a massive coordinated statewide campaign to assist our Congressional delegation in bringing Hawai'i to parity in these regards, given our highest average cost-of-living and cost-of housing circumstance among states. In Medicare alone, the difference between Hawaii's per capita reimbursement and the national average could increase state funding by over one billion dollars if parity is achieved.

7. **<u>Using health care data to improve population health and health outcomes</u>**: SHPDA, in collaboration with Med-Quest, the Insurance Commissioner, HI HIE, UH, and the entire health sector, has an opportunity and responsibility to facilitate the state's ability to become an increasingly sophisticated source of curated, de-identified, and privacy-assured claims and clinical data to support insurers, health systems, hospitals, LTC facilities, and providers in systematically improving healthcare, long-term care, and population health outcomes together. The approach could be parallel how the American College of Cardiology's National Cardiovascular Date Registries (NCDR) has used its 200 million annual inpatient and outpatient records to improve CV care nationally. This can be accomplished by privately and confidentially sharing outcomes data with health care providers (health systems, hospitals, and physicians) to allow them to compare and improve their performance against national standards and benchmarks. Queen's and HPH-Straub already participate in NCDR, but do not see the other's data. What could be shared publicly is how the state at large fares against other states in terms of outcomes and per capita costs, and where the gaps exist that need to be addressed by us collectively. For SHPDA, Med-QUEST, and UH, this challenge requires that the state's All-Payer Claims Database (APCD), legislatively mandated under SHPDA's authority for all insurers, becomes fully operational by 2026. Funding assistance will also be needed to assist the Hawai'i HIE to achieve full functionality, to promote collaboration with the Laulima database of the Healthcare Association of Hawai'i, and to improve health IT connectivity for FQHCs, critical access hospitals, and independent community providers as part of this vision.

   That said, modern and most secure healthcare data systems are evolving to cloud based interoperable systems that enable complex tracking, calculations, and analytics to occur with data being securely retrieved from but remain in its myriad sources for such uses without the

need for data vaults or storage. This approach is not only more secure, but it is much more acceptable to insurers, hospitals, and providers, including government, and should be considered here.

8. **Prior Authorization**: The process of prior authorization (PA) has become very contentious nationally and is an increasing public and provider concern regarding alleged and real denials and delays of appropriate care here. Its intended purpose for insurers is to reduce costs related to unnecessary or inappropriate care. However, the relatively new common practice of insurers choosing to contract with other firms to manage their PA has exacerbated the growing tension, given the perverse incentives of the contracted firms to make more money by denying more claims. While this issue is not a top priority in SHPDA's wheelhouse, we are the agency of government where concerns expressed to the Governor and other state agencies related to healthcare are typically referred for response, along with the office of the Insurance Commissioner in DCCA. SHPDA and the Insurance Commissioner will be conferring about the issue, given the certainty of legislative measures being proposed to attempt to resolve it. The Centers for Medicare and Medicaid Services recently published a new PA -related regulation, *CMS-0057-F* which sets timeline and policy parameters around PA to be fully implemented by 2027. Other states are also submitting bills on proposed improvements and policy parameters for PA. there will be proposals this year in our legislature.

   SHPDA wants to see available high-tech innovations employed in our state approach around this matter. The standards and approved and valid guidelines for most major disease states are available and frequently updated by professional societies and academic institutions – some also from the FDA and the NCCN for cancer. Using AI and electronic means to help doctors assure that their patient work-ups contain all essential information for a PA approval, and offering insurers transparent use of such standards and guidelines (hopefully by statewide agreement among companies) to electronically adjudicate and streamline approvals would greatly improve the process. All participants, including the payers, are frustrated by the hassles and expense of PA as it is currently conducted. Let's fix it in Hawai'i!