HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (SHPDA)
1177 Alakea Street, Suite 402 • Honolulu, HI 96813 • Phone: (808) 587-0788 • www.shpda.org
Universal Access Advisory Council - Plan Development Committee

DRAFT
Meeting Minutes
December 2, 2024 | 1:00 PM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402
https://www.zoomgov.com/rec/share/DRtYBv1wkasg_letyN2XAWR9tiYISUPLpWoUTA8xohFGN11EABYt6LzIMftFiaD4.CrJcVhSpbmtZCZkQ?startTime=1733180506000
Passcode: L%2eeAv6

MEMBERS: Rick Bruno, , Jenn Diesman, Beth Giesting, John McComas, Gary Okamoto, Keʻōpū Reelitz (for Sheri Daniels), Michael Robinson, Linda Rosen, Melvin Sakurai, Marilyn Seeley, Rae Seitz, Charlene Young
MEMBERS ABSENT: Marc Alexander, Jonathan Ching, Lawrence Nitz, Nadine Tenn Salle, John Yang
GUESTS: Joy Soares
SHPDA: John Lewin, Wendy Nihoa

ATTENDANCE RECORD OF MEMBERS

Date	1/19/24	1/22/24	1/30/24	2/7/24	2/23/24	3/12/24	6/6/24	8/14/24	10/23/24	12/2/24
Marc Alexander	X	X	O	/	/	X	X	X	X	O
Rick Bruno	X	O	O	/	/	O	X	O	O	X
Jonathan Ching	X	X	X	/	/	O	X	O	X	O
Sheri Daniels	O	O	O	/	/	O	O	O	O	X
Jenn Diesman	X	O	X	/	/	X	X	X	X	X
Beth Giesting	X	X	X	/	/	X	X	X	X	X
John McComas	O	X	X	/	/	O	X	X	X	X
Lawrence Nitz	X	O	X	/	/	O	O	O	O	O
Gary Okamoto	X	X	X	/	/	O	X	X	X	X
Michael Robinson*	X	X	X	/	/	X	X	X	X	X
Linda Rosen	X	O	X	/	/	X	X	X	O	X
Melvin Sakurai	X	X	X	/	/	X	X	X	X	X
Marilyn Seeley	X	O	X	/	/	O	X	X	X	X
Rae Seitz	O	O	X	/	/	X	X	O	X	X
Nadine Tenn Salle	O	O	O	/	/	O	X	O	O	O
John Yang	/	/	/	/	/	O	O	O	O	O
Charlene Young	/	/	X	/	/	X	X	X	X	X

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

TOPIC	DISCUSSION	ACTION
Call to Order	A quorum was established. The meeting was called to order at 1:02 p.m. by M. Robinson, Chairperson, Universal Access Advisory Council (UAAC) presiding.	
Roll Call	Member roll call. Guest: J. Soares, Project Manager AHEAD Grant, MedQUEST, Hawaii Department of Human Services. M. Robinson greeted members and guests and announced the resignation of Chair Paul Roeder. As Vice Chair, M. Robinson has agreed to assume the role of UAAC Chair.	
Minutes	Approval of the minutes from the October 23, 2024. Motion to accept the minutes from the dates noted above. Vote: Unanimous. Motion carried. Public Testimony - none.	
Permitted Interaction Group (PIG) on Defining Access	Per M. Robinson the group met several times to review various data sources and discuss the definition of "Healthcare Access." J. Diesman shared the findings, explaining that the PIG considered Hawaii's unique characteristics as well as existing definitions from the Department of Health, MedQUEST-Department of Human Services, and Hawaii Revised Statutes. She also mentioned that the PIG aimed to develop a definition that aligns with the UAAC's goals, given the absence of a vision or mission statement for the group. The definition as present is comprised of several elements: Availability, Affordability, Acceptability, Accommodation, Geographic Accessibility, Cultural and Linguistic Appropriateness, Timeliness, and Quality. A copy of the information presented are attached to these minutes as Attachment A. A discussion followed. Members discussed the definition of "Healthcare Access" noting the complexities of access; to aspire to develop a way to measure the elements of access as mentioned; coordination and continuity of care related to healthcare access. Several concepts that surfaced during the discussion did not appear to be included in the elements as presented however, PIG members explained how topics are either included as a part of the definition or may fall under several elements. Members of the PIG will review and incorporate the comments, revise the definition, and be ready to present the revised definition at the next UAAC meeting. Public Testimony.	Schedule PIG meeting to incorporate comments into

		healthcare access statement.
All-Payer Health Equity Approaches and Development (AHEAD) Grant Updates	MedQUEST (MQD). J. Soares reported that the grant is in its early stages, focusing on infrastructure setup. A tentative CMMI site visit is planned for January 2025, with the possibility of attending the State of Reform Conference. The AHEAD project is large, and MQD is providing an experienced project manager to ensure progress. To meet early deliverables, MQD procured consultants for the Medicaid portion of the AHEAD work using Medicaid funding and the IDIQ procurement method – "MQD ID/IQ Payment Transformation". Selections are complete, and contracts are being processed. Once executed, task order will be issue for Medicaid-specific AHEAD work. MQD is also working with SHPDA to develop the AHEAD Governance Structure. While progress may feel slow, these foundational steps are crucial for the project's success. SHPDA. J. Lewin, Administrator of SHPDA, collaborative effort between reported that procurement will take months (4-6) to award contracts, with the current focus on infrastructure setup. Regarding Hospital Global Budgets (HGB) and Primary Care, CMMI is flexible with states in developing tailored models. The AHEAD team has discussed with CMMI and consultants how to construct an HGB using new financing methods. The Hawaii AHEAD team will collaborate with stakeholders to develop state-specific models. During the CMMI's tentative visit in January, they hope to meet with hospitals, physicians, and providers, including those serving Hawaiian and Pacific Islander communities. A discussion followed. J. Soares mentioned the MQD ID/IQ Payment Transformation Awardees may be accessed at https://hands.ehawaii.gov/hands/awards/award-details/178638 Public Testimony – none.	
AHEAD Grant Previously Submitted Question from Universal Access Advisory Council Members	M. Robinson referred to the written responses to previously submitted questions and asked if there were any questions from the members. There were none. A copy of the written responses are attached to these minutes as Attachment B. Public Testimony – none.	
Universal Access Advisory Council Membership	M. Robinson reported that due to P. Roeder's resignation, effective November 4, 2024, the vice chair position is not vacant. Members were encouraged to consider potential nominees for the role. M. Robinson highlighted the importance of maintaining balance (provider vs. consumer), as he represents a healthcare provider. He suggested that diversity and representation be considered in the selection. This topic will be revisited at the next meeting.	Add nominations

	Inactive Members. • S. Daniels requested to remain a member and has appointed K. Reelitz to attend when she unavailable. • E. Gill requested to be removed due to inability to contribute. • L. Nitz – no report. M. Seeley will follow up. Membership. M. Robinson noted that the nominations for additional organizations and members will be called for at a future meeting. Members were encouraged to consider potential candidates based on committee structure. The idea of caping membership was discussed, with suggestions to include representation from neighbor islands, community organizations, and data experts. It was also proposed to identify needed categories of representation, address gaps, and then determine the individuals to invite. Alternate Representatives. It was clarified that a member may send a designee to attend and vote at meetings. Members will provide W. Nihoa with advanced notice, which will be noted at the beginning of the meeting. Public Testimony – none.	for vice chair at the next meeting. Chair and SHPDA to identify categories of representation, gaps, and individuals to add to membership.
Announcements	M. Robinson – reminded members to submit any revisions to the healthcare access statement to W. Nihoa.	
Next Meeting	February 10, 2025, 1 p.m.	
Adjournment	The meeting was adjourned at 2:04 p.m.	

Findings: Definition of Healthcare Access

Universal Access Advisory Council

Permitted Interaction Group on Defining Healthcare Access

Members: J. Diesman, G. Okamoto, M. Robinson, R. Seitz

SHPDA Staff: W. Nihoa

December 2, 2024

Healthcare Access

HEALTHCARE ACCESS in Hawaii refers to the ability of individuals to obtain and utilize necessary healthcare services when they need them. This concept encompasses several key factors specific to the state's unique geography, culture, and healthcare landscape:

Availability: The presence of adequate healthcare facilities, services, and professionals across Hawaii's islands, ensuring that both urban and rural areas have access to the care they need.

Affordability: The financial ability of residents to pay for healthcare services, whether through insurance, state-funded programs like MedQUEST and Medicare, or out-of-pocket payments. Special consideration is given to the high cost of healthcare and insurance in the islands.

Acceptability: This captures the extent to which individuals feel comfortable with the characteristics of their healthcare providers, such as age, gender, social class, ethnicity, and the provider's understanding of local customs. It also considers the patient's diagnosis and insurance coverage, ensuring the service aligns with their needs.

Accommodation: The extent to which healthcare providers in Hawaii organize their services to meet the needs and preferences of patients, particularly in relation to hours of operation, how telephone communications are handled, and the flexibility of scheduling, especially in rural or underserved areas.

Geographic Accessibility: The physical proximity of healthcare services, considering Hawaii's island geography, where travel between islands may limit access to care. This includes ensuring that residents of both urban areas like Honolulu and remote rural areas can access necessary services.

Cultural and Linguistic Appropriateness: The degree to which healthcare services in Hawaii are tailored to meet the cultural, linguistic, and personal preferences of the diverse population, including Native Hawaiian, Pacific Islander, and immigrant communities.

Timeliness: The ability to receive care promptly, minimizing delays that could worsen health outcomes. This is particularly important given the state's geographical isolation and the potential for long wait times or travel distances.

Quality: The level of effectiveness and safety in the healthcare services provided, ensuring that care meets high standards regardless of the island or community receiving the service.

In Hawaii, ensuring comprehensive healthcare access involves addressing the unique challenges of the state's diverse and geographically dispersed population.

Thoughts / Reactions?

Resources / References

HRS 431 Articles 103 https://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435H/HRS0431/HRS_0431-0026-0103.htm

HRS 431 Article 104 https://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435H/HRS0431/HRS_0431-0026-0104.htm

National Library of Medicine
https://pmc.ncbi.nlm.nih.gov/articles/PMC1464050/
https://pmc.ncbi.nlm.nih.gov/articles/PMC1464050/#:~:text=They%20grouped%20these%20characteristics%20into,willingness%20to%20pay%20for%20services

MedQuest
HRS §431:26 – 103(7):)
The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities, or persons with limited English proficiency;

Resources / References

MedQuest Continued.

- CMS Definition www.cms.gov/glossary
- Access – Your ability to get needed medical care and services.
- Accessibility of Services – Your ability to get medical care and services when you need them. What is "needed medical care"?
- QUEST is mandated to provide access to what is medically necessary, based on medical necessity guidelines.
- For Hawaii and medical necessity, we two definitions (State Hawaii Revised Statutes and DHS Hawaii Administrative Rules)
    - HRS Hawaii Revised Statutes - State Definition of Medical Necessity §HRS 432E-1.4
        - https://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435H/HRS0432E/HRS_0432E-0001_0004.htm
        - HAR DHS Hawaii Administrative Rules (HAR)§17-1700.1-2 Definitions
            - "Medical necessity" means those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

UNIVERSAL ACCESS ADVISORY COUNCIL
AHEAD Grant Questions & Comments

	QUESTIONS	RESPONSE
1.	How will hospital financials be protected to include them in the Grant?	*Hospital financials are largely already available in terms of Medicare and Medicaid from CMS publications. AHEAD will not propose further publications of proprietary data attributable to specific facilities, but rather to statewide trends. However, we will work with CMS and individual hospitals to improve outcomes and bottom lines, but each hospital's data and financials will not be shared with their competitors except as already required by law or CMS.*
2.	I have questions based on what Dr. Lewin has previously shared but would like to read the grant application before identifying specific questions.	*This is a statement, not a question.*
3.	Is our objective to reduce costs and expand coverage or are we aiming to improve health and reduce disparities?	*All of those things at once. They are interconnected. Increasing population health will reduce costs and disparities. Increasing primary care expenditures should also reduce costs and disparities and improve outcomes.*
4.	How are we improving healthcare practices and emphasizing primary care and the integration of behavioral health with that primary care?	*For traditional Medicare, there is $200/year attached to every patient to include behavioral health and social support services as a part of primary care for those who need these additional services. Medicaid will also seek to incentivize improving primary care. We believe commercial insurance will want to be included also.*
5.	Are we focusing on underserved areas, especially neighbor islands, and people with health disparities? Or are we looking at specific populations like children or the elderly?	*All of those populations in both rural and urban areas, noting that rural areas need more immediate focus. Keiki and kupuna health will be important foci.*
6.	Are our data systems ready to produce information that will guide us, helping us target problems and progress toward solutions?	*We are getting there. The APCD (All-Payer Claims Database, which is partnership of SHPDA, Med-QUEST and UH) will go live in 2025 and keep expanding its capabilities over the course of AHEAD. Other clinical data can be*

		obtained from the HI Health Information Exchange and Laulima databases as required to monitor our progress.
7.	Are our objectives based on what WE understand to be most important (and how did we decide that?) or on what the grant will pay for?	*The grant will be investing in improving primary care, hospital viability, and health coverage access and affordability, and in reducing disparities. Are these things not what all states feel to be important?*
8.	Can we get a detailed milestone target date schedule for the pre-implementation period?	*We are just beginning to develop these kinds of milestones, but they will be publicly available.*
9.	Can we get a detailed presentation from MedQuest about what they are planning, resources (including consultants), and budgets? The have been "missing in action".	*MedQUEST has agreed to be present and make updates at all future UAAC meetings. We will make available as required reports on progress with respect to Medicaid, Medicare, total health spending, population health outcomes and progress with AHEAD goals.*
10.	How does the UAAC interact with the AHEAD grant? What's our relationship?	*AHEAD requires a Governing Body that advises and reports to CMS and the state on progress made. UAAC can directly advise the Governing Body through SHPDA.*
11.	What are ways that we could partner and support your work on the HI-AHEAD Grant?	*Advise us and suggest ways to improve our outcomes goals.*
12.	Who will be on the Advisory Committee and how will they be chosen…and how will their role be defined?	*There will likely be 11 members of the Governing Body, which will advise SHPDA & Med-QUEST and CMS. There are requirements in the model for assuring that the body represents the entire population, including neighbor islands and disadvantaged populations as well as the provider/hospital/health sector community*
13.	What is our role vis-a-vie the Ahead Grant and the Advisory Committee?	*As described above.*
14.	Can we get quarterly updates on progress and any information on any major issues and concerns?	*Absolutely! Of course.*
15.	How would the development of the model and the AHEAD collaboration with CMMI be affected under a Trump Administration scenario?	*That remains to be seen, but likely no real change. Maybe the word equity is changed to disparity of something else.*

16.	I believe MQD and SHPDA either are engaging with consultants or have already contracted with consultants. What is the scope of work for these consultants?	*Unfortunately, the process of procurement and hiring consultants in Hawai`i often takes 6-9 months. We are just developing what the complicated and various needed RFPs will be and beginning the process. Lucky, we have 2 years of pre-implementation. However, we are already organizing pour thoughts and objectives around the kinds of help we will need.*
17.	For MQD and SHPDA over the next 12-18 months, what is the planned timeline of work for the AHEAD grant?	*Outline the workplan objectives, set goals and benchmarks, begin the consultant procurement process in parallel, and be ready by January 2027 to launch the grant.*
18.	What type of Alternative Payment Methodology is envisioned for Medicaid managed care? What are MQD's thoughts on payment transformation, and how will stakeholders be included in that conversation? Specifically, will there be public stakeholder workgroup convening to engage in iterative dialog and provide feedback?	*AHEAD aspires to alternative payment models to FFS that promote value in terms of better outcomes at lower costs. No matter how clinicians and hospitals are paid, the investment needs to improve hospital viability and promote recruitment and retention of health professionals and with adequate reimbursement. This is possible if we ferret out wasteful practices like unnecessary ED visits, avoidable hospitalizations, failure to prevent morbidity, better chronic disease treatment, etc. This all needs to apply to Medicaid, Medicare, and commercial insurance*.
19.	What is the anticipated impact to PPS rates?	*AHEAD is voluntary for all participants. PPS rates will not change. But the model may be able to help FQHCs improve their financial positions if we design it right with alternative payment models that increase their bottom lines and abilities to serve their populations*.
20.	I have in my notes a "12% increase in primary care investment." Please explain to which population (Medicare FFS only?) and how this increase will be administered.	*That is not correct. The goal is to increase the overall investment in primary care from our estimated current spending of about 5-6% of total costs of care (TCOC) to about 12%. That is 100% increase in primary care spending if we can do it.*

21.	I also have in my notes a "$17 PMPM increase for Medicare FFS". a. I presume this will go to each FFS Medicare beneficiary's primary care provider? b. Will this be coordinated and distributed at the state or federal level? c. How will this be administered? d. What about the Medicare Advantage population? Will there be a $17 PMPM increase as well?	*This is correct. AHEAD will fund in Medicare $17 PMPM or about $200/year for increasing physician or providers for each of their beneficiaries.* *This could include MA patients as well, but we need to negotiate the terms with CMS. It could also include FQHCs. For employed physicians. The payments to docs, clinics, hospitals, and all providers will go directly from CMS to the providers – not through the state.*
22.	What is the anticipated impact to Medicare-Medicaid dually enrolled populations?	*AHEAD could greatly enhance their care.*
23.	Please describe the proposed plans and timelines for stakeholder engagement and public input, including the formal work of establishing a Governing Body. Will the Governing Body have meetings open to the public? Is the intent for the Governing Body to create various stakeholder committees?	*I've covered much of this question earlier. But the Governing Body should have stakeholder feedback and subcommittees or advisory groups to help it understand how we are doing. It will be open to the public, but most meetings may be virtual (Zoom).*
24.	What is the definition of "universal access" as described by our committee?	*Everybody should be covered or "in." But access is more than coverage with workforce shortages, right? Ideally, we should define the essential services all citizens receive (which will vary by age and medical condition) and assure they are provided to all, including having access to care as well as coverage.*
25.	How is that definition of "universal access" defined in the grant?	*It isn't defined. The grant seeks to improve population health, reduce inequities, expand primary care spending and access, modernize hospital funding to promote their viability and to incentivize them to improve the health of their communities, and measure total spending to monitor if health costs are inflating faster than general inflation toward unaffordability.*
26.	What is the working definition of "health equity" used for purposes of the AHEAD grant?	*It isn't defined—it's up to each state. But it's understood to be: Health equity is the idea that everyone should have a*

		fair and just chance to achieve the best health possible. It's based on the principle that everyone deserves to be valued equally, and that societal efforts should be focused on addressing health disparities and inequalities.
27.	Hawai'i and other states have had challenges managing external contracts related to the management of health insurance and health care informatics (e.g. Hawai'i Health Connector). How will those pitfalls be avoided?	*We'll all need to figure that out together!*
28.	Besides receiving updates of the AHEAD grant progress, what are some of the other main duties & responsibilities of the AHEAD Grant?	*I've fairly covered this in previous questions*.
29.	What are the roles of the other related committees related to the UACC (e.g. Data, Keiki, Kupuna)?	*Their inputs, recommendations, and deliberations need to be to included in how AHEAD is designed and implemented directly through SHPDA and or through input to the Governing Body. They all have been developing amazing recommendations.*
30.	What has been the output from those (Data, Keiki, Kupuna) committee meetings to date?	*Wendy Nihoa and Terry Visperas can provide information on progress and recommendations as they develop for all SHPDA advisory Councils. It's all public record.*
31.	Given the needs identified related to neighbor island access, is there a separate committee or sufficient representation by neighbor island constituents on the UAAC?	*The UAAC has representation from the counties among its members. But, SHPDA also has Subarea Advisory Councils for Honolulu, Windward, and West O'ahu regions and for each of the neighbor island counties. Their feedback can and will be available to the Governing Body, CMS, and AHEAD needs that feedback to succeed.*

COMMENTS:

1. "It's hard to comment on something I haven't read. The process on this grant is more opaque than I recall from the many Federal HHS grants that I have been involved with in my career. I don't understand why. In my experience, once a grant is awarded it is shared with others. I would like to assess how the proposed activities are expected to lead to greater access to needed healthcare."

2. "So far, I feel like I'm in the dark about what we're doing and why. It doesn't help that we have nothing in writing we can refer to as our anchor. I understand that the latter is partly due to restrictions placed on us by CMS, but perhaps we can develop a brief statement of our mission and goals. "
3. "A continuing series of all-stakeholder Round Table informational briefing and strategic/tactical exchange sessions should be established and convened immediately with CMS SMEs and decision makers on-site to provide first hand unfiltered information."
4. "How and when will the AHEAD Advisory Committee be developed?"
5. "Congratulations! This is a big win!"