HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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Kupuna Advisory Council - Plan Development Committee

DRAFT

Meeting Minutes

December 17, 2025 | 8:00 AM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS: Hilton Raethel, Kelly Withy, Chris Lutz, Elizabeth Ann Ignacio, Laura Reichhardt, Jenn Diesman, Jon Lim, Lara Nitta, Richard Chung, Robert Gluckman, Sheri Daniels, Paula Arcena,

GUESTS: Senator Joy San Buenaventura, Kamana Levy (Office of Senator San Buenaventura), Paul Meyers (Smart Health Network), Stuart Hansen (Smart Health Network), Preetha P (Representing Ranjani Starr), Cristina Vocalan (Representing Robert Hirokawa)

SHPDA: John Lewin, Terry Visperas, Dailin Ye, Jonas Yee, Jason Espero

ATTENDANCE RECORD OF MEMBERS

Date	11/14/25	12/17	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Jack Lewin*	X	X								
Hilton Raethel	X	X								
Aimee Rodriguez	X	0								
Kelly Withy	X	X								
Chris Lutz	X	X								
Gary Okamoto	X	0								
Elizabeth Ann Ignacio	X	X								
Amy Ono	X	0								
Laura Reichhardt	X	X								
Jenn Diesman	X	X								
Jon Lim	X	X								
Lara Nitta	X	X								

George Mcnutt	X	0								
Ranjani Starr	X	0								
Richard Chung	X	X								
Robert Gluckman	X	X								
Robert Hirokawa	X	0								
Sheri Daniels	0	X								
Paula Arcena	0	X								
Dailin Ye	X	X								

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

Video: https://www.zoomgov.com/rec/share/FDM5qOuNtyRBG5pC3fJtRE28vLcpcL5rl1qjx1xeDkVF4nlBcx1edB_lQxrk6cLW.nGUG_g0Zx-_aCzSS
Passcode: bCr$r+Y3

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 8:08 AM by Chair Jack Lewin MD	
Roll Call	After participant introductions and attendance was document.	
Welcome	J. Lewin welcomed members	
J. Lewin, Chair	The Prior Authorization Working Group (WG) was convened by Chair J. Lewin MD, the meeting was convened at 8:08 AM, delayed several minutes to accommodate security measures. These protocols were implemented to identify participants and prevent the "hacker invasions" that occurred during the previous meeting. • T. Visperas called roll • No one in the public room Chair Lewin reviewed the progress from the prior meeting, noting a fragile consensus to attempt using the new Medicare PA reporting format for the first reporting process (due to SHPDA by January 31, 2026). Key Discussion Points: • Format Consistency: The WG intends to simplify the format to remain as consistent as possible with current Med-QUEST reporting categories.	

- Drug Reporting: Physician members were insistent on including drug reporting, which is not required in the standard Medicare draft format.
- Technical Support: Dailin Ye (SHPDA) is preparing the format based on WG feedback.

Amendments to Previous Minutes

Kelley Withy, MD requested the record show her opposition to the Medicare format, characterizing it as “too non-specific.” She and Dr. Ignacio proposed the following language to better reflect the group's deliberation:

"The Task Force (TF) discussion included commentary on specific Prior Authorization (PA) data categories of information that are needed, not limited to CMS format, including specific diagnostic tests, medications, and consults. The TF carefully considered the volume and complexity of big data sets, feasibility of analyses, and the 2026 deadline."

Motion Clarification: The motion passed in the previous meeting utilized the Medicare format for 2024/2025 data, including drug data as feasible. It also included reporting the percentage of denials vs. total claims and the top five clinical triggers for denials. This format applies to the first cycle only and is subject to re-evaluation.

Formation of the Permitted Interaction Group (PIG)
The WG approved a motion to create a Permitted Interaction Group (PIG) to finalize the reporting format under Sunshine Law requirements. PIG Members:

- Elizabeth Ann Ignacio, MD (Physician/Provider)
- Kelley Withy, MD (Physician/Provider)
- Laura Reichhardt (Physician/Provider)
- Lara Nitta (EUTF/Consumer)
- Sheri Daniels (Consumer)
- Robert Gluckman, MD (Insurer)
- Jennifer Diesman (Insurer/HMSA)
- Chris Lutz (Insurer/Kaiser)

	• Hilton Raethel (Hospital Association) • Jack Lewin and Dailin Ye, (Ex Officio SHPDA) Assigned Purpose: Finalize specifics of the reporting format without exceeding a quorum of the full WG. Recommendations will be submitted for a full WG vote at the January meeting.	
Legislative Update: Senator Joy San Buenaventura	Senator San Buenaventura joined the meeting to stress the WG's importance to the Legislature. • New Legislation: She is submitting a bill to further streamline PA determinations and wishes to include WG recommendations. • Timeline: The deadline for bill submission is January 23, 2026. She requested feedback from the WG 10-14 days prior to that date.	
Guest Presentation: Smart Health Network	Paul Meyer and Stuart Hanson presented on reducing administrative waste ("No More Faxes"). • Presentation Attached • National Progress: They discussed their work with federal officials and states like Delaware and New Hampshire to automate and streamline PA. • Offer: They offered to share materials and progress reports for consideration by the WG and Hawai`i leadership.	
Action Item/Next Steps:	The Chair urged the PIG to complete their tasks expeditiously. Written recommendations from the PIG will be appended to the next meeting agenda for member review. The meeting was adjourned at 9:03 AM by the Chair.	
Announcements	The Prior Authorization PIG will be sent a doodle poll to meet the week of December 22, 23, 29 or 30.	
Next Meeting	The meeting is TBA, after the Prior Authorization PIG meeting but before January 14, 2026, to ensure we meet legislative deadlines.	

Prior Auth in Hawaii

Simplified proposal for data collection

12/17/25

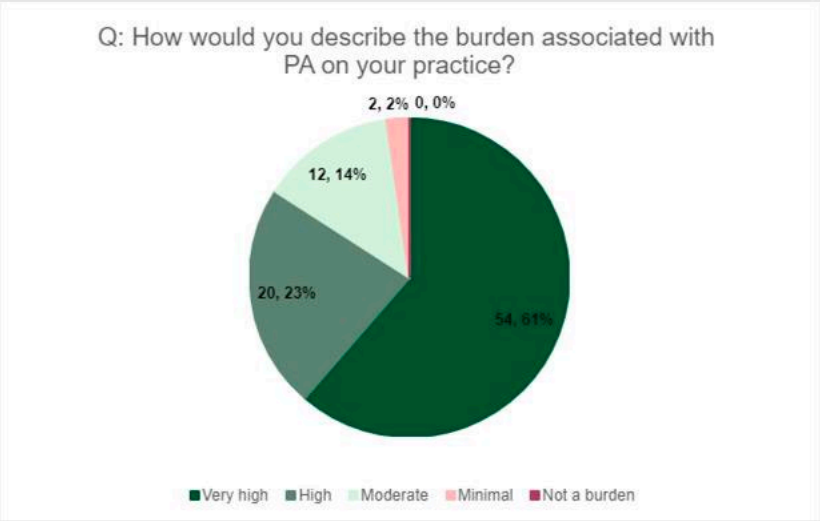
Kelley Withy, MD, PhD

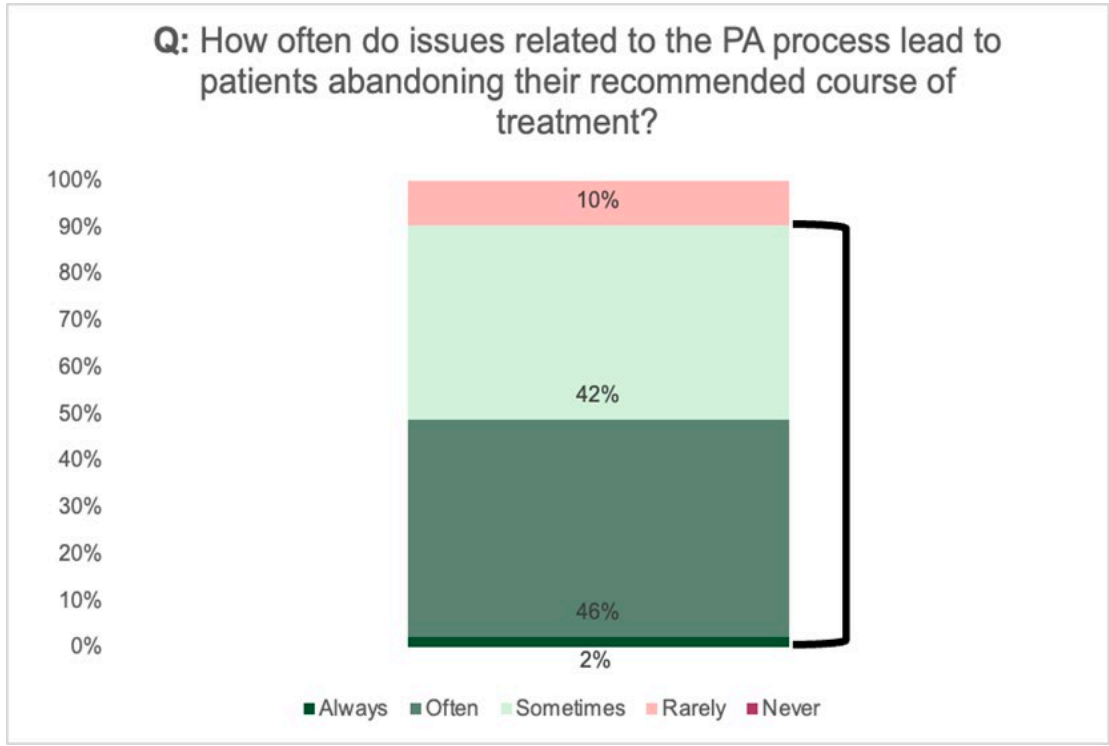
withy@Hawaii.edu

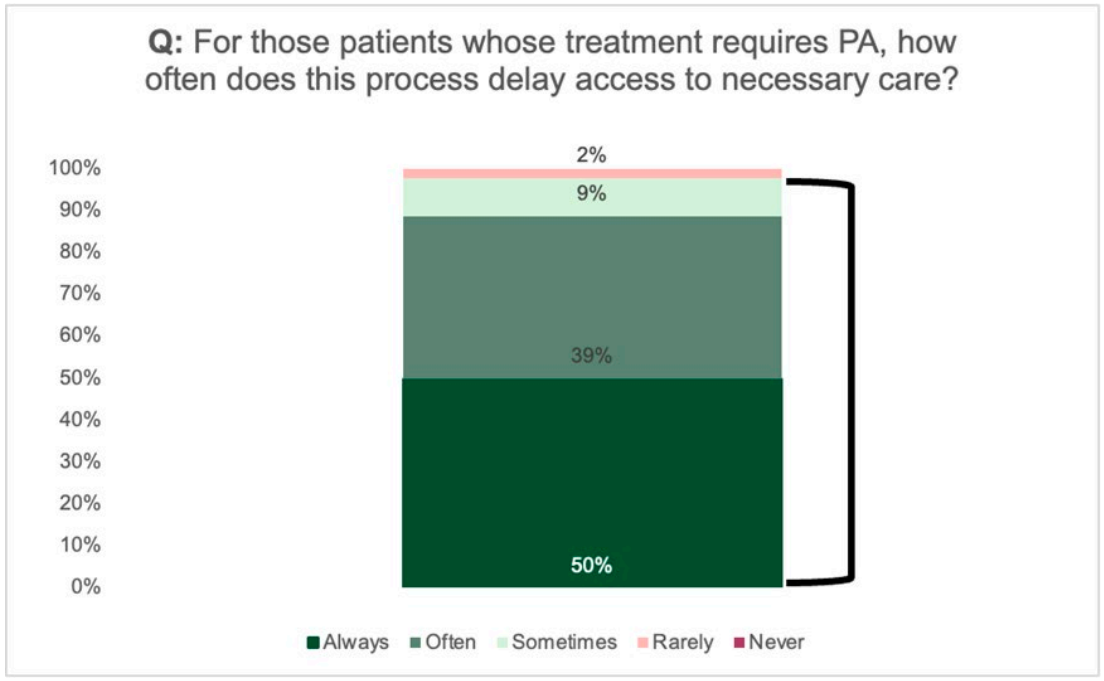
Time to care/costs nationally

- In the US, we spend $35 billion to do prior auths per year. (Sahni NR, Carrus B, Cutler DM. Administrative simplification and the potential for saving a quarter-trillion dollars in health care. JAMA. 2021;326(17):1677–1678. 10.1001/jama.2021.17315)
- The average cost of PA is $40 to $50 per submission for private payers and $20 to $30 for providers (Sahni NR, Gupta P, Peterson M, Cutler DM. Active steps to reduce administrative spending associated with financial transactions in US health care. Health Aff Sch. 2023;1(5):qxad053. 10.1093/haschl/qxad05)
- 92% clinicians reported that patient care was delayed due to PAs and 14% reported that care was delayed longer than 2 weeks due to PAs and 42% of provider respondents said it is a high contributor to burnout (//pmc.ncbi.nlm.nih.gov/articles/PMC11425057/)
- 82% said PA can lead to care abandonment and 29% says it has lead to serious adverse events (2024 AMA prior authorization physician survey).

Local clinician survey results

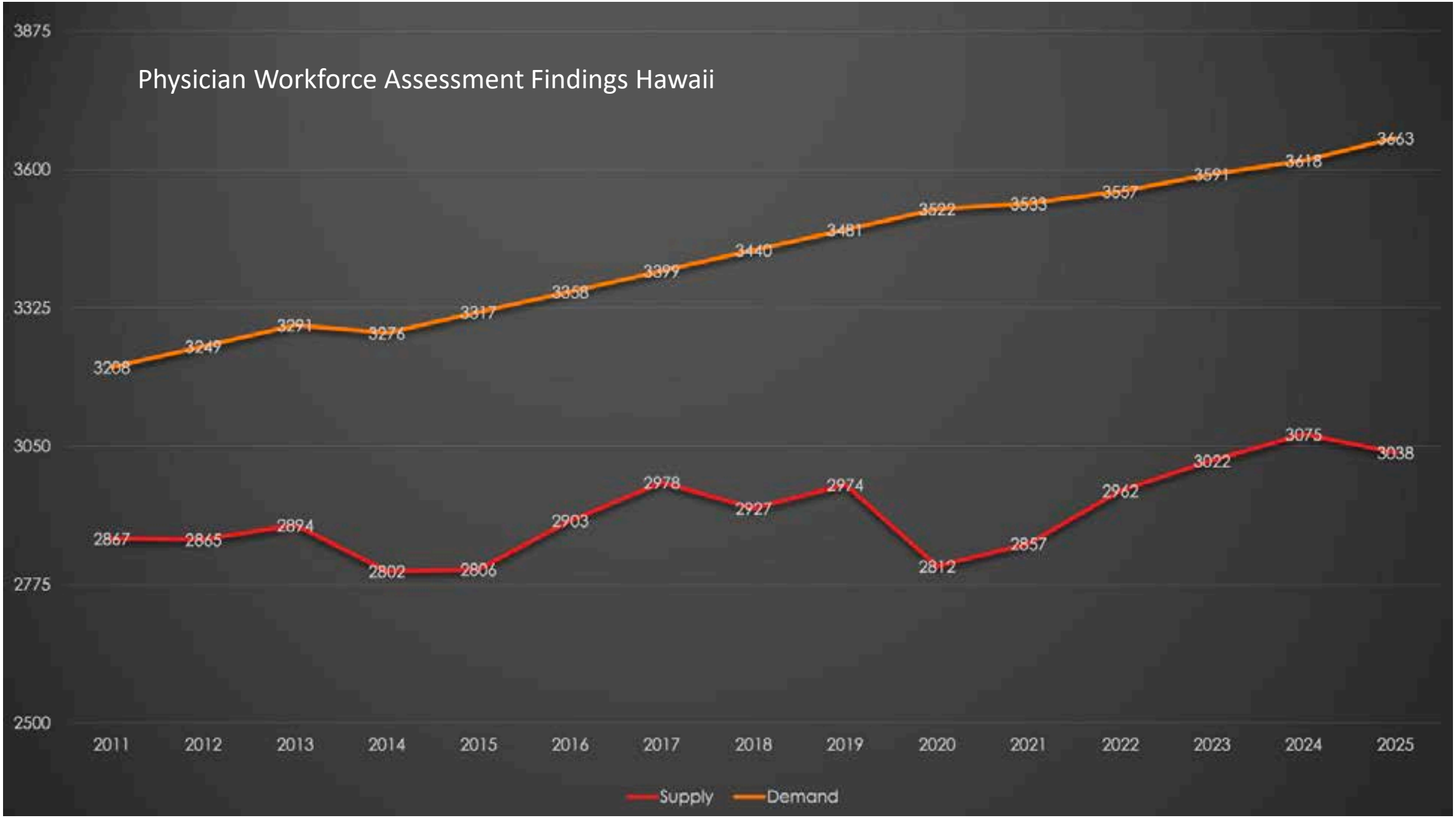






Physicians and their staff:

- *Spend 19.8 hrs per week processing PAs*
- *Wait 8 business days for a PA decision*
- *Wait 13.8 business days for a decision after an appeal*


Physician Workforce Assessment Findings Hawaii
3875
3600
3325
3050
2775
2500
2011
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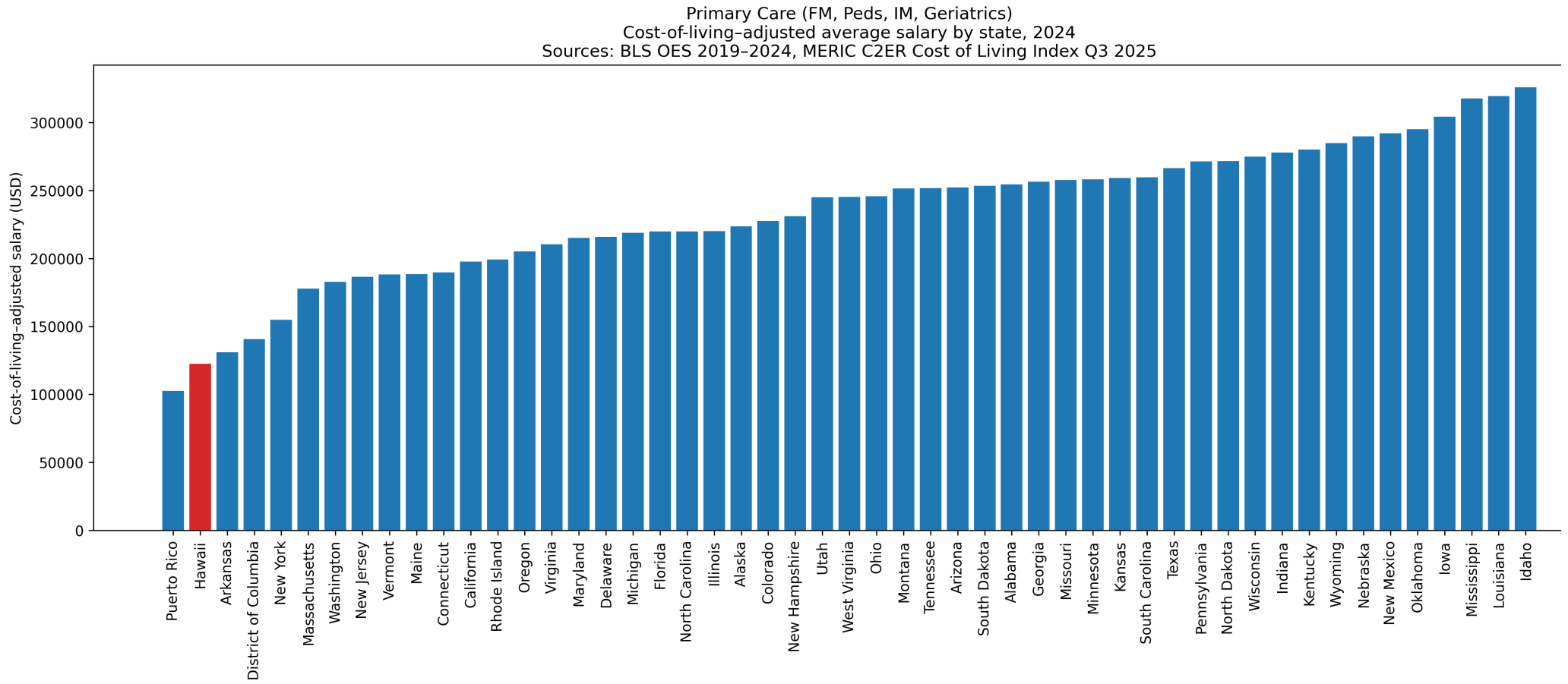
Supply
Demand

Local data


Primary Care (FM, Peds, IM, Geriatrics)
Cost-of-living–adjusted average salary by state, 2024
Sources: BLS OES 2019–2024, MERIC C2ER Cost of Living Index Q3 2025
Cost-of-living-adjusted salary (USD)
0
50000
100000
150000
200000
250000
300000
Puerto Rico
Hawaii
Arkansas
District of Columbia
New York
Massachusetts
Washington
New Jersey
Vermont
Maine
Connecticut
California
Rhode Island
Oregon
Virginia
Maryland
Delaware
Michigan
Florida
North Carolina
Illinois
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South Dakota
Alabama
Georgia
Missouri
Minnesota
Kansas
South Carolina
Texas
Pennsylvania
North Dakota
Wisconsin
Indiana
Kentucky
Wyoming
Nebraska
New Mexico
Oklahoma
Iowa
Mississippi
Louisiana
Idaho

Clinician perspective

- prior authorizations carry a cost that is harder to quantify but impossible to ignore. The constant administrative drag contributes directly to burnout. It pushes older physicians into early retirement and drives younger physicians out of insurance-based practice entirely and into direct payment models. In a system already struggling with severe shortages of physicians and other clinicians, these losses are profoundly damaging.
- I have about two hours of prior authorizations to do at the end of this clinic day: It isn't sustainable and it isn't appropriate.
- If I see a denial I open a chart note and immediately reorder it. I do not do an appeal because appeals have a much longer reply time allowed - like a month I think.
- One of my staff had a baby 4 months ago. HMSA is denying a test for the baby. She is appealing but now HMSA wont let her appeal because as the mother, "she does not have authority to appeal" on the baby's behalf. The baby needs to sign an authorization to appoint a personal representative and the form HAS TO BE MAILED.

PAM Report and Unintentional System Errors

Per the PAM report on prior auths, in the one quarter (3 months) of data we received there were ~17,000 prior auths required for diagnostic tests (for MedQuest). Per the time documented in the PAM report to respond to these PAs, this caused an extra accumulative 55,000 days of care delay.

Based on national studies of costs of prior auth process, this costs about $1.5 million to do these prior auths. So roughly $6 million a year spent on doing prior auths.

Plus, 172 PAs required for things that were not allowed by the contract.

Recommendations

- Eliminate PAs
- Have uniform evidence based guidance come up in the chart when ordering study/lab/consult/DME/Med
- APCD make sure the study/lab/consult/DME/Med hasn’t been ordered/provided recently
- Until then, how about…

1/1/2026-12/1/2026
REGULAR Prior Approval Requests
EXPEDITED Prior Approval Requests

Plan name:			Company:		Number of beneficiaries:				
Service Category	Company that oversees- if applicable	# Prior Authorizations submitted	# Submissions Not required (provider education to be provided)	# PAs approved (percentage calculate)	# PAs Appealed	# appealed PAs approved	# submitted again	# approved	What happens after 2 denials?
Outpatient Visits (consults)									
Imaging (CT, MRI, PET, etc.)									
Pharmacy (High-Cost Meds)									
Durable Medical Equipment									
Behavioral Health									
Transportation Services									

Smart Health Infrastructure for Hawaii's Rural Transformation

December 2025

Executive Summary

American healthcare still runs on **9 billion faxes a year**—wasting over **$1 trillion on administrative expenses**—while families reel from $27,000 annual premiums and rural hospitals close at record rates.

Hawaii's rural hospitals are dying—not from poor clinical care, but from **administrative exhaustion**. A typical Critical Access Hospital loses **$150,000+ annually** to fax-based insurance friction. That's three nursing salaries consumed by phone holds, denied claims, and resubmissions.

The Rural Health Transformation Program offers a once-in-a-generation opportunity to fix this. But **funding alone won't solve a structural problem.** Without modern digital rails, new dollars will be absorbed by old inefficiencies.

The choice is stark: Fund disconnected pilots and patch broken systems, or build **shared infrastructure that delivers results in 90 days and sustains itself permanently.**

The Solution: Deploy a shared administrative backbone connecting providers, payers, and patients through the **Smart Health Infrastructure Alliance**—a coalition of states deploying Smart Health Network (SHN) infrastructure through their RHTP plans. Think of it as **interstate highways for healthcare administration**—neutral, shared rails that any provider or payer can use.

SHN doesn't replace EHRs, clinical systems, or care delivery. It connects them—so a rural hospital on MEDITECH can transact with a payer's system as easily as a large system on Epic. State HIEs remain the **local backbone and conveners**; SHN provides the **shared national rails** they can plug into instead of building alone.

This is ready-to-deploy infrastructure—proven across **68M+ lives** with **99.93% transaction success in <5 seconds**—not a new state IT build.

What Hawaii Gets:

Outcome	Timeline
Real-time eligibility verification (<3 seconds)	90 days
30% reduction in first-pass claim denials	Year 1
75% reduction in prior auth processing time	Year 2–3
Self-sustaining operations (no state appropriation)	Year 5

The Math Works: Both providers and payers save more than they pay. The utility fee (0.05% per party) costs less than the proven savings—so both sides come out ahead on **Day One** and every day after.

Builds on HHIE. The infrastructure leverages Hawaii's existing HIE investment—adding an administrative transaction layer on top of the clinical data backbone HHIE has already built. This creates a revenue-generating capability that helps sustain **HHIE**'s essential clinical data interoperability services with **no ongoing state appropriation after Year 5**.

RHTP Multiplier. Smart Health Infrastructure strengthens Hawai'i's Rural Health Transformation investments by delivering a shared administrative backbone that unlocks measurable impact across multiple initiatives:

- **Accelerates Results Across RHTP Goals:**
    - Expands access by automating eligibility checks and coverage decisions, reducing administrative delays that impede patient care.
    - Improves financial stability for rural and neighbor-island providers by reducing claim denials and manual resubmissions.
    - Reduces workforce burden by replacing manual, fax-based workflows with real-time transactions.

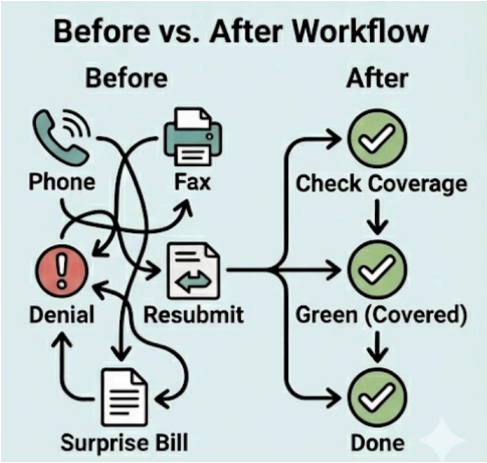
- **Supports AHEAD Multi-Payer Alignment:**
    - Provides standardized administrative transactions across Medicare, Medicaid, and commercial payers.
    - Creates consistent data flows that align with AHEAD's measurement and performance goals.
    - Reduces redundant integrations for providers participating in multiple payers, improving efficiency and care coordination.

- **Operationalizes Prior Authorization Reform:**
    - Enables real-time, electronic prior authorization aligned with Hawai'i's recent legislation and timelines.
    - Improves transparency and reporting for regulatory compliance.
    - Reduces the administrative burden that causes care delays and denials.

- **Enables Sustainable Innovation:**
    - Makes telehealth, mobile care, and community-based models financially viable by ensuring coverage and authorization at the point of care.
    - Strengthens data interoperability in support of future digital health advancements.

States are already moving. The Smart Health Infrastructure Alliance is a growing coalition of states building shared administrative rails through their RHTP plans. Rather than each state building its own solution, Alliance members share core technology and payer integrations—reducing costs and accelerating deployment. From Delaware's public RHTP plan:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations:*** *"This initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN… [It] will dramatically accelerate prior authorization processing… physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange."*



A Day in the Life: Before vs. After

Today: Patient arrives for MRI. Clerk calls insurance and is put on hold for 20 minutes. Faxes 23 pages of clinical notes. Denied 3 days later—wrong form. Resubmit. Approved after 2 weeks. Patient gets surprise bill for $500. Angry call to billing. Staff spend 45 minutes resolving.

With Smart Health Infrastructure: Patient arrives. Clerk clicks "Check Coverage." Screen shows green: *Covered, $20 copay, no prior auth required.* Three seconds. Procedure done. Claim auto-submitted. Paid in 5 days. No surprise bill. No angry call.

That's the difference between 1980s infrastructure and modern rails.

By connecting providers, payers, and patients through a neutral, shared utility infrastructure, states can eliminate administrative waste and simultaneously create the secure foundation for AI, precision medicine, and the next generation of healthcare innovation. **The infrastructure that keeps rural hospitals alive today is the same infrastructure that enables the medical breakthroughs of tomorrow.**

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1. Why This Matters Now

No More Faxes

American healthcare still runs on **9 billion faxes** a year. The average prior authorization still requires **23 pages of faxed documentation**. The fax machine has become the symbol of everything broken in American healthcare.

This isn't a glitch. It's the predictable result of three digital islands that were never designed to connect:

- Clinical data trapped in EHRs
- Payment systems built on 1980s EDI standards
- Patients locked out of their own information

The Result: ***"Hey Doc, we'd love to approve your prior authorization. Can you fax us the clinical notes?"***

The "Bleeding Margin" Reality

Hawaii's rural hospitals are not failing because of poor clinical care. They are failing because of **administrative exhaustion**. A typical Critical Access Hospital:

- Spends **3–4% of net patient revenue** on fax-based insurance communications
- Has billing staff spending **60% of their time** on phone holds, faxes, and resubmissions
- Loses **$150,000+ annually** in pure administrative friction—roughly **three nursing salaries**

For a facility operating on **0.3% margins**, that burden could be the difference between staying open and becoming the next closure.

The Workforce Multiplier

Administrative waste is also a **workforce crisis multiplier**:

- Billing staff burn out chasing faxes and denials
- Clinical staff spend time on prior auth appeals instead of patients
- Rural providers already struggle to recruit staff; every hour of administrative drudgery pushes people toward the exit

Eliminating coverage phone calls and manual eligibility checks saves **2–3 FTEs worth of work**. That's not just cost savings—it's staff who stay. Rural hospitals in Hawaii cannot out-pay urban centers. They must compete on **quality of professional life**. Infrastructure that removes prior-auth phone queues makes Hawaii's rural hospitals more attractive places to work.

The Only Option That Helps Everyone

The options for addressing skyrocketing healthcare costs and budget shortfalls are stark:

Option	Result
Cut clinical care	Harmful to patients
Reduce provider reimbursement	Accelerates rural closures
Shift costs to consumers	Defeats the purpose of healthcare access
Eliminate administrative waste	**The only option that helps everyone**

The Resilience Imperative

The 2024 Change Healthcare cyberattack showed that **administrative infrastructure is critical infrastructure**. When the commercial clearinghouse went down:

- Rural hospitals faced liquidity crises within days
- Providers went weeks without payments
- The breach cost over **$3.09 billion** and affected **100 million** Americans

Clearinghouse rails were built decades ago—COBOL mainframes, 1980s X12 standards, thousands of fragile point-to-point connections. The question isn't *if* another disruption will occur; it's **when**.

When the national clearinghouse failed, Hawaii had no fallback to keep its hospitals paid. By deploying on **modern, shared infrastructure**, Hawaii:

- Moves off fragile 1980s architecture to **cloud-native, zero-trust infrastructure**
- Eliminates the "honeypot"—SHN routes transactions but doesn't store clinical or claims data centrally, so there's no single database to breach
- Treats healthcare administrative rails as **critical infrastructure**—like power, water, and broadband

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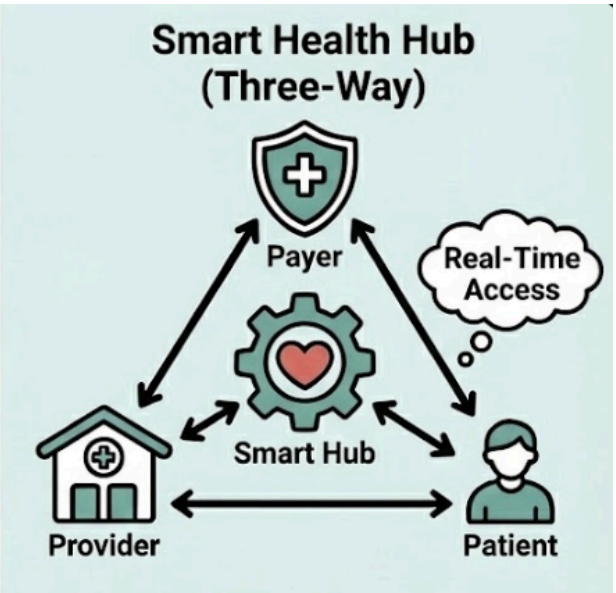
2. The Shared Infrastructure Model

This paper describes how Hawaii can join the **Smart Health Infrastructure Alliance**—a public-private partnership of states deploying shared administrative rails—and connect to the **Smart Health Network**.

A Three-Way Hub

Traditional clearinghouses connect providers to payers and lock patients out. Smart Health Network is different: a **three-way digital hub** connecting providers, payers, **and patients** through neutral, shared infrastructure.



Traditional Clearinghouse	Smart Health Infrastructure
Provider ↔ Payer only	Provider ↔ Payer ↔ **Patient**
Patients locked out	Patients see transactions in real time
"We'll mail your EOB"	Instant visibility into coverage, auths, claims
Information asymmetry	Transparency by design

Why this matters:

- **For patients:** No more playing telephone between doctor and insurer. Track authorization status; see claims before the surprise bill.
- **For providers:** Fewer inbound calls; better-informed patients.
- **For payers:** Transparent transactions; fewer angry "I never knew this was denied" calls.

This isn't just operational efficiency. It's a **philosophical shift**: patients become participants, not afterthoughts.

Proven at Scale

The underlying technology has been validated across:

Metric	Result
Lives processed	**68M+** nationally
Transaction success rate	**99.93%**
Typical transaction time	**<5 seconds**

Metric	Result
Provider savings per claim	**$3.36–$5.75**
Payer savings per claim	**$0.57–$1.65**

This isn't theoretical. The technology is proven at scale. What's new is deploying it as shared state infrastructure through the Alliance and operating it under a neutral Public Benefit governance structure.

A Practical Mechanism for Payers and Providers to Work Together

Today, health plans and providers both want to reduce administrative waste—but they lack a practical way to do it together. The friction isn't anyone's strategy; it's an accident of incompatible systems built over decades. Both sides lose:

- Providers spend 25–30% of revenue on billing, prior auth, and collections
- Payers spend billions on claims processing, denials management, and manual review
- Neither can unilaterally fix infrastructure that requires both sides to connect

SHN operates as **neutral infrastructure**—not a vendor selling to one side, but a utility serving both.

One Backbone, Many Nodes

By joining the Alliance, Hawaii connects to a **single national backbone** for identity, coverage, and administrative transactions. Each state configures its node to local rules; all states share core technology and payer integrations.

Payers integrate **once** and reach every Alliance state. Development costs are **shared**, not duplicated.

How This Differs from EHR Vendor Solutions

"Doesn't Epic already do this?" It's the most common question—and the answer matters for rural providers.

EHR-native automation works inside one ecosystem. Large EHRs' prior auth tools work well for same-vendor transactions. But a Critical Access Hospital on MEDITECH can't use Epic's automation. A rural clinic on athenahealth can't tap into Cerner's payer connections.

Rural providers run diverse systems. Hawaii's rural landscape includes MEDITECH, CPSI, athenahealth, eClinicalWorks, and dozens of smaller platforms. No single EHR vendor serves them all—and none has an incentive to build cross-platform interoperability.

Connect Once, Reach Everyone

Payers need a single integration point. Today, a payer maintaining connections to 50 different provider systems bears 50x the integration cost. SHN gives payers one connection that reaches all participating providers, regardless of EHR.

Providers need a single integration point too. Today, a rural hospital juggles dozens of payer portals—each with different logins, workflows, and quirks. SHN gives providers one connection that reaches all participating payers, eliminating portal fatigue.

	EHR Vendor Tools	Smart Health Network
Works across EHR platforms	❌	✅

	EHR Vendor Tools	Smart Health Network
Single payer integration point	❌	✅
Single provider integration point	❌	✅
Available to CAHs and small practices	Limited	✅
Patient visibility	Varies	✅
Neutral governance	❌ Vendor-controlled	✅

SHN doesn't compete with EHRs—it connects them. Large systems with Epic can participate if they choose. But the primary value flows to the providers who need it most: the rural hospitals and independent practices running fragmented legacy systems without IT departments to build their own integrations.

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3. Enabling Hawaii's RHTP Goals, AHEAD Implementation, and Prior Authorization Reform

Hawai'i's Rural Health Transformation Plan (RHTP) is rooted in the **five federal strategic goals** of the Rural Health Transformation Program:

1. **Support rural health innovations and new access points** to improve preventive health and address root causes of disease.
2. **Sustainable access** by strengthening efficiency, coordination, and continuity of care.
3. **Workforce development** by attracting and retaining clinicians and supporting expanded roles.
4. **Innovative care models** that improve outcomes and lower costs.
5. **Technology innovation** to enhance care delivery, data sharing, and digital access. Engage Hawai'i+1

At the same time, Hawai'i is advancing complementary statewide initiatives — **participation in the AHEAD (Achieving Healthcare Efficiency through Accountable Design) multi-payer model** and comprehensive **prior authorization reform legislation** — that align with RHTP's strategic direction and require durable administrative infrastructure to succeed.

Smart Health Infrastructure provides that **unified administrative backbone** — enabling real-time, standards-based coordination among payers and providers — and supports Hawai'i's RHTP goals, AHEAD implementation, and operationalization of prior authorization policy.

A. Supporting RHTP Strategic Goals with Smart Health Infrastructure

RHTP Goal 1: Rural Health Innovation & New Access Points
Smart Health Infrastructure enables *emerging models of care* (e.g., telehealth, mobile clinics, community paramedicine) by providing real-time coverage verification, authorization, and claims submission at the point of service. This reduces administrative friction that otherwise limits innovation and patient access across neighbor islands.

RHTP Goal 2: Sustainable Access
Administrative inefficiency — including manual eligibility checks and delayed prior authorization decisions — undermines provider financial stability and continuity of care. A shared administrative utility streamlines

eligibility, prior authorization, and claims processes for rural providers, improving cash flow and reducing barriers to offering sustainable services.

RHTP Goal 3: Workforce Development
Much of the administrative burden in rural settings falls on clinicians and support staff, detracting from patient care and contributing to burnout. Automating administrative transactions lets clinicians spend more time on clinical activities, increases job satisfaction, and supports retention in hard-to-staff areas.

RHTP Goal 4: Innovative Care Models
Smart Health Infrastructure accelerates adoption of value-based care, population health solutions, and coordinated care pathways by ensuring consistent, standardized administrative data exchange across payers — a foundational requirement for measuring outcomes and aligning incentives.

RHTP Goal 5: Technology Innovation
By supporting real-time connectivity across eligibility, benefits, authorizations, and claims, Smart Health Infrastructure aligns with RHTP's emphasis on technology-enabled care delivery, data security, and digital health access — enabling rural providers to leverage digital tools without multiple bespoke integrations. CMS

B. Enabling Hawai'i's AHEAD Multi-Payer Model Participation

The **AHEAD model** (Achieving Healthcare Efficiency through Accountable Design) is Hawai'i's multi-payer effort to improve care coordination, reduce cost growth, and equitably improve outcomes across Medicare, Medicaid, and commercial payers. Successful AHEAD implementation relies on *consistent, standardized, transparent administrative data exchanges* that support shared measurement and aligned payment strategies.

Smart Health Infrastructure contributes by:

- **Standardizing administrative transactions across all participating payers**, improving comparability of utilization and outcomes data.
- **Providing a shared, centralized administrative layer** that reduces redundant integration costs for providers and supports coordinated care across payment models.
- **Creating data flows that enhance evaluation of performance indicators** tied to AHEAD goals, including preventive care uptake, chronic disease outcomes, and cost trends.

By aligning administrative infrastructure with AHEAD's design goals, Hawai'i strengthens its ability to meet multi-payer performance metrics while improving provider experience and patient access.

C. Operationalizing Hawai'i's Prior Authorization Reform

Hawai'i's recent prior authorization reform legislation aims to *reduce administrative burden, increase transparency, and ensure timely decision-making* across payers. Legislative success requires infrastructure that can execute on these policy objectives in practice — beyond establishing requirements on paper.

Smart Health Infrastructure enables:

- **Real-time, standards-based prior authorization** submissions and responses (e.g., leveraging advanced electronic prior authorization standards), reducing delays and administrative labor.

- **Timeframe tracking and analytics** to demonstrate compliance with statutory requirements and support ongoing reporting and oversight.
- **Transparent, standardized processes** that improve predictability for providers and patients, helping reduce care delays and denials.

This infrastructure directly enables the law's policy objectives, supporting efficient utilization review and compliance.

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4. Creating an Integrated Foundation for Long-Term Impact

Smart Health Infrastructure unifies eligibility verification, prior authorization, claims routing, and payment reconciliation into a **shared state-scale administrative layer**. This foundation:

- **Reduces fragmentation across payers**, critical in Hawai'i's multi-plan environment.
- **Supports real-time decision-making at the point of care**, enhancing access and reducing administrative delays that disproportionately affect rural/neighbor-island patients.
- **Enables scalable, sustainable models of digital health and care coordination**, aligned with RHTP, AHEAD, and legislative goals.
- **Strengthens data transparency for policy, planning, and quality measurement**, advancing equity and outcomes tracking across rural populations.

Summary

Smart Health Infrastructure is more than a technology project — it is a **strategic enabler** of Hawai'i's RHTP vision. By directly advancing RHTP's strategic goals, operationalizing AHEAD's multi-payer alignment, and fulfilling the practical requirements of prior authorization reform, this infrastructure accelerates transformation, reduces administrative burden, and enhances equitable access to quality care across Hawai'i's rural and neighbor-island communities.

States Are Already Moving

Several states have included participation in the Smart Health Infrastructure Alliance as a core element of their RHTP strategies. Delaware's published RHTP plan provides a template:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations***
>
> **Description:** Nationally, insurance verification and prior authorization requirements delay treatment for 89% of patients, causing unnecessary stress, administrative delays, and, in some cases, poor health outcomes – with rural providers facing particularly severe impacts due to limited staff and resources. Rural patients face compounded challenges from prior authorization delays when treatment requires specialist referrals, or transportation barriers mean multiple trips for authorization-related appointments, leading some patients to abandon treatment entirely.
>
> In August 2025, Delaware enacted the Pre-Authorization Reform Act (SB 12) to reduce administrative burdens, improve patient access to timely care and increase transparency in the pre-authorization process. The law establishes processing time limits (2-48 hours), requires electronic provider portals by 2027, limits prior authorizations to one per care episode, and

mandates that denials are made by qualified, non-financially incentivized physicians with detailed justifications reported to the Delaware Health Information Network (DHIN).

To fully realize SB12's promise and address persistent connectivity gaps in rural Delaware, this initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN. This electronic health information exchange will dramatically accelerate prior authorization processing by allowing providers to exchange data electronically and allowing payers to report faster authorization decisions. Cloud-based infrastructure will minimize maintenance and operations management, while vendor-neutral standards will prevent vendor lock-in and stakeholder councils will ensure fair governance. By building streamlined conduits for data transmission, physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange. The state will track key health metrics including reduced readmissions, increased preventive care utilization, improved chronic disease management, enhanced behavioral health coordination, reduced provider burnout, increased value-based care participation, and lower total cost of care.

Main strategic goal: Tech Innovation

Key stakeholders: Smart Health Network, DHIN, DHSS, DPH Office of Provider Resources, Provider Organizations, payers, Medicare, Health Systems, VA

Outcomes:

- Reduction in elapsed time for response to prior authorization request (Target: 75% reduction by Year 3)
- Reduction in first pass denials related to coverage errors (Target: 90% reduction, initially 15-20% to less than 2% by Year 3 for enrolled payers)
- Rural healthcare provider adoption (Target: Year 1 at 30%+, Year 2 at 55%+, Year 3 at 70%+, Year 4 at 80%+, Year 5 at 90%+)
- Clean claims rate (Target: Year 3 at 85%, Year 5 at 90%+)
- Patient portal launch by year 3 (Target: patient adoption of 30% by Year 5)

Estimated Required Funding: $50 million over 5 years

Sustainability plan: After initial implementation, the model will break even in Year 4 and become fully self-sustaining in Year 5 through a utility fee model of 0.05% of revenue equally applicable for all payer and provider participants – including state agencies, state Medicaid programs, rural and non-rural healthcare providers, and public (including Medicare) and private insurers.

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4. How It Works in Hawaii

What Deploys in 90 Days

In the first **90 days**, Hawaii completes a **Phase 1 technical stand-up**—the core infrastructure is configured, tested, and connected to initial payers.

In scope for 90-day stand-up:

- **Identity Service** — secure, cross-participant patient matching

- **Coverage Direct** — real-time eligibility verification ("Is this patient covered? What's the copay? Does this need prior auth?") in **under 3 seconds**
- **Initial payer connections** — 3-4 payers representing >50% of Hawaii's covered lives

What happens after 90 days: - Provider onboarding ramps over Months 3–12

- Additional payers added as LOIs convert to live connections
- Real-time claims routing (Phase2) begins Month 6

Because Hawaii uses the same standardized node as other Alliance states, implementation is **configuration, not custom code**. This is a proven SaaS platform, not a build-from-scratch project. That's why 90 days is realistic for technical stand-up—while recognizing that adoption scales over the following year.

In other words: 90 days gets Hawaii live and connected; full provider adoption is a 12–24 month change-management effort.

The Deployment Roadmap

Phase	Timeframe	Capabilities	RHTP Alignment
1	Months 1–6	Identity + Coverage	Financial stabilization
2	Months 6–18	Claims Workflow	Operational efficiency
3	Months 12–24	Prior Auth Automation	Workforce retention
4	Months 18–36	Patient Access Platform	Care coordination
5	Months 24–48	Analytics & VBP Support	Value-based payment readiness

RHTP funds support Phases 1–3. Phases 4–5 are funded through the utility model once volume reaches sustainability.

Each phase turns on **when Hawaii is ready**, not on a fixed national schedule.

Rural providers see value in Month 1, not Year 3.

Voluntary Adoption — No Mandates

Participation is entirely voluntary. There are **no new mandates and no penalties**, and with RHTP underwriting first-year fees, rural providers see savings from day one. Adoption spreads because it works and delivers value—not because the government requires it.

Practical on-ramps:

- RHTP underwrites first-year fees for rural providers—no upfront cost
- Existing EHR workflows preserved—SHN integrates with current systems
- Quarterly ROI reports show each provider their savings

EHR Integration: Who Pays What

Rural providers often face "connection fees" from their EHR vendors to enable new integrations. Left unaddressed, these fees can block adoption.

RHTP funds cover:

- SHN node configuration and connection
- Provider onboarding and training
- First-year utility fees for rural providers
- EHR vendor integration fees for participating rural providers (where applicable)

Providers are responsible for:

- Staff time for training (typically 2–4 hours)
- Ongoing utility fees after Year 1 (offset by proven savings)

By covering EHR vendor fees through RHTP, Hawaii removes the most common barrier to rural provider adoption.

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5. The Business Model

The Transaction Economics

Transaction Type	Legacy Process	With SHN
Eligibility verification	Phone call, 8–12 minutes	Real-time API, <3 seconds
Prior authorization	Fax + phone, 3–14 days	Instant or hours where clinical review needed
Claim submission	$25–$30 per claim (manual)	$0.30–$0.50 per claim
Denial / resubmission	$30–$50 per rework episode	Largely eliminated via accurate coverage info & clean claims

The Utility Fee Model

0.05% of revenues from each party — payer pays 0.05%, provider pays 0.05%, total system fee is 0.10%.

Transaction Value	Payer Pays	Provider Pays	Total
$1,000 claim	$0.50	$0.50	$1.00
$10,000 procedure	$5.00	$5.00	$10.00

Why the Math Works—For Everyone

	Per Claim	On 1M Claims/Year
Provider savings (proven)	$3.36–$5.75	$3.36M–$5.75M
Payer savings (proven)	$0.57–$1.65	$570K–$1.65M

Both sides save more than they pay. Savings from the coverage solution alone—reducing first-pass denials for providers and coordination of benefits for payers—more than justifies the entire utility fee. Every additional capability (prior auth, claims automation) increases ROI.

No hidden costs:

- The 0.05% utility fee is all-in—no additional per-transaction charges
- No provider integration or upgrade fees
- No new state appropriations required post-RHTP

The Opportunity for HIE Sustainability

Hawaii has invested in building HHIE as essential health information infrastructure. Like HIEs nationwide, HHIE was built with federal grants and state investment to move clinical data—lab results, discharge summaries, care plans. But clinical data exchange doesn't generate sufficient sustainable revenue:

- Providers benefit but resist paying subscription fees
- Payers benefit but view HIE connectivity as a provider responsibility
- The result: perpetual grant dependency, uncertain year-to-year funding, inability to invest long-term

SHN creates an opportunity: **add a revenue-generating layer** that sustains the entire operation. When eligibility, prior auth, claims, and payment flow through the same infrastructure as clinical data, **utility fees from administrative transactions can sustain the entire operation**.

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6. Governance & Accountability

Built for Perpetual Independence, Neutrality & Sustainability

The Neutral Operator. Smart Health Network operates as a Public Benefit Corporation—legally required to balance public mission with sustainability. The "No Raw Data" rule prohibits accessing or monetizing patient data.

The Mission Guardian. An independent Benefit Trust governs the PBC, ensuring it remains true to its public mission. The Trust holds "Golden Share" rights preventing any sale or merger that would compromise the network's role as permanent public utility.

Multi-Stakeholder Governance

Governance is structured to ensure representation across all sectors of healthcare:

Council	Representation
Members' Council	Patients and families
Provider Council	Physicians, nurses, clinicians
Care Delivery Organizations Council	Health systems, medical groups, FQHCs
Payer Council	Insurers, employers, government payers
Public Health Council	Health departments, community health
Research Council	Academic centers, researchers
Technology & Innovation Council	Digital health, EHRs, cloud & AI platforms
State Advisory Councils	Local stakeholder input and compliance oversight

This structure ensures the infrastructure serves everyone equally—permanently.

Hawaii Voice

Each participating state appoints a representative to its **State Advisory Council** with input on:

- Data privacy rules

- Network policies
- Roadmap priorities

No Lock-In

State officials rightly worry about vendor lock-in. This infrastructure eliminates that concern:

- **Built on open FHIR standards** — not proprietary protocols
- **Data stays at endpoints** — Hawaii never surrenders data to a central repository
- **Portable by design** — if better infrastructure emerges, Hawaii can unplug without losing data

This is not a walled garden. It's a reversible infrastructure choice.

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7. Data & Security

Hawaii data remains under Hawaii's legal and regulatory control. SHN is a trust fabric, not a data platform—it routes transactions but doesn't store clinical or claims data centrally.

Key architecture principles:

- **No honeypot.** Unlike centralized clearinghouses, there's no central database to breach. Data stays at the endpoints.
- **Zero-trust.** Every transaction authenticated and authorized independently.
- **Cloud-native.** Modern infrastructure, not legacy COBOL mainframes.
- **Resilience.** Because SHN routes transactions without storing claims or clinical data, a breach in one participant does not compromise the entire network.
- **Compliance:** SOC 2 Type II certified, HITRUST CSF aligned, HIPAA BAAs with all participants.

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8. Next Steps

1. **Review alignment** — Map to Hawaii's RHTP application and priorities
2. **Convene stakeholder discussion** — RHTP leadership, HHIE, SHN, key providers & associations, major payers
3. **Develop implementation plan** — Hawaii-specific timeline, budget, and milestones

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The Fax Machine Era Is Over.

For more information: Smart Health Network: info@smarthpbc.net

Smart Health Infrastructure Alliance

Ending the $1 Trillion Administrative Crisis

Building the Foundation for Healthcare's Digital Future

Smart Health Infrastructure Alliance & RHTP

The Smart Health Infrastructure Alliance is a growing coalition of states implementing shared administrative rails through their RHTP plans. Rather than each state building its own solution, Alliance members share core technology and payer integrations - reducing costs and accelerating deployment. From Delaware's public RHTP plan:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations:*** *"This initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN... [It] will dramatically accelerate prior authorization processing... physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange."*

Why Does Healthcare Send 9 Billion Faxes & Waste $1 Trillion on Admin?

We built 3 separate digital islands that don't connect:

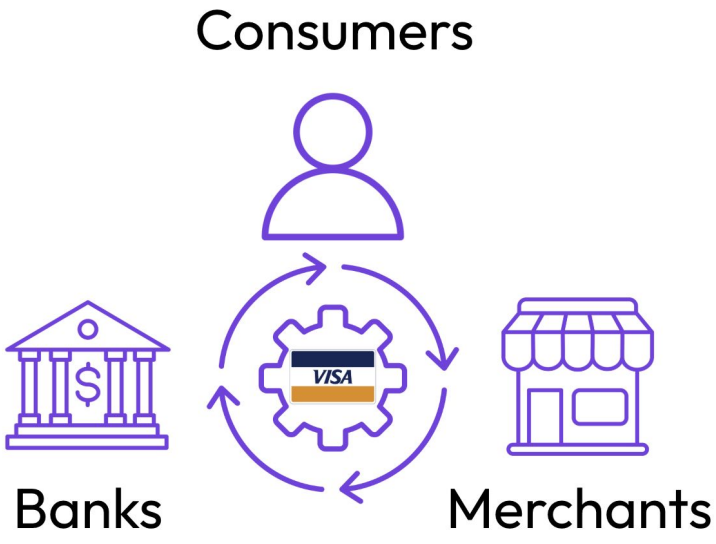
Clinical Island - Holds all the medical data in EHRs - but can't transmit it to payers when payment decisions are made.

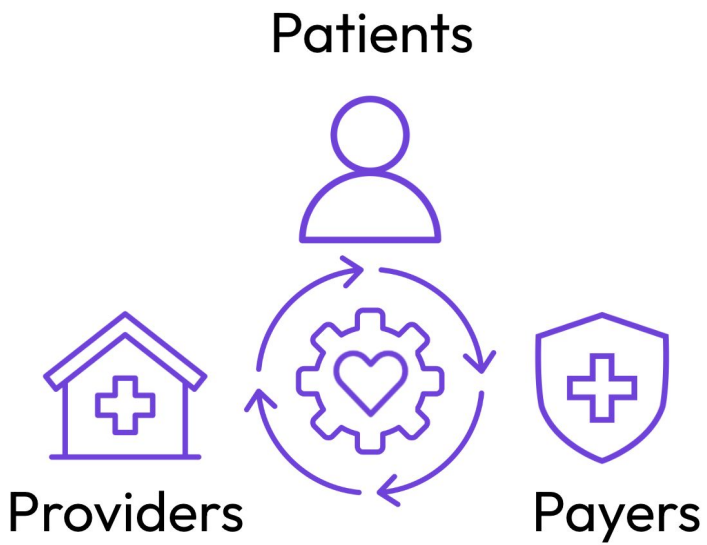
Administrative Island - Uses fragile 1980s tech to processes eligibility, prior auth, and claims - but without any clinical context, forcing manual back-and-forth.

Consumer Island - Leaves patients in the dark, unable to access their data or see their coverage, authorizations or costs.

"Hey Doc, we'd love to approve your prior auth. Can you fax us the clinical notes?"

VISA Connects Banks + Merchants + Consumers

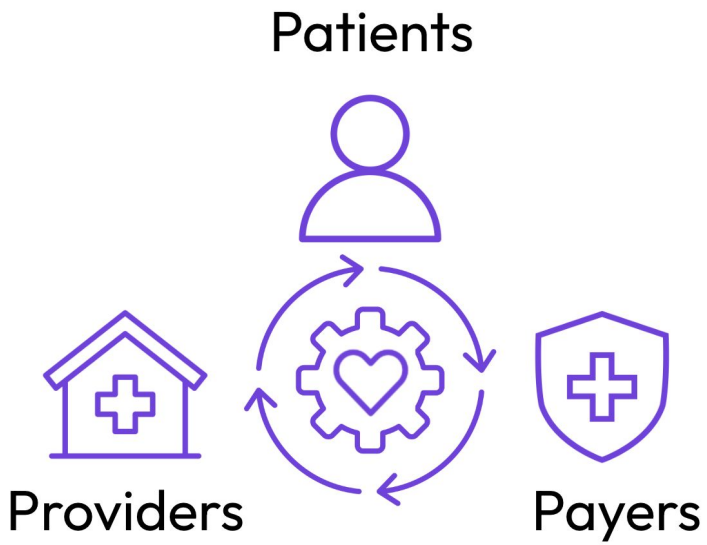




We’re connecting Providers + Payers + Patients for the first time.

Connect Once, Reach Everyone

- Decisions in seconds instead of days or weeks
- Fewer first-pass denials, faster payments
- Dramatically lower processing costs for everyone
- Complete visibility for patients

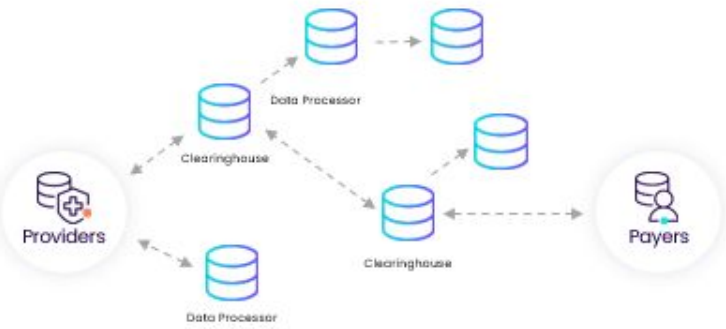


Operated as a Common Utility

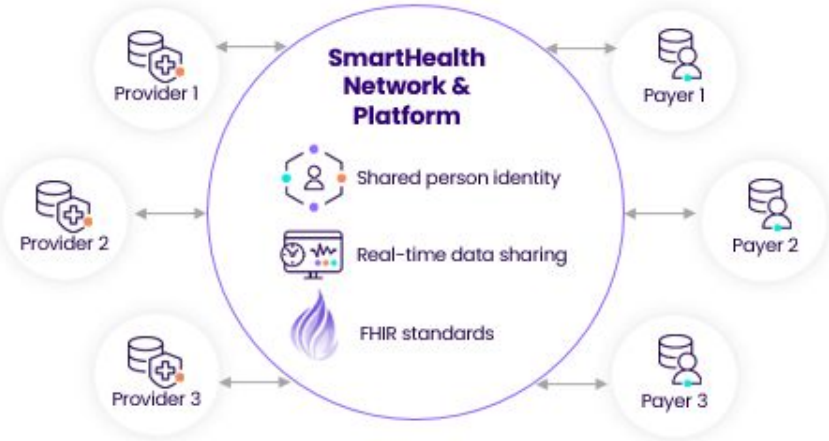
Our modern approach to interoperability

Smart Health Network
Public Benefit Corporation

Current Industry Approach



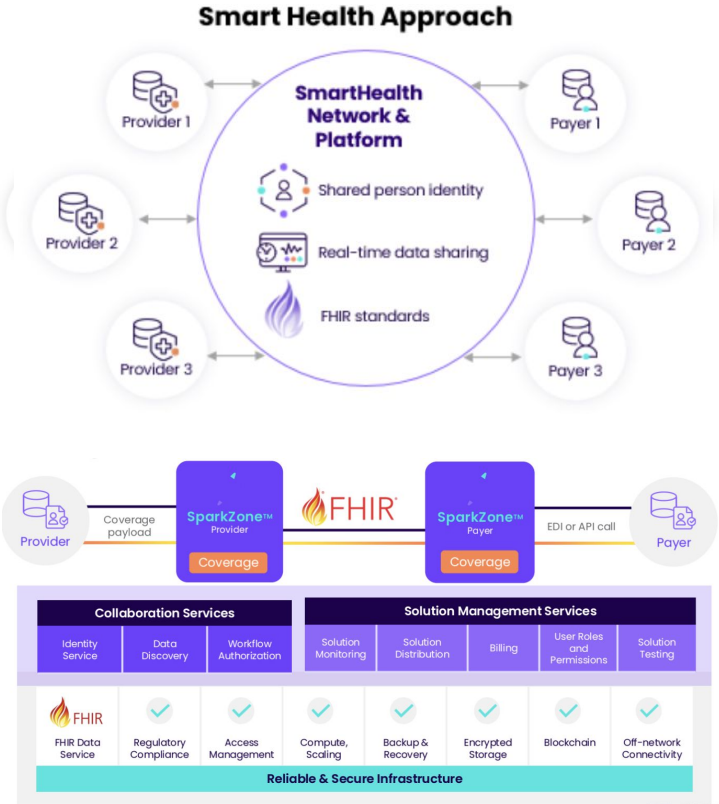
Smart Health Approach



Many point-to-point connections	→	Connect once to many
Data copied & aggregated	→	Retain control using your own encryption keys, no centralized aggregation
Security determined by intermediary	→	Granular permissioned access
Aged data presented to portals	→	Real-time updates published to source systems

This isn't Theoretical. It's Already Built and Proven.

- Proven across **68M+ lives** connected with real-time identity & coverage
- Claims processing with **99.93% success in <5 seconds**
- **Proven ROI:** Providers save $3.36-$5.75 per claim. Payers save $0.57-$1.65
- Modern, federated architecture
- Secure, resilient, scalable
- AI native



Simple Utility Fee: 0.05% of Revenue for Payers and Providers Free for Patients

Savings from coverage solution alone – reducing first-pass denials – more than justifies utility fee. Every additional use case increases ROI.

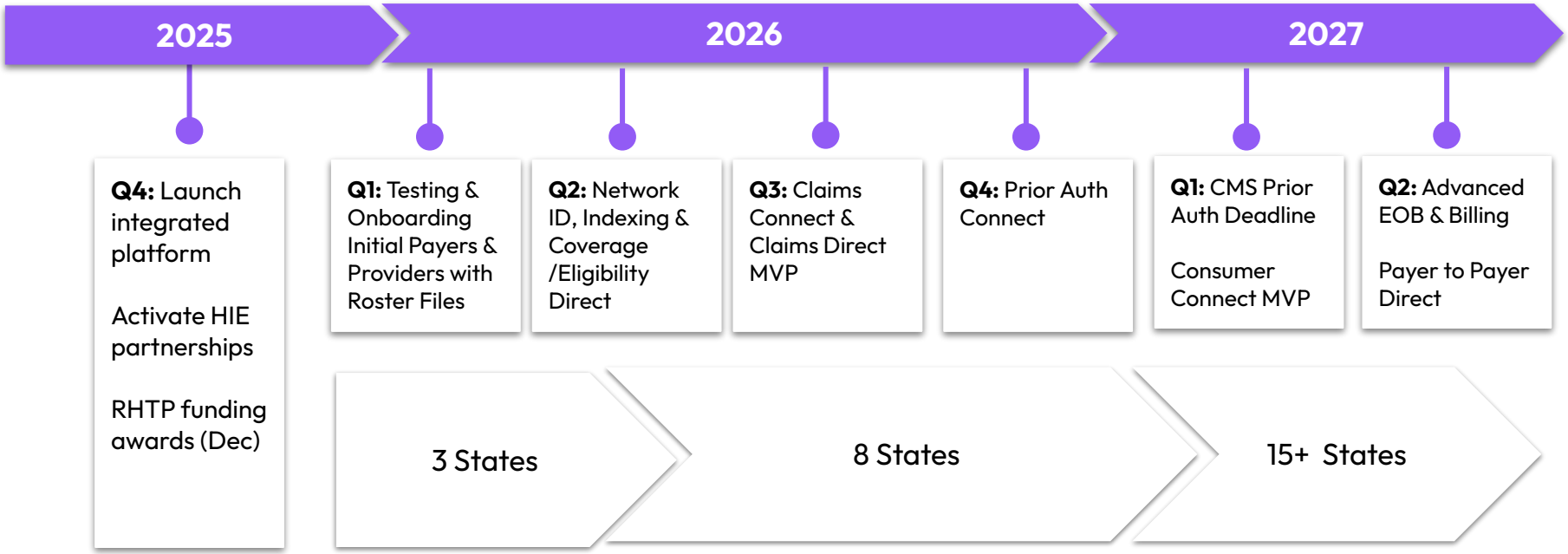
Provider Savings
Immediate Savings ($3.36-$5.75 per claim): • Administrative savings, reduced rework of denials • Reduction in claim write-offs from payers • Reduction in patient bad debt, overall uncompensated care • Avoided retroactive prior authorizations • Reduced clearinghouse costs

Payer Savings
Immediate Savings ($0.57-$1.65 per claim): • Administrative savings • Claim adjudication & manual verification • Call center savings • Discovery of coordination of benefit (COB) leads • Reduced recovery costs (payment integrity) • Reduced clearinghouse costs

Sample Health System ROI	
Revenue	$1B
Utility Fee (0.05%)	$500K
Annual Claims	2M
Savings	$6.72M - $11.5M
ROI	**13.4X - 23X**

Sample Health Plan ROI	
Revenue	$10B
Utility Fee (0.05%)	$5M
Annual Claims	30M
Savings	$17.1M - $49.5M
ROI	**3.5X - 9.9X**

Planned Product & Onboarding Roadmap



Building on the HIE Foundation

In many states, Health Information Exchanges provide the connectivity backbone for clinical data sharing. The Alliance completes this infrastructure by adding three critical components:

- **Administrative Transactions.** HIEs move clinical documents. The Alliance adds business transactions—claims, prior authorizations, eligibility - creating complete infrastructure.
- **Patient Access.** Traditional HIEs serve providers and payers. The Alliance includes patients as active participants with full visibility into their health data and transactions.
- **Sustainable Revenue.** The simple utility fee sustains both new infrastructure and existing HIE capacity, reducing reliance on cyclical grants.

The model leverages existing investments while ensuring permanent sustainability.

Public Benefit Utility Structure

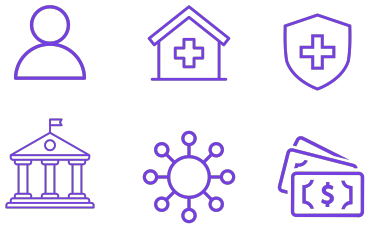
Stakeholder Councils

- Patients
- Providers
- Payers
- Public Health

Smart Health
Benefit Trust

Smart Health
Public Benefit Corporation

State / Community Councils

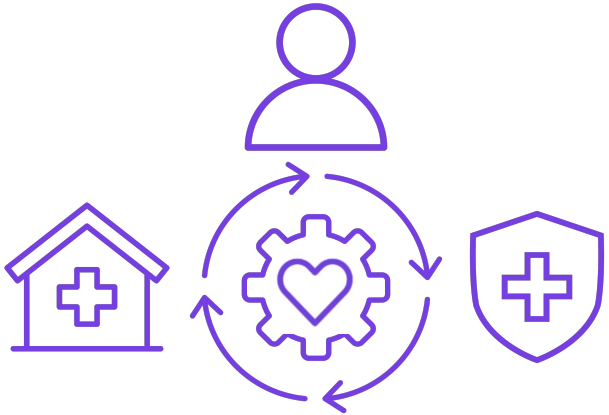


Our mission is to make better health easier for everyone. We do this by building shared digital infrastructure that empowers people, takes away friction, and lowers costs for all.

Our highest duty is to the people and communities we serve.

Smart Health Network

Public Benefit Corporation



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