

Primary Care AHEAD Overview

Steering Committee Education Session

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MAY 6, 2025

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Limitations

- This project is performed under the Actuarial Services Contract (contract #MQD-2024-008) between Milliman and the State of Hawai'i Med-QUEST Division (MQD) dated July 1, 2024.
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- This presentation and Q&A is not intended to be an actuarial opinion or advice, nor is it intended to be legal advice.
- In preparing this presentation, we relied on data and information from the Centers for Medicare and Medicaid Services (CMS), the State of Hawai'i, and publicly available sources. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the information we present may likewise be inaccurate or incomplete.

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AHEAD Background



Key Components of AHEAD

The AHEAD model framework consists of three components to meet statewide accountability targets to improve health care outcomes while controlling overall growth in health care costs

Primary Care AHEAD



Increases primary care investment through provider payments and program alignment to reach care transformation goals

Hospital Global Budgets



Provides hospitals with fixed revenue for a specific patient population to encourage care coordination management of preventable hospitalizations

Cooperative Agreement Funding



Funding provided by CMS to support initial investments during the pre-implementation period and initial performance years

Statewide Accountability Targets



CMS and State agreed-upon targets to control the total cost of care growth in Medicare specifically, and supported by a calculation across all payers

Primary Care AHEAD Overview



Background

CMS intends for primary care to be the central focus for various programs

To achieve reductions Total Cost of Care (TCOC) growth, CMS is creating Primary Care Investment guidelines.

Primary Care AHEAD serves as the main alignment mechanism for the various payers within a state (Medicare, Medicaid, and commercial) and allows smaller practices such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Providing an enhanced, up-front payment to providers allows them to engage in care transformation activities such as:

- Behavioral health integration
- Care management & specialty coordination
- Addressing health-related social needs



Increase primary care investment



Enable care transformation activities



Increase quality and population health outcomes

Source: <https://www.cms.gov/files/document/ahead-primarycare-fs.pdf>

Primary Care AHEAD Practice Eligibility and Participation Requirements

Who can participate?	Participation Requirements
<ul style="list-style-type: none">▪ Primary care practices, Federally Quality Health Centers (FQHCs), and Rural Health Clinics (RHCs) that are located in Hawai`i and that are eligible to bill Medicare▪ If owned by hospital system, the hospital must participate in hospital global budget <p><i>NOTE: As CMMI is ending the Primary Care First (PCF) demonstration 12/31/2025, practices participating in PCF are eligible for Primary Care AHEAD</i></p>	<ul style="list-style-type: none">▪ Participate in the Medicare FFS Enhanced Primary Care Payment▪ Participate in the Medicaid Primary Care Advanced Payment Model▪ Implement Care Transformation Requirements

Source: NOFO

Primary Care AHEAD Roles

Program Element		CMS Role	MQD Role
Provider Support	Primary Care Practice Participation	Develop and oversee Participation Agreements with primary care practices	Recruit primary care practices to participate in AHEAD
	Technical Assistance	Provide technical assistance to participating primary care practices (HRSN screening, quality measurement, demographic data collection)	Provide technical assistance to participating primary care practices for the Medicaid Primary Care APM
Program Development and Operations	Medicare FFS Enhanced Primary Care Payment (EPCP)	Develop and operate	Provide input to CMS on measures
	Medicaid Primary Care APM	Approve regulatory pathways	Develop and operate
	Care Transformation Requirements (CTRs)	Establish CTRs	Provide input to CMS to align CTRs with Medicaid Managed Care Quality Strategy
	Alignment with Commercial Plans (Optional)	Provide technical assistance to Hawai'i in pursuing alignment with commercial payers	Pursue alignment with commercial plans, including but not limited to Medicare Advantage products

■ Leading
 ■ Providing Input
 ■ Assisting

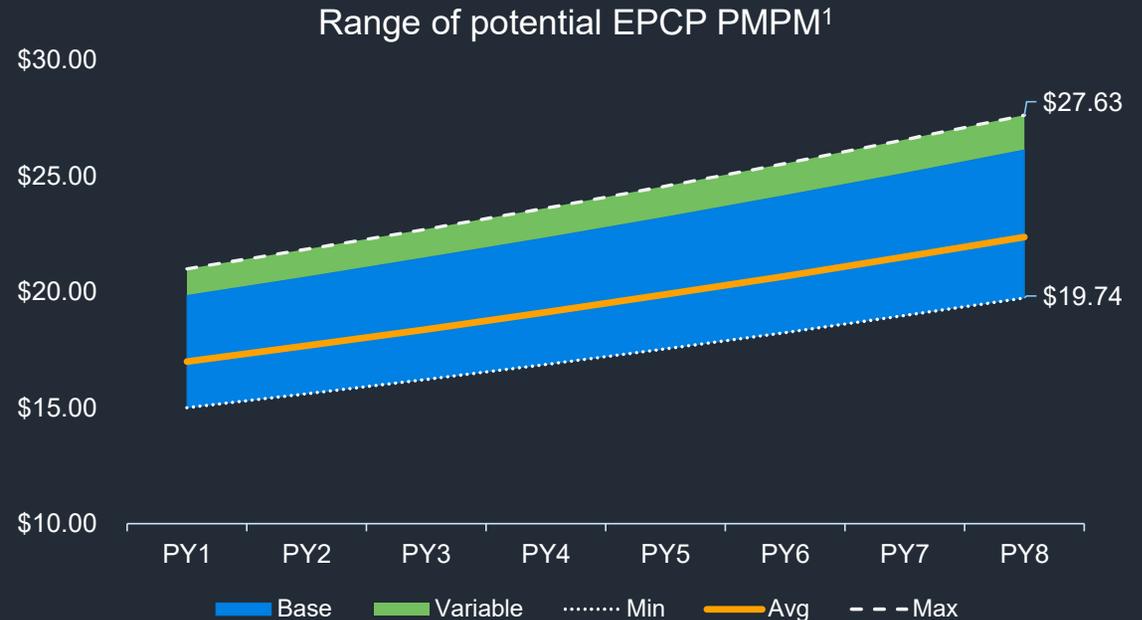
Medicare FFS Enhanced Primary Care Payment



EPCP Overview

Enhanced Primary Care Payment (EPCP) is a care management fee applicable to Medicare FFS beneficiaries. Each practice's EPCP is set annually based on the social and medical risk of attributed patients.

- The EPCP paid to each recruited practice will vary based on the social and medical risk of its assigned patients.
 - The NOFO targeted an average EPCP of \$17 for PY1, but this amount is subject to negotiation.
 - If EPCP is set at \$17, a practice could receive between \$15 and \$21
 - EPCP increases annually with inflation
- Payments are made prospectively and quarterly based on practice-level attribution
- A portion of the EPCP will be at risk based on quality performance, starting at 5%, but increasing to 10% over time
- Average EPCP may be adjusted up or down based on changes in total cost of care
- Practices receiving EPCP cannot bill for "overlapping" care management services (codes to be provided by CMS)



¹ Chart is currently modeled with 4% annual growth. Actual EPCP trend will vary

EPCP Quality Measures

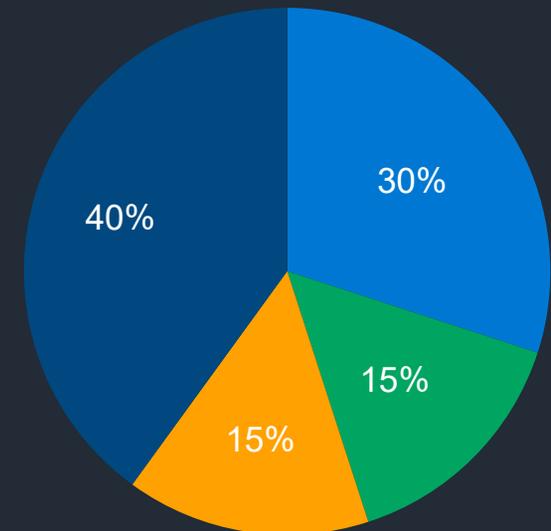
Participant Primary Care Practices will be accountable, through the EPCP, for performance on a set of at least 5 measures

Domain	Measure	Data Source ¹
Behavioral Health <i>Required</i>	<ul style="list-style-type: none"> Preventive Care and Screening: Screening for Depression and Follow-Up Plan 	eCQM
Prevention & Wellness <i>State chooses at least 1</i>	<ul style="list-style-type: none"> Colorectal Cancer Screening Breast Cancer Screening: Mammography 	eCQM
Chronic Conditions <i>State chooses at least 1</i>	<ul style="list-style-type: none"> Controlling High Blood Pressure Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) 	eCQM
Health Care Utilization <i>Required</i>	<ul style="list-style-type: none"> Emergency Department Utilization Acute Hospital Utilization 	Claims

- Hawai'i can customize some measures, and others are required.
- Hawai'i may propose alternative measures to align with other ongoing state efforts. Potential measure replacements, should align to the domains below or to Model goals broadly.

Quality Measure Domains

- Behavioral Health
- Chronic Conditions
- Prevention & Wellness
- Hospital Utilization



¹ NOFO says "More information on health IT requirements for quality reporting under Primary Care AHEAD is available upon request."

Interactions with State-level TCOC and Primary Care Investment Targets

The AHEAD program has both a Medicare FFS and All-Payer TCOC growth target

An additional amount of the EPCP may be at risk based on the state's TCOC performance regardless of provider level attribution

States are required to define their TCOC growth targets for both Medicare and All-Payer

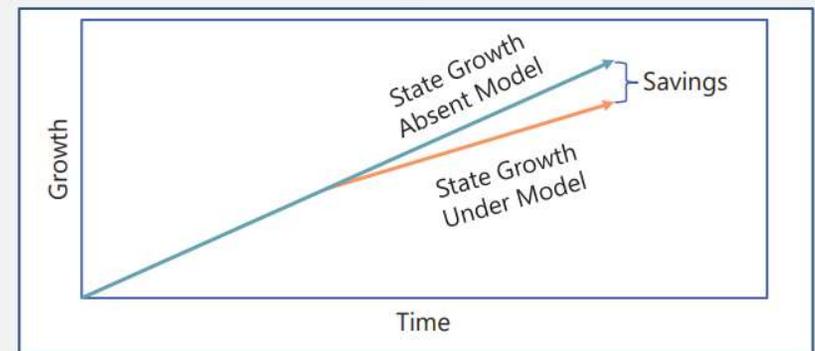
TCOC includes any investments in primary care

- Payments made through the EPCP will increase the TCOC growth directly
- “Overlapping” care management fees are no longer paid which will reduce TCOC growth

Improvements to health outcomes will prevent higher costs (e.g., hospitalizations and emergency visits)

Medicare FFS TCOC Targets

Medicare TCOC Growth and Savings to CMS Under the AHEAD Model



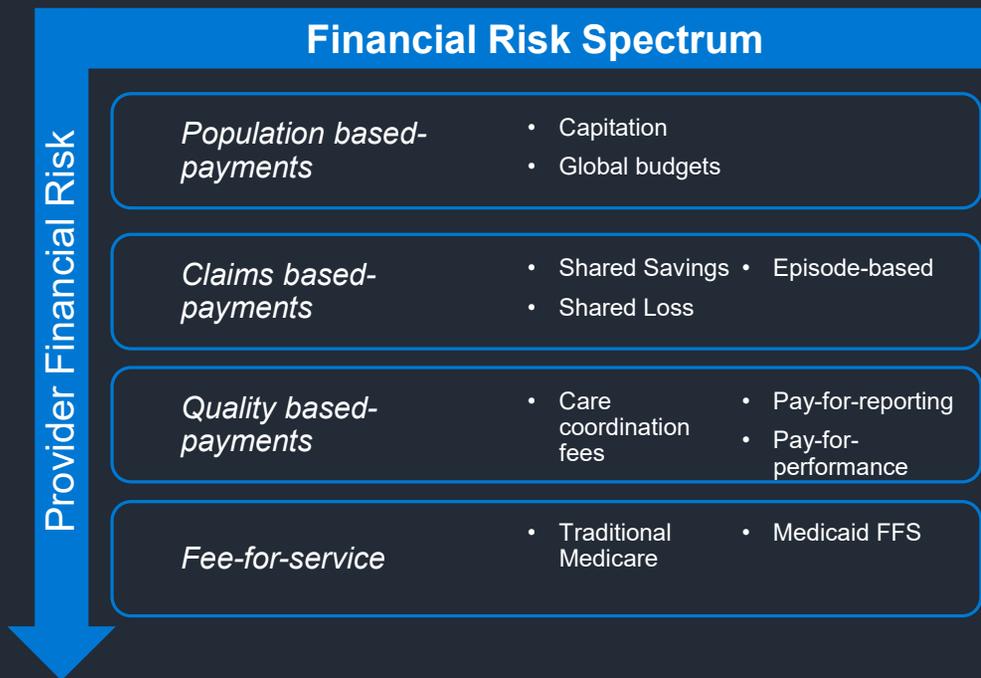
- Maryland and Vermont are using a 2023 baseline (PMPY cost)
- Trends are based on a blend of the USPCC and AHEAD ACPT², adjusted for state-specific savings targets
- There are provisions to adjust if expected trend differs greatly from experience

APM for Primary Care



Building Blocks of a Primary Care APM

When thinking about APM strategy across Medicare FFS, Medicaid, and Commercial, distinct features of an APM can be leveraged to foster alignment. Populations served by different payer types have unique healthcare needs so the building blocks of an APM do need not to be identical for programs to be aligned



Any financial risk track above fee-for-service will require several program details to be aligned with program success, likely leveraging the HMSA model. It may be important to understand variance across MCOs or establish:

- **Attribution:** Impact of using a single approach to attribution
- **Financial Benchmark:** Determine financial targets for uniform comparisons
- **Risk Adjustment:** Accounting for varying severities
- **Quality:** Metric selection and target setting
- **Performance period:** Baseline period and frequency of measurements
- **Payment period:** Timing for receipt of variable incentives

HCP-LAN APM Categories

The Healthcare Payment Learning and Action Network (HCP-LAN) APM categories create standard language when discussing an APM, and can be used as a framework to align on level of risk and the components that will be at risk

<p>Category 1</p> <p><i>Fee for service – no link to quality & value</i></p>	<p>Category 2</p> <p><i>Fee for service – link to quality & value</i></p>	<p>Category 3</p> <p><i>APMs built on fee-for-service architecture</i></p>	<p>Category 4</p> <p><i>Population-based payment</i></p>
	2A	3A	4A
	<p>Foundational payments for infrastructure & operations (e.g., care coordination fees)</p>	<p>APMs with Shared Savings (e.g., shared savings with upside risk only)</p>	<p>Condition-specific population-based payment (e.g., PMPM payments for diabetes patients)</p>
	2B	3B	4B
	<p>Pay for reporting (e.g., bonuses for reporting data or penalties for failing to report data)</p>	<p>APMs with Shared Savings and Downside Risk (e.g., shared savings with upside and downside risk)</p>	<p>Comprehensive population-based payment (e.g., global budgets, capitation)</p>
	2C	3N	4N
	<p>Pay for performance (e.g., bonuses based on quality performance)</p>	<p>Shared savings without quality (e.g., financial only shared savings)</p>	<p>Capitated payments without quality (e.g., unadjusted capitation payments)</p>

Source: <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

What does AHEAD require in the Medicaid Primary Care APM?

MQD must develop and receive approval for a program that meets requirements specified by CMS

CMS defines a Medicaid Primary Care APM for AHEAD as either of the following:

A patient-centered medical home (PCMH) program

A primary care value-based payment arrangement that includes increased accountability and care transformation structure for

- care coordination,
- health-related social needs, and
- behavioral health/specialty integration.

Med-QUEST does not currently offer a program that meets the requirements AHEAD's Medicaid Primary Care APM, but has identified the following opportunities for exploration:

- State directed payments
- Contractually requiring Managed Care Plans to align quality measures
- Supporting the overall Med-QUEST Managed Care Quality Strategy
- Aligning Med-QUESTs MCO P4P program with the Medicaid Primary Care APM

Source: AHEAD NOFO, Hawaii Project Narrative

Medicaid Primary Care APM Program Design and Regulatory Authorities

In designing the Medicaid Primary Care APM, Med-QUEST Division will need to consider Medicaid specific regulatory authorities, depending on the ultimate design of the APM

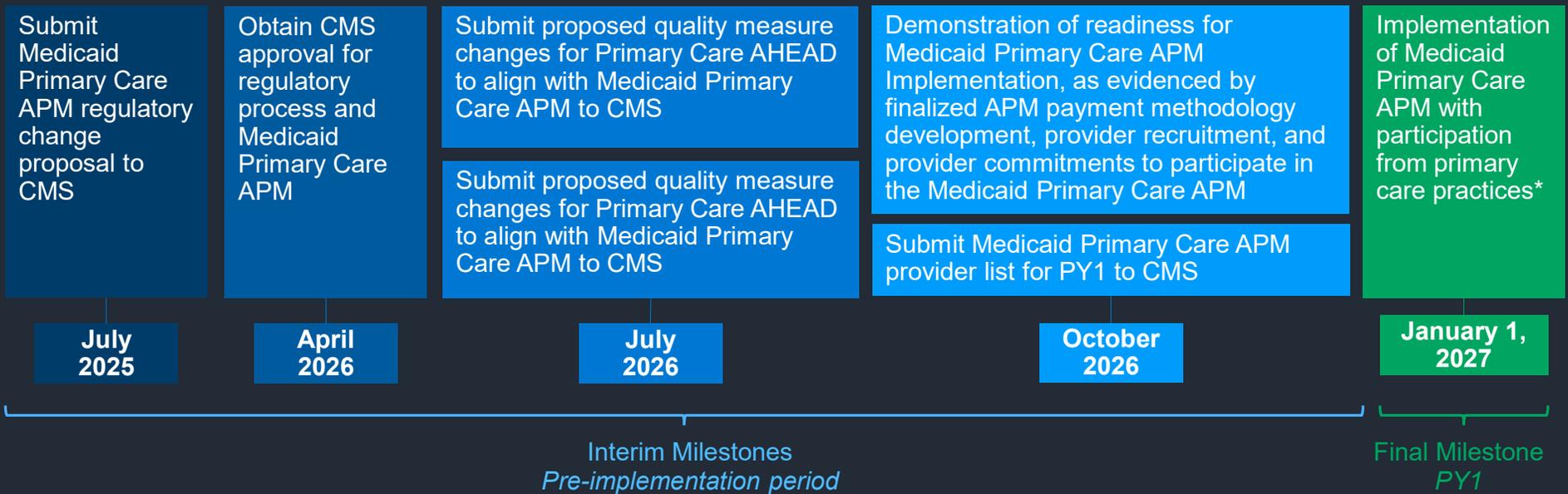
Example Design Options

Managed Care Contract	State Directed Payment	Participation Agreement
<ul style="list-style-type: none"> Require MCOs to use standardized quality measures and specifications, member attribution methodology, or social and medical risk adjustment methodology for VBP arrangements Require MCOs to engage in types of APMs by broad category (IE MCOs must develop a prospective payment with two-sided risk for providers participating in primary care AHEAD) <p style="text-align: center;"><i>MQD Responsibility CMS Approves</i></p>	<ul style="list-style-type: none"> Require MCOs to pay a specific amount for a service already included in the state plan or approved waiver (IE PMPM of a specified amount) Require MCOs to pay an enhanced rate to certified PCMHs for a defined set of CPT codes <p style="text-align: center;"><i>MQD Responsibility CMS Approves</i></p>	<ul style="list-style-type: none"> Require Primary Care AHEAD providers to participate in specific care transformation activities for Medicaid and Medicare FFS populations such as <ul style="list-style-type: none"> HRSN screening and referrals Care management and specialty coordination Behavioral health integration <p style="text-align: center;"><i>CMS Responsibility MQD Provides Input</i></p>

NOTE: Additional authorities, such as state plan amendments or an 1115 waiver may be needed depending on the ultimate design of the Medicaid Primary Care APM. At this time, MQD intends to utilize managed care contracts and/or a state directed payment program. Increasing primary care reimbursement may require additional legislative approval.

State Milestone: Implementation of Medicaid Primary Care APM

The following milestones are included in Hawai'i's Cooperative Agreement Terms and Conditions between Hawai'i and CMS. Failure to meet the final milestone may result in termination of the demonstration.



*If Medicaid Primary Care APM is not implemented by PY1, CMS will take an enforcement action. If the Recipient has not corrected the deficiencies raised by CMS and if the Medicaid Primary Care APM will not be in place by PY2, CMS will terminate the Cooperative Agreement Award and State Agreement.

Source: AHEAD Notice of Award Program Terms and Conditions for Hawai'i

Alignment with Med-QUEST Managed Care Quality Strategy Goals

The Medicaid Primary Care APM will align with Med-QUESTs quality strategy goals and objectives

The quality aspects of the EPCP can be customized to align with Med-QUESTs quality strategy goals

Med-QUEST Managed Care Quality Strategy Goals

1. Advance primary care, prevention, and health promotion

2. Integrate behavioral health with physical health across the continuum of care

3. Improve outcomes for high-need, high-cost individuals

4. Support community initiatives to improve population health

5. Enhance care in LTSS settings

6. Maintain access to appropriate care

7. Align payment structures to improve health outcomes

Source: [Hawaii Quality Strategy 2023](#)

Alignment with Med-QUEST MCO Pay-for-Performance Program

MQD is exploring opportunities to evolve and align the MCO P4P program and MCO VBP requirements as AHEAD is implemented

Medicaid Managed Care Organizations (MCOs) are currently accountable for performance through a pay-for-performance (P4P) program

Med-QUEST MCO P4P Program Overview

- A percentage of an MCOs PMPM is withheld (equal to roughly 1%)
- MCOs can earn back the withhold by improving performance or exceeding benchmarks for quality measures

Performance Targets

- MCOs must have performance at or above the national HEDIS 75th percentile to earn full payment for a measure
- MCOs that make significant improvements in a measurement year may be eligible for bonus funding

Sources: [Hawaii's States Advancing All-Payer Health Equity Approaches and Development \(AHEAD\) Model Project Narrative QI-2221 MCO P4P Guidance for Measurement Year 2023 and Measurement 2026_m \(part 1\) - signed.pdf](#)

Alignment with Med-QUEST MCO Provider VBP Arrangements

MCOs encouraged to establish value-based requirements with contracted providers

Med-QUEST encourages MCOs to establish sub-capitated and other value-based payment arrangements with providers.

These arrangements must be equivalent to or above Medicare payment levels for MDs and DOs for most services* (and 85% of Medicare for mid-levels)

*exclusions include EPSDT and FQHC/RHC PPS

MCO VBP Adoption

- Most MCOs have some VBP arrangements with PCPs
- Some MCOs have sub-capitated arrangement with PCPs

MCO VBP Alignment

- There are varying levels of alignment between Med-QUEST's MCO P4P program and an MCO's VBP arrangements with contracted providers
- Both MCOs and MQD are interested in standardizing VBP strategies and developing primary care APMs that cut across plans

Sources: QI-2341, CCS-2314, FFS-23-24 Professional Fee Schedule Update to 100 Medicare (part 1) - signed.pdf; Hawai'i States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Project Narrative

Alignment with HMSA Medicaid Primary Care Payment Model (PCPM)

Originally launched in 2016 as Payment Transformation. Model is used across Medicare Advantage and Commercial programs. As of 2023, includes 610 participating Medicaid PCPs covering >150,000 QUEST members.

MQD proposes using HMSA's PCPM as a starting point for the Medicaid Primary Care APM

Potential changes:

Addressing concerns from physician community

Developing model that is specific to pediatrics

Key Features of the PCPM

- PCPs receive a **PMPM** for all attributed and non-attributed patients; PMPM amount is based on attributed patients
- Up to **20% of PMPM at risk** based on a PCPs performance on process and outcome performance measures
- Separate PMPM for each line of business

Impact of Payment Model

- Concern from physician community about the level of reimbursement broadly (not payer type specific)
- Some providers like the stability of the payment model
- Limited evidence that model improves total cost of care

HCP-LAN Category 4A

Quality Measure Alignment

	HMSAs Medicaid PCPM Model 2025	Med-QUEST MCO P4P 2024	Medicare FFS EPCP ¹
Aligned Measures	<ul style="list-style-type: none"> ■ Breast Cancer Screening ■ Child and Adolescent Well-Care Visits ■ Childhood Immunization Status ■ Colorectal Cancer Screening ■ Controlling Blood Pressure ■ Screening for Depression and Follow-Up Plan ■ Well-Child Visits in the First 30 Months of Life 	<ul style="list-style-type: none"> ■ Child and Adolescent Well-Care Visits ■ Childhood Immunization Status ■ Well Child Visits in the First 30 Months of Life 	<ul style="list-style-type: none"> ■ Breast Cancer Screening ■ Colorectal Cancer Screening ■ Controlling High Blood Pressure ■ Screening for Depression and Follow-Up Plan <i>(Required)</i>
	<ul style="list-style-type: none"> ■ Blood Pressure Control of Patients with Diabetes ■ Cervical Cancer Screening ■ Eye Exam for Patients with Diabetes ■ Glycemic Status Assessment for Patients with Diabetes (8.0) ■ Immunizations for Adolescents ■ Kidney Health Evaluation for Patients with Diabetes ■ Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy 	<ul style="list-style-type: none"> ■ Asthma Medication Ratio—Total ■ Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up ■ Hemoglobin A1c Control for Patients With Diabetes —HbA1C Control (< 8.0%) ■ Plan All-Cause Readmissions—O/E Ratio ■ Prenatal and Postpartum Care—Postpartum Care ■ Prenatal and Postpartum Care—Timeliness of Prenatal Care 	<ul style="list-style-type: none"> ■ Acute Hospital Utilization <i>(Required)</i> ■ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) ■ Emergency Department Utilization <i>(Required)</i>

¹ Although EPCP measures are specifically described in the NOFO, the measures and their relative weights may be negotiable. Response pending from CMS.

Sources: QI-2412 MCO P49 Guidance for MY2024 Regarding Measure Weighting and LTSS Benchmark (part 1) - signed.pdf; AHEAD Notice of Funding Opportunity; HMSA 2025 Thresholds, Adjustment Factors, and Weights (PCPM Performance Measure)

- Adult Measure
- Pediatric Measure
- Adult & Pediatric Measure
- Maternal Health Measure

Care Transformation Requirements



Care Transformation Requirements

Participating Primary Care Practices will be required to advance their care transformation activities throughout the duration of the Model.

Key Elements

- Integrate behavioral health as a function of primary care
- Enhance care management and specialty coordination
- Address health-related social needs

Participating PCPs will receive technical assistance to support transformation efforts

The required activities will be tailored based on

- state and community context,
- the specific needs of the practices' attributed Medicare FFS and Medicaid populations, and
- each state's existing Medicaid primary care transformation efforts

Example activities include diabetes management, behavioral health integration, and industry accreditation or certification.

Hawai`i Primary Care Landscape



Primary Care Landscape – PCPs and MLPs

Accounting for MLPs exacerbates Hawaii's primary care supply shortage

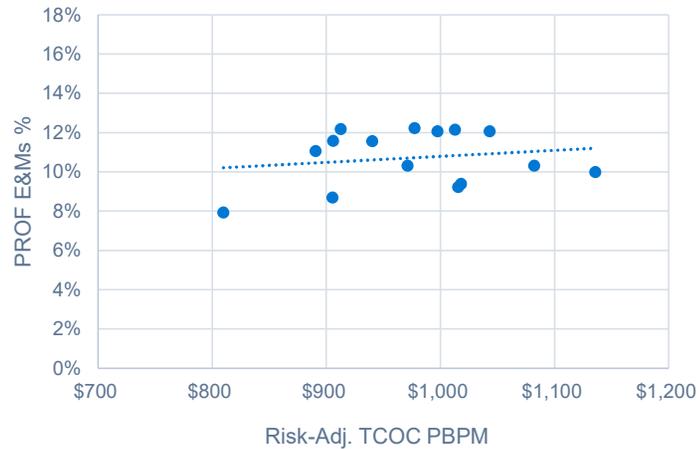
Component	Item	National	State	Hawaii	Honolulu	Kauai	Maui	Source
Count of Primary Care Physicians	A	240,869	1,271	115	1,021	58	75	Milliman Research
Primary Care Physician FTEs	B	255,100	972	126	715	44	86	2024 Physician need studies
Demand for Physician FTEs	C	285,400	1,124	146	801	50	126	2024 Physician need studies
Primary care physician shortage	$D = C - B$	30,300	152	20	86	6	41	
Unmet percent of Demand	$E = D / C$	11%	14%	13%	11%	12%	32%	
<u>Supply/Demand Taking into account MLPs</u>								
Supply of Primary Care MLPs	F	272,957	763	105	570	28	60	Milliman research
Demand for MLP FTEs	$G = 1.07 \times C$	305,378	1,202	156	857	54	135	Apply national ratio to demand
Primary Care MLP Shortage	$H = G - F$	32,421	439	51	287	26	75	
Unmet percent of Demand	$I = H / G$	11%	37%	33%	33%	48%	56%	
<u>Supply/Demand as Physician Equivalence</u>								
MLP : Physician Equivalence	J	70%	70%	70%	70%	70%	70%	Milliman research
Adjusted MLP Supply	$K = J \times F$	191,070	534	74	399	20	42	
Combined Physician and MLP Supply	$L = K + B$	446,170	1,506	200	1,114	64	128	
Adjusted MLP Demand	$M = J \times G$	213,765	842	109	600	38	95	
Combined Physician and MLP Demand	$N = M + C$	499,165	1,965	255	1,401	88	221	
Adjusted Primary Care Physician Shortage	$O = N - L$	52,995	459	56	287	24	93	
Unmet percent of Demand	$P = O / N$	11%	23%	22%	20%	28%	42%	

2024 MEDICARE FFS CLAIMS DATA, RESDAC. LOCATION BASED ON PROVIDER RESIDENCE.

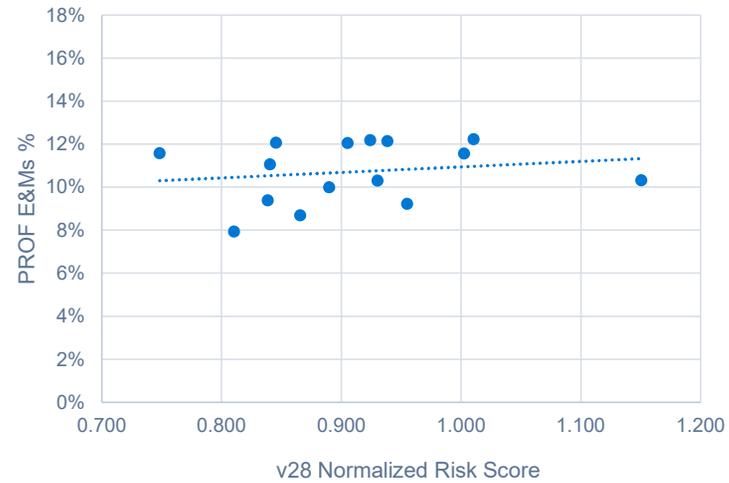
Primary Care Landscape – TCOC vs E&Ms Relationship

Medical groups with the largest market share show that higher proportions of primary care generally does not correlate with lower risk-adjusted total cost of care

E&M % of TCOC and Risk-Adj. TCOC
PBPM



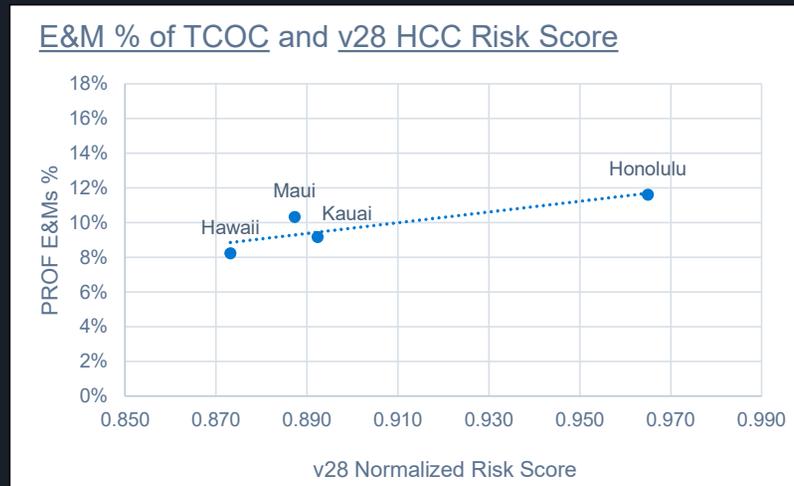
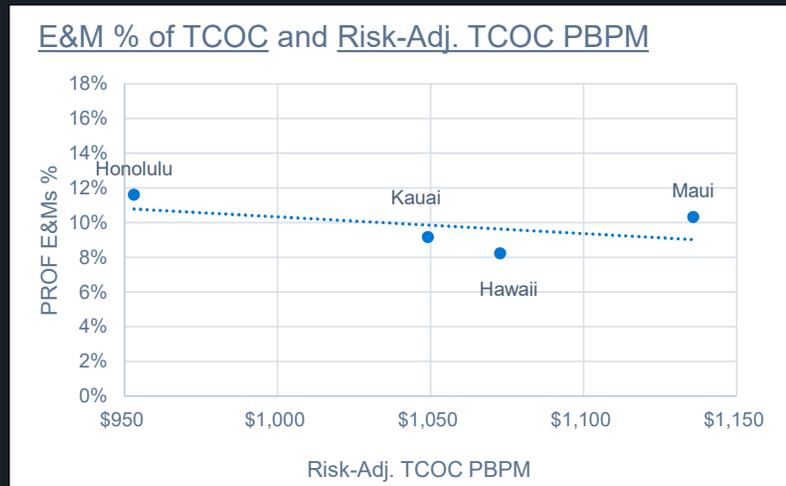
E&M % of TCOC and v28 HCC Risk Score



2022 Medicare FFS claims data. Largest medical groups (15) based on total Medicare FFS enrollment across the state of Hawaii.

Primary Care Landscape – TCOC vs E&Ms Relationship

On the county level, a positive correlation exists between increased proportions of primary care and lower-risk adjusted total cost of care.



Greater quantities of E&M services tends to lead to increased risk scores (potentially through more documentation).

2022 Medicare FFS claims data.

Primary Care Landscape – Physician Recruitment

The largest medical groups serving Medicare FFS patients make up approximately 40% of attributed lives.

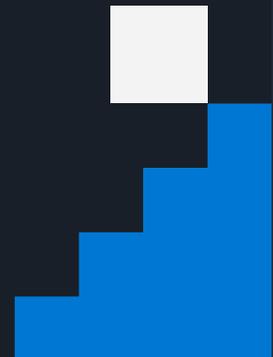
Provider Name	% of Total Beneficiaries				
	Honolulu	Maui	Hawaii	Kauai	State
Straub Clinic & Hospital	19.5%	3.6%	0.3%	0.7%	12.5%
Queens University Medical Group	7.5%	0.2%	0.2%	0.2%	4.7%
The Queens Medical Center	7.2%	0.2%	0.3%	0.2%	4.5%
The Maui Medical Group Inc	0.0%	34.4%	0.0%	0.0%	3.6%
Kauai Medical Clinic	0.0%	0.0%	0.0%	38.9%	2.7%
Pearl City Medical Associates Inc	3.7%	0.0%	0.0%	0.0%	2.3%
Hawaii Permanente Medical Group Inc	1.8%	3.5%	1.0%	0.8%	1.7%
Castle Medical Center	1.9%	0.0%	0.0%	0.0%	1.2%
Kihei-Wailea Medical Center Llc	0.0%	11.2%	0.0%	0.0%	1.2%
Hilo Academic Physicians Inc	0.0%	0.0%	5.1%	0.0%	1.1%
Ecare Hawaii Llc	0.0%	0.0%	4.3%	0.0%	0.9%
Hawaii Family Medical Centers	0.0%	0.0%	0.0%	12.7%	0.9%
Alii Health Center	0.0%	0.0%	4.1%	0.0%	0.9%
Charlie Y Sonido Md Llc	0.6%	0.0%	0.7%	5.1%	0.9%
Hawaii Island Healthcare Inc	0.0%	0.0%	3.3%	0.0%	0.7%
Subtotal	42.2%	53.2%	19.2%	58.8%	39.6%
FQHCs	2.5%	5.2%	13.5%	4.0%	5.2%
RHCs	0.5%	3.0%	16.1%	6.7%	4.5%
Others	54.9%	38.6%	51.1%	30.6%	50.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

2022 Medicare FFS claims data with attribution based on retrospective MSSP methodology.

Hawai`i Population: Medicare FFS vs Medicaid Estimates

Medicare FFS and Medicaid enrollees have vastly different demographic characteristics, largely driven by differences in age. Both programs include people who are older than 65 and who are disabled.

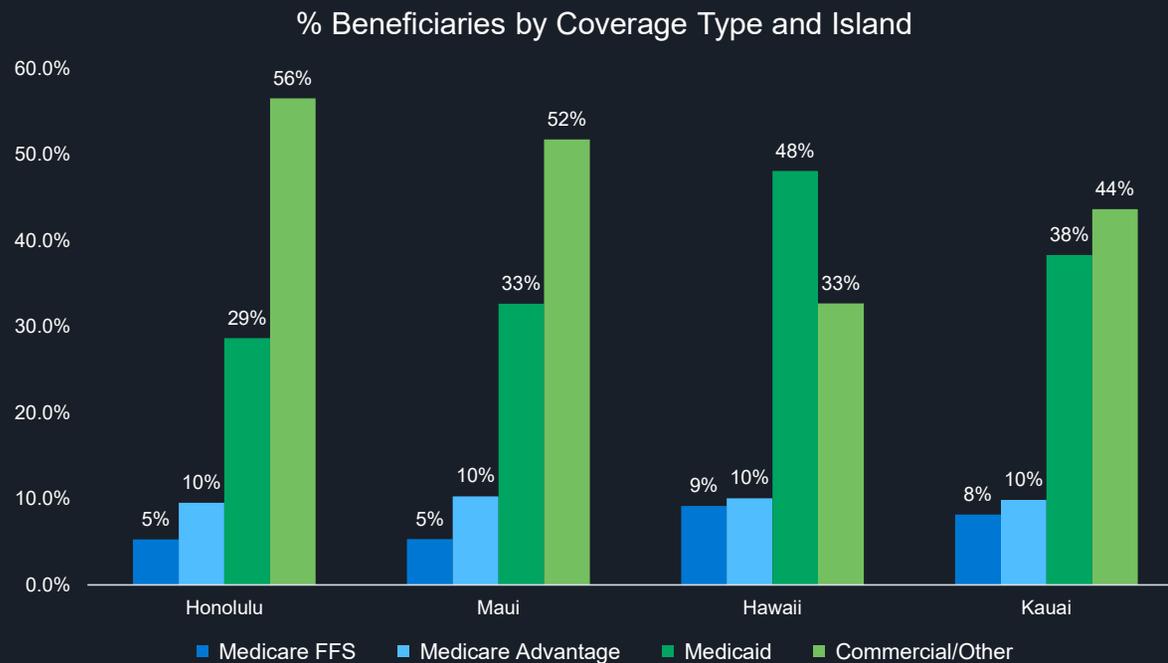
Population	Medicare FFS	Medicaid
Enrollment (2021)	145,600	442,300
Enrollment Eligibility	100% of enrollees qualify because of age or disability status	Approximately 15% of enrollees qualify because of age or disability status
Age	~90% age 65 or older	~10% age 65 or older ~33% age 18 or younger
Other distinct features	~1.5% of enrollees with End State Renal Disease	Medicaid pays for 33% of births in Hawaii



Source: Medicare Newly Enrolled Beneficiaries by Type of Entitlement | KFF; Total Number of Medicare Beneficiaries by Type of Coverage | KFF;

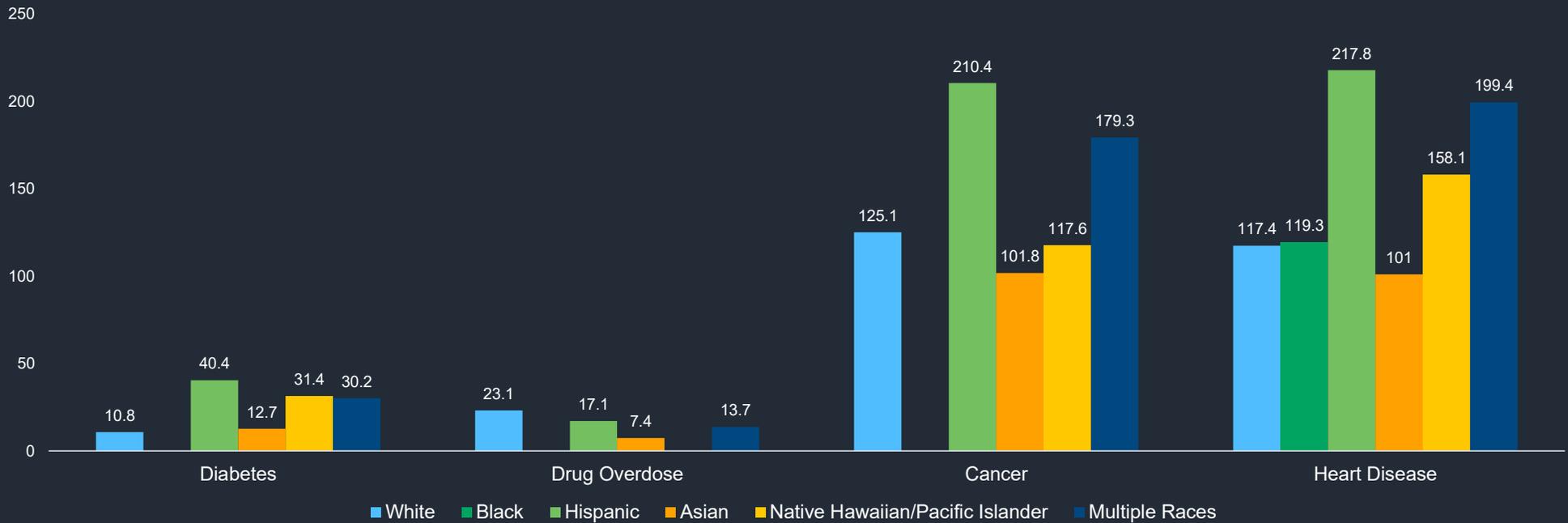
Primary Care Landscape – Coverage Distribution

Similar proportions of coverage type are observed within the state of Hawaii, although Medicaid is more prevalent than any other coverage type in the county of Hawaii.



Population Health: Disparities

Death rate by race/ethnicity for select underlying causes¹
 Age Adjusted Per 100,000 Population
 Hawai'i 2022



¹ Blank columns relate to statistics that were not reported because of insufficient data.

Notes: Death rates are age-adjusted rates per 100,000 U.S. standard population
 Sources: [Health Status Archives](#) | KFE;



Thank you

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