Hawai`i AHEAD Medicaid APM Quality Framework: Primary Care Working Group

Draft for discussion purposes

Adam Klein, CVA
Noelle Gaughen, MPAff, CPHQ
Rachel Ferguson, MHA, CAPM

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Milliman has developed certain models to estimate the values included in this analysis. The intent of the model is to compare Hawai'i Medicaid managed care payments to estimated payments under average commercial rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

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Agenda

1. Objectives for Today's Meeting
2. Utilization Patterns
3. Advanced Payment Model (APM) Guiding Framework
4. Participation Requirements
5. Group Discussion

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Objectives for Today's Meeting

Objectives for Today's Meeting

1. Provide reactions to proposed model
2. Consider trade-offs of potential roll-out scenarios
3. Discuss participation requirements and their practical implications

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Utilization Patterns

Analysis Framework

PCP visits are identified from claims data using the following criteria

Based on Milliman HGG Grouper (v2025.1.0.0), claims are flagged with the following MR Lines:

- P32c (PROF Office/Home Visits – PCP)
- P32d (PROF Office/Home Visits – Specialist)
- P42 (Preventive Well Baby Exams)
- P43 (Preventive Physical Exams)
- P40 (Other Preventive)

Provider specialty type matches one of the designated types from slide 7

- Please see the Limitations page for data quality issues with the provider specialty field.
- For FQHC and RHC providers, we are including these as PCP visits regardless of provider specialty type.

Place of service (POS) limited to:

- Office (11)
- FQHC (50)
- RHC (72)
- Telehealth (02)

Approach Limitations
Data quality impacts results. Claims missing provider specialty type or procedure codes will not be identified as PCP visits, potentially understating actual utilization.

Analysis Framework – Providers Included

We started with Maryland PC AHEAD specs and removed several specialty types.

Specialty Code	Specialty Description
01	General Practice
08	Family Practice
11	Internal Medicine
~~16~~	~~Obstetrics/Gynecology~~
~~17~~	~~Hospice and Palliative Care~~
~~26~~	~~Psychiatry~~
~~27~~	~~Geriatric Psychiatry~~
37	Pediatric Medicine
38	Geriatric Medicine
~~42~~	~~Certified Nurse Midwife~~
50	Nurse Practitioner
~~79~~	~~Addiction Medicine~~
84	Preventive Medicine
~~86~~	~~Neuropsychiatry~~
89	Certified Clinical Nurse Specialist
97	Physician Assistant

Source: Primary Care AHEAD Payment Specifications: Beneficiary Attribution, Payments, and Performance Assessment, Model Year 2026 - Maryland

Findings

How many Medicaid members have at least 1 PCP visit per year?

- About **48%** of Medicaid members had at least one PCP visit in CY 2024 and the average number of visits is **1.6.**
- For members who had at least one visit, the average number of PCP visits per year is around **3.4**. Most of these members went to one provider.

CY 2024 Island	% Mbrs No PCP Visit	% Mbrs Have PCP Visit	Adult + Child Mbr Count	Avg Visit Count per Mbr	Avg Visit Count for Mbrs w/ PCP Visit
Oahu	52%	48%	282,107	1.7	3.5
Hawaii	54%	46%	95,253	1.5	3.3
Maui	51%	49%	55,790	1.6	3.3
Kauai	54%	46%	27,593	1.4	3.1
Molokai	49%	51%	4,047	1.7	3.3
Lanai	44%	48%	1,034	2.5	3.5
All	**52%**	**48%**	**465,824**	**1.6**	**3.4**

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

Findings

Differences by MCO

- **Aloha Care, HMSA, and Kaiser** have the highest percentages with about **45% - 53%** of members having at least one PCP visit.

CY 2024 MCO	% Mbrs No PCP Visit	% Mbrs Have PCP Visit	Adult + Child Mbr Count	Avg Visit Count per Mbr	Avg Visit Count for Mbrs w/ PCP Visit
Aloha Care	54%	**46%**	84,898	1.6	3.4
United	73%	27%	47,968	0.9	3.2
HMSA	47%	**53%**	240,955	1.9	3.5
Kaiser	45%	**45%**	57,743	1.7	3.1
Ohana	73%	27%	34,260	0.9	3.3
All	**52%**	**48%**	**465,824**	**1.6**	**3.4**

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

Findings

% of Total Members by MCO and by Island

CY 2024 MCO	Oahu	Hawaii	Maui	Kauai	Molokai	Lanai	All	Mbr Count
Aloha Care	10.4%	3.5%	2.2%	1.5%	0.5%	0.1%	**18.2%**	**84,898**
United	6.2%	2.4%	1.0%	0.6%	0.1%	0.0%	**10.3%**	**47,968**
HMSA	31.4%	12.8%	3.9%	3.3%	0.2%	0.1%	**51.7%**	**240,955**
Kaiser	8.2%	0.0%	4.2%	0.0%	0.0%	0.0%	**12.4%**	**57,743**
Ohana	4.3%	1.7%	0.8%	0.5%	0.1%	0.0%	**7.4%**	**34,260**
All	**60.6%**	**20.4%**	**12.0%**	**5.9%**	**0.9%**	**0.2%**	**100.0%**	**465,824**
Mbr Count	**282,107**	**95,253**	**55,790**	**27,593**	**4,047**	**1,034**	**465,824**	

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

Findings

% of Members Who Have PCP Visit by MCO and by Island

- **HMSA** has the highest % of members visiting a PCP for most islands.
- **Hawaii** has the lowest % of members visiting a PCP at 46% and **Lanai** has the highest at 56%.

CY 2024 MCO	Oahu	Hawaii	Maui	Kauai	Molokai	Lanai	All	Mbr Count
Aloha Care	45%	45%	49%	46%	58%	62%	**46%**	**84,898**
United	28%	22%	24%	35%	14%	38%	**27%**	**47,968**
HMSA	54%	54%	50%	51%	53%	56%	**53%**	**240,955**
Kaiser	54%	No Mbrs	57%	No Mbrs	No Mbrs	No Mbrs	**55%**	**57,743**
Ohana	28%	23%	25%	32%	20%	49%	**27%**	**34,260**
All	**48%**	**46%**	**49%**	**46%**	**51%**	**56%**	48%	**465,824**
Mbr Count	**282,107**	**95,253**	**55,790**	**27,593**	**4,047**	**1,034**	**465,824**	

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

Normalizing for Differences in Age-Blind-Disabled (ABD) Populations

How do age-blind-disabled (ABD) population differentials impact PCP utilization?

- Most ABD members are dual eligible (i.e., excluded from this analysis), thus a relatively small proportion of members were ABD
- Even so, non-dual ABD populations still represent a higher share of members for United and Ohana
- When the same analysis is performed across health plans excluding ABD members, the results are similar

CY 2024 MCO	Member Count	Member Count, Excl. ABDs	Difference (ABDs)	% ABD	% Members w/ PCP visit	% Members w/ PCP visit, Excl. ABDs
Aloha Care	84,898	81,880	3,018	3.6%	46.2%	45.7%
United	47,968	43,635	4,333	9.0%	26.6%	24.9%
HMSA	240,955	234,631	6,324	2.6%	53.4%	53.1%
Kaiser	57,743	56,354	1,389	2.4%	55.2%	55.0%
Ohana	34,260	30,223	4,037	11.8%	26.7%	24.1%
All	**465,824**	**446,723**	**19,101**	**4.1%**	**47.6%**	**47.3%**

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

Normalizing for Differences across Health Plans

To what extent are non-PCPs providing primary care services?

- Only around 4% of primary care services are rendered by non-PCPs
- United and Ohana are higher, but both are under 10%
- United and Ohana members' access, relative to HMSA, is similar both before and after adjusting for differences in ABD populations and use of non-PCPs for primary care services

CY 2024 MCO	% Members w/ PCP Visit from PCP, Excl. ABDs	% Members w/ PCP Visit from Any Practitioner, Excl. ABDs	% of PCP Visits Performed by Non-PCPs, Excl. ABD	Access to PCP Service from Any Practitioner Excl. ABD Compared to HMSA	Access to PCP Service by PCP Compared to HMSA (original analysis)
Aloha Care	45.7%	47.2%	3.3%	(7.4%)	(8.0%)
United	24.9%	27.6%	10.8%	(28.2%)	(27.7%)
HMSA	53.1%	55.3%	4.0%	N/A	N/A
Kaiser	55.0%	57.1%	3.7%	1.9%	1.8%
Ohana	24.1%	26.1%	8.2%	(29.0%)	(29.1%)
All	**47.3%**	**49.4%**	**4.3%**	**(5.8%)**	**(5.9%)**

Source: CY 2024 Hawaii Medicaid population from encounter data. Excludes members who have at least one month of dual eligibility.

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APM Guiding Framework

Regulatory Pathways Discussion

State-Directed Payment (SDP) Approach

- State establishes a standardized payment methodology across plans
- Promotes uniform expectations and incentives for participating practices
- Supports consistency in program design, reporting, and evaluation
- May simplify provider experience by reducing variation across plans
- May trigger regulatory limits on payments above Medicare rates

Plan-Led Participation Approach

- State defines program parameters, with plans given flexibility in implementation
- Allows plans to align the APM with existing strategies and infrastructure
- May support innovation and plan-specific tailoring
- Requires coordination to ensure alignment on core measures and expectations

APM Eligibility

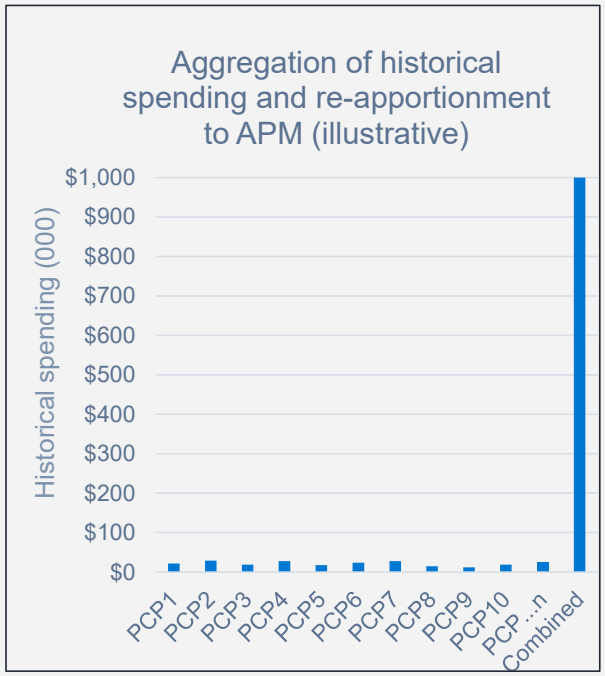
APM eligibility is conditioned on meeting all the following criteria; participation is mandatory for PCPs in eligible primary care practices

Primary Care Practices	Primary Care Practitioners (PCPs)	Primary Care Services
• Practices and practitioners are physically located in Hawaii • Majority of practitioners within a TIN are PCPs • Majority of services are Primary Care Services billed under POS 11 and POS 02 • Practice has met the minimum care transformation requirements (TBD) within the stipulated time frame (TBD) applicable to eligibility for the Medicare EPCP.	Physician specialties [specialty codes] • General practice [01] • Family practice [08] • Internal medicine [11] • Pediatric medicine [37] • preventive medicine [84] Advanced practice providers (APPs) [specialty codes] • Nurse practitioner [50] • Certified clinical nurse specialist [89] • Physician assistant [97] Note: APPs in Primary Care Practices that primarily support specialty care are not eligible for APM participation.	The following MR lines will be considered Primary Care Services for purposes of determining APM eligibility: • P32c – Professional office/home visits • P33 – Professional urgent care visits • P42 – Preventive well baby exams • P43 – Preventive physical exams • P40 – Other preventive

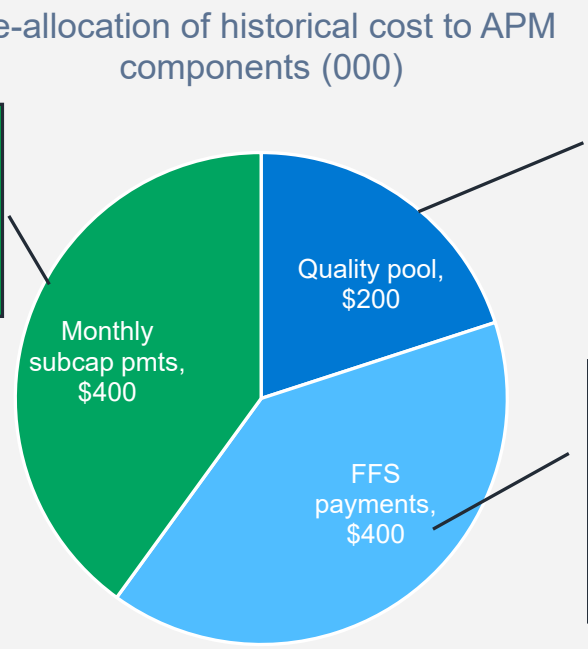
The APM is not applicable to dual-eligible members or PCPs in an FQHC/RHC.

Directed Payment Approach: Payment Model for Primary Care Bundle

The primary care bundle includes all HCPCS codes, except for those included on the schedule of "strategic services" that MQD updates annually; strategic services are paid using a standard fee schedule (typically, 100% of Medicare).



Rate setting factors
- Member type
- Health/social risk
- Practitioner type
- Geographic



Allocation from pool
- Based on performance of all members assigned to PCPs in a participating practice
- While average quality payment will be 20% of cost, a practice may receive more or less based on actual performance

Fee schedule
- Paid at 40% of standard fee schedule
- Applicable when a participating PCP renders any bundled service to a member, regardless of assignment/attribution

In addition, participating PCPs in an advanced participation tier (described later) will receive a monthly care management fee

Assignment and Attribution

- Members may only be assigned to PCPs at practices that meet certain criteria (specifics TBD)
- All members will be assigned to a PCP; a subset of members will be also attributed to their assigned PCP
- Monthly subcapitation payments are only for attributed members

Assignment

New member assignment

- Step 1: Priority given to member choice
- Step 2: Absent member choice, match based on family member's PCP
- Step 3: Absent family member match, geographic proximity to practice with requisite capabilities and capacity

After assignment, health plan notifies member of assignment and process to request change.

Periodic auto-reassignment

- Auto-reassignment reviewed annually.
- Reassignment indicated when plurality of primary care services in prior 12 months were provided by a PCP in a different practice.
- Member notified of pending reassignment and given opportunity to reject reassignment and remain with current PCP.

Attribution

Attribution logic

- Upon initial assignment: members will be attributed to their assigned PCP for at least 12 months unless member is reassigned to a PCP in a different practice before 12 months have elapsed.
- Thereafter, members will be attributed to their assigned PCP only if member has received Primary Care Services from a PCP within their assigned practice in the prior 18 months.

Measure Domains

Measures are organized across three domains that reflect progression from foundational capacity to system impact

Participation Requirements *Administrative Measures*	Pay for Performance Pool *Quantitative Measures*	
Care Transformation	**Process and Outcomes**	**Utilization**
• Behavioral health integration • Care coordination across clinical, behavioral health, and community services • Patient self-management support and engagement activities • Implementation of access expansion strategies	• Preventive screening • Chronic disease management • Behavioral health integration	• Avoidable emergency department use • Potentially avoidable hospitalizations • Access-sensitive service patterns

Medicaid APM Tier Structure Components

Tier 1: Foundational	Tier 2: Intermediate	Tier 3: Advanced
Demonstrates all care transformation capabilities required for Medicare EPCP	Requirements TBD: Features will be ones that expand access to primary care, especially for underserved populations and that improve population health through enhancement of primary care capabilities	Possesses all capabilities required for Medicare Advanced Primary Care Management (APCM) with behavioral health and directly supports Medicaid initiatives

Medicaid APM Tier Structure Examples

Tier 1: Foundational	Tier 2: Intermediate	Tier 3: Advanced
Capabilities align with basic EPCP Care Transformation Requirements and provides practices with support to build core infrastructure and progress toward Tier 2 capabilities.	Capabilities align with EPCP Care Transformation Requirements and support expanded access to care, with a higher payment reflecting increased scope.	Capabilities support participation in Hawai'i-specific initiatives and advanced integration, with the highest payment reflecting expanded access and service scope.

Practice Transformation Coaching: Optional
Required Capabilities
• Minimum care coordination workflows
• Initial behavioral health (BH) and HRSN screening and referral pathways
• Patient self-management support (e.g., education, care plans)
• At least one method of expanded access to care (e.g., evening and weekend hours, same day appointments)
• Report eCQMs
**Capabilities in Tier 1 will be optional during the initial implementation period as practices build capacity*
	Practice Transformation Coaching: Required
	Required Capabilities
	• Care coordination and population management
	• Additional behavioral health screening and care pathways
	• Offer multiple methods of expanded access to care
	• Expanded capabilities related to advanced primary care management
		Practice Transformation Coaching: Required
		Required Capabilities
		• Advanced BH integration capabilities
		• Advanced care coordination across clinical and community settings
		• Patient self-management and longitudinal care planning
		• Participation in state initiatives and data exchange infrastructure
		  • CQIE participation
		  • C-Hub participation
		  • IHH care coordination participation
		  • Demonstrated bidirectional data exchange (HHIE)

- Validating tier qualification TBD (either external review or attestation)
- MQD can use existing administrative processes to verify enrollment in some initiatives

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Group Discussion

Group Discussion

Reactions to proposed model

- Comments on model structure
- Discussion of trade-offs between a directed payment model vs. health plan led approach

Timing

- Implications of different roll-out scenarios
- Phased by geography
- Phased by health-plan
- Simultaneous

Participation

- Proposed tiers
- Mandatory vs. optional

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Thank you

Adam Klein
Adam.Klein@milliman.com

Noelle Gaughen
Noelle.Gaughen@milliman.com

Rachel Ferguson
Rachel.Ferguson@milliman.com