Hawai`i AHEAD Medicaid APM Framework

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Agenda

- Agenda and goals for today – *5 minutes*
- Review prior meeting discussion – *5 minutes*
- Care coordination standards – 10 minutes
- Health promotion activities – 10 minutes
- Behavioral health integration – 10 minutes
- Specialty care coordination – 10 minutes
- Recap and closing – *5 minutes*

Goals for Today's Discussion

Establish priorities for program design:

- Select at least 2 to 3 key priorities in each of the 4 areas
- Describe potential standards and goals for the selected priorities

CONTENT FROM PRIOR MEETING

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CMS's Program Requirements for Medicaid Primary Care APM

Overview of Medicaid Advanced Primary Care Program Criteria

Areas for PC AHEAD Alignment	Medicaid Advanced PCP Criteria	
Medical Home Model	1. Program eligibility	Type of practitioners and settings of care
	2. Clinical standards	Four categories of clinical standards
	3. Care coordination standards	Establish standards for three of six coordination activities
Care Transformation	4. Health promotion activity	Screening and referral requirements plus two additional care transformation activities
	5. Behavioral health integration	Screening and referral requirements plus two additional care transformation activities
	6. Specialty care coordination	Screening and referral requirements plus two additional care transformation activities
Alternative Payment Model	7. Performance accountability	Escalating requirements for measurements and payment risk
	8. Enhanced primary care investment	Multiple approaches available

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Medical Home Requirements (1 of 3)

1. Eligibility Standards

Establish a payment arrangement under title XIX of the Social Security Act that applies to primary care and/or multispecialty practices that include eligible primary care clinicians and offer primary care services within the state or sub-state AHEAD Model region.

Eligible clinicians practice under one or more of the following CMS physician specialty codes:

- 01 - General Practice;
- 08 - Family Medicine;
- 11 - Internal Medicine;
- 16 - Obstetrics and Gynecology;
- 37 - Pediatric Medicine;
- 38 - Geriatric Medicine;
- 50 - Nurse Practitioner;
- 89 - Clinical Nurse Specialist; and
- 97 - Physician Assistant

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Medical Home Requirements (2 of 3)

2. Clinical Standards

Establish statewide primary care standards for each of the following four areas:

Clinical Standard	Description
A: Person-centered care through a team-based model	Person centered refers to prioritizing needs beyond disease management to account for physical, mental, emotional, social, and environmental factors that contribute to a person's health. Team-based model means a physician-led approach between two or more health care professionals that collaborate to meet patient needs.
B: Empanelment of each patient to a primary care clinician	Standards to attribute a patient population to eligible primary care practices. APM performance measurement (discussed below) will be based on the attributed population.
C: Patient data collection and management requirements	Refers to standards that establish data collection procedures (e.g., guidance on demographic data collection, medication management, ADT notices).
D: Quality improvement	Refers to standards around process and outcome measurement and improvement (e.g., strategies to promote continuous improvement and align multi-payer strategies).

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Medical Home Requirements (3 of 3)

3. Care Coordination Standards

Establish care coordination standards that include at least three of the following six standards (may apply at practice and/or MCO level):

Category	Type of Standards
Planned coordination of chronic & preventive care:	Coordinate chronic and preventive care management. Examples include standards for care transition teams
Risk-stratified care management:	Support identifying patient health risk level and providing medically appropriate care
Coordination of care across clinician types:	Coordination of activities between primary care and other clinicians (e.g., closed-loop referral systems, provider referral list maintenance, and cross-provider billing integration)
Patient access and continuity:	Patient access to primary care and patient health information (e.g., same day appointments, extended practice hours, 24/7 access to patient portals, and connecting members to primary care providers)
Patient and caregiver engagement:	Support of caregivers as well as patients (e.g., offering caregiver support services and developing individualized care plans)
Patient and clinician shared decision-making:	Empower patients and engage them in making choices about their health care options (e.g., providing health education to patients and caregivers, offering linguistically appropriate care, providing follow-up consultations, and supporting self-management and self-care techniques)

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Care Transformation Requirements (1 of 3)

4. Health Promotion Activity

To demonstrate promotion of healthy activities, establish a screening and referral requirement for health promotion activities, plus at least two of the following ten activities (may apply at practice and/or MCO level):

Acceptable Health Promotion Activities
Routine screening process for social support services (e.g., transportation, nutrition, supportive housing services, etc.)
Routine screening process for physical activity, health behavior, and/or lifestyle habits
Facilitate referrals/ warm hand-offs to community organizations and/or social support services
Facilitate referrals/ warm hand offs to initiatives on physical activity and lifestyle wellness
Develop plan for increased referrals to community organizations/ social support services
Establish a closed-loop referral system and coordination process for integrated care team
Create shared workflows & training material for social support services referral process
Develop a process for creating an integrated care team (e.g., community health workers) to identify and connect patients needing social support services
Form partnerships to link to housing and other social support systems with data sharing and accountability
Other (as identified by the state)

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Care Transformation Requirements (2 of 3)

5. Behavioral Health Integration

To demonstrate behavioral health integration, establish screening and referral requirements for mental health and/or substance use disorder treatment services plus at least two of the following eleven activities (may apply at practice and/or MCO level):

Behavioral Health Integration Activities
Establish a routine universal screening process for behavioral health (e.g., PHQ-9)
Facilitate referrals/warm hand offs to specialty behavioral health services (e.g., certified community behavioral health clinics)
Increase patient access to behavioral health consultations (e.g., psychiatric consultations)
Establish a closed-loop referral system and coordination process for behavioral health team
Create shared workflows & training material for staff on integrated behavioral care approach
Develop Crisis Protocol for high-risk patients
Hire In-House Behavioral Health Providers
Co-locate behavioral health providers & primary care providers in the same facility
Deliver behavioral health services through teleconsultation
Develop a process for creating an integrated care team to identify and connect patients needing behavioral health services
Other (as identified by the state)

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Care Transformation Requirements (3 of 3)

6. Specialty Care Coordination *(distinct from primary care or behavioral health)*

To demonstrate specialty care integration, establish screening and referral requirements for specialty care coordination plus at least two of the following twelve activities (may apply at practice and/or MCO level):

Specialty Care Coordination Activities
Establish a screening process to identify patients who could benefit from care management services
Facilitate referrals/ warm hand offs to care management programs or specialist providers
Facilitate referrals/ warm hand offs to registered dieticians or specialized nutrition programs
Increase patient access to consultations (e.g., care management services or specialty services)
Establish a closed-loop referral system and coordination process for integrated care team
Create shared workflows & training material for staff on care management screening and referral process
Hire in-house registered dieticians
Develop a process for creating an integrated care team matched to the needs of the identified patient
Deliver specialty care services through teleconsultation
Increase clinician engagement with specialists through telemedicine (e.g., e-consults, Project ECHO)
Integrate systemic, collaborative partnership with care management programs & specialty providers in one or more locations to meet patient needs through automated data sharing & ongoing monitoring of patient outcomes
Other (as identified by the state)

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Alternative Payment Model Requirements (1 of 2)

7. Performance Measurement and Accountability

Adopt and report on quality measure sets that are consistent with the primary care quality measures selected for Primary Care AHEAD. Include at least one validated standardized measures (e.g., NCQA HEDIS measure) from the following quality measure domains:

Behavioral Health | **Prevention & Wellness** | **Chronic Conditions**

Timing	Measurements	Payment
PY1 and PY2	At least one measure from two of the three domains	Payments for the selected measures must be at least pay-for-reporting.
PY3 and beyond	At least one measure from all three domains	Payment arrangements for all three measures must be at least pay-for-performance.

States will determine their risk arrangements (e.g., two-sided, upside-only) for their quality incentive payments and may have exceptions for community health centers.

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Alternative Payment Model Requirements (2 of 2)

8. Enhanced Primary Care Investment

Establish enhanced primary care investment payment arrangements made in addition to, or substituting for, fee-for-service payments, to primary care providers for both children and adults

Potential areas for additional investment
Enhanced provider rates
Care management fees
Value-based shared savings
Capitated payments

Source: 2026 AHEAD Medicaid Advanced Primary Care Program Criteria - September 2025

Overview of Medicaid Advanced Primary Care Program Criteria

Areas for PC AHEAD Alignment	Medicaid Advanced PCP Criteria		Decision point status
Medical Home Model	1. Program eligibility	Type of practitioners and settings of care	Type of practitioners and settings of care decision point alignment has been completed.
	2. Clinical standards	4 components	Statewide primary care standards for each of the following four areas are required. No decision point.
	3. Care coordination standards	6 components	At least 3 of the 6 components must be chosen.
Care Transformation	4. Health promotion activity	Minimum of 3 activities	At least 3 of 10 activities must be chosen.
	5. Behavioral health integration	Minimum of 3 activities	At least 2 of 12 activities must be chosen in addition to the mandatory establishment of screening and referral requirements for mental health and/or substance use disorder treatment services.
	6. Specialty care coordination	Minimum of 3 activities	At least 2 of 12 activities must be chosen in addition to the mandatory establishment of screening and referral requirements for specialty care coordination.
Alternative Payment Model	7. Performance accountability	Escalating requirements for measurements and payment risk	Approach has not yet been established.
	8. Enhanced primary care investment	Multiple approaches available	Approach has not yet been established.

Source: AHEAD Medicaid Advanced Primary Care Program Criteria (Draft) September 2025

Guiding Principles for Primary Care APM

- Alignment with goals of hospital global budget
- Standardize plan requirements to reduce provider burden
- Maintain operational simplicity (e.g., unified claims submission, quality reporting)
- Increase utilization of primary care services
- Expand value-based payment and care transformation
- Advance population health and reduce disparities
- Improve access to timely, actionable data for accountability
- Enable innovation while maintaining core program goals

Questions for the Working Group

VARIABILITY

At what level should standards vary?

Survey response: Single statewide, standard, by practice size, geographically, practice-level, other

Questions for the Working Group

SPECIFICITY

How broadly or specifically should standards be defined?

Survey response: detailed rules, required guidelines/framework, generalized approach

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Group Discussion

TODAY'S DISCUSSION

1. Which standards should be prioritized?
2. Within the prioritized standards, are there practice characteristics (e.g. size, rurality, etc.) that would allow for lesser standards?
3. Where standards can be customized, what concepts should be incorporated?

Questions for the Working Group

MONITORING

What mechanism or body should be used to validate and monitor that standards are adopted and applied?

Survey response: attestation, health plan review, PO review, State audit

Questions for the Working Group

PRIORITY

Which components or activities will benefit most from having standards?

Survey response: force rank (1=highest priority)

Care Coordination Standards

In-meeting survey followed by discussion

Category	Ranked Priority	Comments
Planned coordination of chronic & preventive care:		
Risk-stratified care management:		
Coordination of care across clinician types:		
Patient access and continuity:		
Patient and caregiver engagement:		
Patient and clinician shared decision-making:		

Health Promotion Activity

In-meeting survey followed by discussion

Acceptable Health Promotion Activities	Ranked Priority	Comments
Routine screening process for social support services (e.g., transportation, nutrition, supportive housing services, etc.)		
Routine screening process for physical activity, health behavior, and/or lifestyle habits		
Facilitate referrals/ warm hand-offs to community organizations and/or social support services		
Facilitate referrals/ warm hand offs to initiatives on physical activity and lifestyle wellness		
Develop plan for increased referrals to community organizations/ social support services		
Establish a closed-loop referral system and coordination process for integrated care team		
Create shared workflows & training material for social support services referral process		
Develop a process for creating an integrated care team (e.g., community health workers) to identify and connect patients needing social support services		
Form partnerships to link to housing and other social support systems with data sharing and accountability		
Other (as identified by the state)		

Behavioral Health Integration

In-meeting survey followed by discussion

Behavioral Health Integration Activities	Ranked Priority	Comments
Establish a routine universal screening process for behavioral health (e.g., PHQ-9)		
Facilitate referrals/warm hand offs to specialty behavioral health services (e.g., certified community behavioral health clinics)		
Increase patient access to behavioral health consultations (e.g., psychiatric consultations)		
Establish a closed-loop referral system and coordination process for behavioral health team		
Create shared workflows & training material for staff on integrated behavioral care approach		
Develop Crisis Protocol for high-risk patients		
Hire In-House Behavioral Health Providers		
Co-locate behavioral health providers & primary care providers in the same facility		
Deliver behavioral health services through teleconsultation		
Develop a process for creating an integrated care team to identify and connect patients needing behavioral health services		
Other (as identified by the state)		

Specialty Care Coordination

In-meeting survey followed by discussion

Specialty Care Coordination Activities	Ranked Priority	Comments
Establish a screening process to identify patients who could benefit from care management services		
Facilitate referrals/ warm hand offs to care management programs or specialist providers		
Facilitate referrals/ warm hand offs to registered dieticians or specialized nutrition programs		
Increase patient access to consultations (e.g., care management services or specialty services)		
Establish a closed-loop referral system and coordination process for integrated care team		
Create shared workflows & training material for staff on care management screening and referral process		
Hire in-house registered dieticians		
Develop a process for creating an integrated care team matched to the needs of the identified patient		
Deliver specialty care services through teleconsultation		
Increase clinician engagement with specialists through telemedicine (e.g., e-consults, Project ECHO)		
Integrate systemic, collaborative partnership with care management programs & specialty providers in one or more locations to meet patient needs through automated data sharing & ongoing monitoring of patient outcomes		
Other (as identified by the state)		

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Thank you