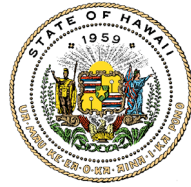


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December 22, 2025

MEMORANDUM

MEMO NO.

QI-2530
CCS-2510
FFS 25-13

TO: QUEST Integration Health Plans (HP)
Medicaid Fee-For-Service Providers
Community Care Services Behavioral Health Organization (BHO)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator 

SUBJECT: HAWAII STATE HOSPITAL TO COMMUNITY CARE SERVICES PROVISIONAL
ENROLLMENT TRANSITION FOR MEDICAID BENEFICIARIES - PILOT PROGRAM

The purpose of this memorandum is to provide guidance to QUEST Integration (QI) health plans (HP), the Community Care Services (CCS) Behavioral Health Organization (BHO) and the Department of Health (DOH) including the Adult Mental Health Division (AMHD) and Hawaii State Hospital (HSH) regarding a pilot program that begins on January 1, 2026, and ends on January 1, 2027. This pilot program grants ninety (90) days provisional CCS eligibility and enrollment for Medicaid beneficiaries discharged from HSH.

This pilot program provides Medicaid beneficiaries transitioning from HSH to the community with immediate and targeted behavioral health support from the BHO through the CCS program. MQD believes this approach ensures continuity of care during a critical transition

period and represents a thoughtful use of valuable resources to better serve Medicaid beneficiaries with persistent or serious mental illness in transition.

HSH Responsibilities

During hospitalization, HSH shall assist patients to apply for or reinstate their Medicaid coverage. Once the patient's Medicaid eligibility is confirmed, during their hospitalization, HSH shall secure the Medicaid beneficiary's consent and authorization for provisional enrollment transition from HSH to CCS. These actions ensure immediate Medicaid coverage and CCS enrollment upon discharge from HSH.

QUEST Integration Health Plan (QI HP) Enrollment

Medicaid enrollment is a critical component of this pilot. Health Plan enrollment will be assigned as follows:

1. If beneficiaries were disenrolled from their previous QI HP within the last six (6) months, they will be re-enrolled in that same QI HP.
2. If there are more than six (6) months of disenrollment from the beneficiaries' previous QI HP or they were not enrolled with a QI HP prior to HSH, unless they choose otherwise, they will be enrolled into Ohana QI HP to provide Medicaid services.

Health Plan Changes

DHS shall allow all beneficiaries to change Health Plans without cause within fifteen (15) days of the date of the enrollment choice notice.

After beneficiaries have been enrolled in their QI HP for at least twelve (12) months, they have the option to change QI HP at any time. CCS services will continue to be provided by the BHO.

Coordination between the HSH, BHO and QI HP

Upon receipt of the member's consent to participate in the program, HSH, the BHO and QI HP will work collaboratively to develop an individualized treatment plan to arrange appropriate services and settings, to support the Medicaid beneficiary's transition back into the community.

AMHD Transition Services

Adult Mental Health Division (AMHD) case management services may need to be initiated prior to or shortly after discharge to ensure continuity of care until Medicaid eligibility is established. HSH will engage AMHD to provide the necessary services. Upon Medicaid coverage activation,

the beneficiary will be disenrolled from AMHD and AMHD, MQD, QI HP, and BHO will coordinate to manage the beneficiary's transition into CCS.

Exclusions to the Pilot

The following are exceptions to participation in the HSH CCS Provisional Enrollment Transition:

- **Assistive Community Treatment Petition or Order**
For beneficiaries with an active Assistive Community Treatment (ACT) petition or order from another source, such as a Case Management Agency or Intensive Case Management, enrollment will not occur through this pilot but instead occur through the standard CCS re-enrollment process, and they will be automatically re-enrolled accordingly to ensure a seamless transition.
- **ACT 26**
ACT 26 is a criminal justice diversion program. Those that are admitted into HSH as ACT 26 are low level misdemeanants with probably high but non-acute behavioral health needs. They may not have the capacity for consent and typically have very short stays at HSH. Enrollment will not occur through this pilot but instead occur through the standard CCS re-enrollment process. If the member was enrolled in CCS prior to admission, they will be automatically re-enrolled accordingly, resuming their CCS services immediately upon discharge.
- **Medicaid Developmental Disability Beneficiaries**
For the Medicaid Developmental Disability beneficiaries, the Developmental Disabilities Division (DDD) will provide services post HSH discharge. And, if at any time, DDD feels the beneficiary could benefit from CCS, DDD will evaluate the beneficiary and submit the DHS 1157 referral for CCS.

Post-Discharge Pilot Eligibility Limit

After ninety (90) days of post-discharge from HSH, if the patient's Medicaid eligibility is not determined, the beneficiary is no longer eligible for provisional CCS enrollment. When these individuals are determined to be eligible for Medicaid, the QI HP shall follow the standard CCS referral process.

CCS Enrollment

Provisional enrollment into CCS is designed to support a seamless and timely transition for Medicaid beneficiaries' post-discharge. Following the receipt of the beneficiary's consent and discharge from HSH, all Medicaid eligible beneficiaries will be enrolled into a QI HP and CCS at

Level 5. CCS Level 5 is the highest service level, providing specialized, high-intensity care for the highest acuity cases. The HSH-CCS Provisional Enrollment Transition spans ninety (90) days.

CCS Service Level Determination and Continued CCS Enrollment

After thirty (30) days of the HSH-CCS provisional enrollment transition, the BHO shall conduct a CCS service level determination to ensure the Medicaid beneficiary receives appropriate services. By forty-five (45) days, the BHO shall submit a completed 1157 referral packet to MQD for each Medicaid beneficiary in this pilot program for formal CCS eligibility determination.

- **If the Medicaid beneficiary is determined ELIGIBLE** for continued CCS services, the BHO will continue providing services at the approved service level.
- **If the Medicaid beneficiary is determined INELIGIBLE for continued CCS services**, the BHO will coordinate with the Medicaid beneficiaries' QI HP to assess and transition the Medicaid beneficiaries to appropriate Behavioral Health Coordination Services and address housing navigation needs prior to CCS disenrollment.

All the referenced attachments are an essential part of this HSH CCS Provisional Enrollment Transition process and must be followed and used.

Please submit any questions to HCSBInquiries@dhs.hawaii.gov.

Attachments:

HSH CCS Provisional Enrollment Transition Procedure

HSH CCS Consent Form

HSH-CCS Provisional Enrollment Transition Checklist

HSH-CCS PROVISIONAL ENROLLMENT TRANSITION PROCEDURE

GOAL:

Provisional COMMUNITY CARE SERVICES (CCS) enrollment for Medicaid beneficiaries discharged from Hawaii State Hospital (HSH).

- 90-day provisional CCS enrollment.
- Start as a pilot from January 01, 2026 to January 01, 2027.
- DHS/DOH/BHO collaboration.
- The following WILL NOT be included in this procedure:
 - Department of Health (DOH) Developmental Disabilities Division (DDD) members
 - Members admitted under ACT 26
 - Members with active Assistive Community Treatment (ACT) petitions and orders

PROCEDURE:

ACRONYM KEY

AMHD	ADULT MENTAL HEALTH DIVISION
BHO	BEHAVIORAL HEALTH ORGANIZATION (CCS CONTRACTOR)
CCS	COMMUNITY CARE SERVICES
CSO	CLINICAL STANDARDS OFFICE (MQD)
DMO	DHS MEDICAID ONLINE
HCOB	HEALTH CARE OUTREACH BRANCH (MQD)
HCSB	HEALTH CARE SERVICES BRANCH (MQD)
HSH	HAWAII STATE HOSPITAL
MQD	MED-QUEST DIVISION
PIER	PERFORMANCE, INFORMATION, EVALUATION & RESEARCH BRANCH (AMHD)
QI	QUEST INTEGRATION
UM	UTILIZATION MANAGEMENT (AMHD)

UPON HSH ADMISSION/INTAKE PROCESS:

1. HSH staff shall obtain consent for CCS services from members using the HSH-CCS Provisional Enrollment Transition Consent Form. The consent will begin the process for the member to receive CCS services, upon discharge, including Medicaid Health Plan designation.
2. HSH to check the DMO for Medicaid status upon admission and start the Medicaid application process.
3. If members did not have prior Medicaid coverage or Medicaid termed for more than one year, a new Medicaid application shall be completed by HSH.
4. HSH will submit the Medicaid application and Consent form to HCOB.
5. HCOB will confirm receipt of correspondence from HSH.

** All parties will ensure a secure process to exchange Protected Health Information (PHI) (i.e., Medicaid eligibility data, member medical information).*

PRIOR TO HEARING/ DISCHARGE

HSH Responsibilities

At least 30 days prior to discharge:

1. Contact HCOB to confirm pending hearing/discharge date and any updates regarding Medicaid eligibility status.
2. Notify AMHD UM and PIER Branch of pending hearing discharge.
3. Notify the BHO of all upcoming hearing dates/pending discharge dates.
4. Prepares CCS transition packet which includes:
 - Completed HSH-CCS Provisional Enrollment Transition Consent Form.
signed/dated by member, legal guardian, or authorized representative
 - Master Recovery Plan – *signed/dated*
 - History & Physical/Biopsychosocial Assessment – *signed/dated*
 - Most recent dated/signed Psychiatrist progress note
 - Medication list – *if not included in the Master Recovery Plan or Psychiatrist progress note(s)*
 - Upon availability, copies of member's vital records (i.e., ID, birth certificate)
 - Legal guardianship documents, if applicable.
 - Completed HSH-CCS Provisional Enrollment Transition Checklist.
5. Sends completed transition packet to the BHO.
6. Arrange appropriate services for each member, as needed, until Medicaid is active.

BHO responsibilities:

1. Upon notification of pending discharge and receipt of the CCS transition packet, the BHO shall establish a procedure and work closely with HSH to ensure a seamless transition for all members transitioning into CCS.
2. the BHO may reach out to the member's chosen QI HP (if indicated on the Consent Form) to participate in the discharge planning for the member.

HSH DISCHARGE STATUS/HEARING OUTCOME

OFFICIAL DISCHARGE

HSH Responsibilities

1. Notify HCOB to activate Medicaid.
2. Notify the BHO and work together to ensure a seamless transition.

HCOB Responsibilities

1. If member is Medicaid eligible, request Medicaid activation.
2. If member is Medicaid ineligible, continue to work with BHO after discharge if more information is required.

BHO Responsibilities

1. Once notified, work with HSH and HCOB to ensure a seamless transition.

NOT DISCHARGED or LEGALLY ENCUMBERED

HSH Responsibilities

1. Notify HCOB to pause Medicaid activation.
2. Notify the BHO to cancel transition.

BHO Responsibilities

1. After notification from HSH, if collaboration started prior to discharge, notify the QI HP.

AFTER DISCHARGE FROM HSH

MEDICAID ENROLLMENT ACTIVATED

BHO Responsibilities

1. The BHO will contact MQD to request CCS enrollment once member is enrolled in Medicaid.
2. Upon discharge from HSH, all members will be placed in Service Level 5.
3. If the QI HP has already been participating prior to discharge, the BHO shall continue collaboration with the QI HP to ensure seamless continuity of care.
4. If the QI HP did not participate prior to discharge, the BHO shall contact the QI HP to begin Health Coordination services to ensure continuity of care.

QI HP Responsibilities

1. Continue or start Health Coordination services and collaboration with the BHO for transitioning members from HSH to ensure continuity of care.

MEDICAID ENROLLMENT NOT ACTIVATED

Members will be eligible for the HSH-CCS PROVISIONAL ENROLLMENT TRANSITION for ninety (90) days after HSH discharge.

AMHD Responsibilities

1. Enroll and begin engagement with members until Medicaid is active.
2. Will continue to work with HCOB, as needed, to establish Medicaid eligibility and check the CMO for Medicaid activation.
3. Will notify the BHO if Medicaid becomes active within ninety (90) days of HSH discharge and work together to transition the member to CCS services.
4. If it is after ninety (90) days since the member was discharged from HSH, and Medicaid becomes active, AMHD shall then be responsible to complete and submit a 1157 CCS referral to MQD as a routine eligibility determination.

BHO Responsibilities

1. Will continue to check the DMO for Medicaid activation and work with AMHD, as needed, for ninety (90) days after HSH discharge.
2. After ninety (90) days of HSH discharge, the HSH-CCS PROVISIONAL ENROLLMENT TRANSITION process stops.

AFTER CCS ENROLLMENT – CCS ELIGIBILITY DETERMINATION:

BHO Responsibilities

1. After 30 days of HSH-CCS provisional enrollment, shall conduct a CCS service level determination.
2. By the 45th day of the HSH-CCS provisional enrollment period, for all HSH to CCS presumptive eligible members, shall submit a complete 1157 packet to CSO for CCS eligibility determination.

MQD (CSO/HCSB) Responsibilities

1. CSO Psychiatrist or Medical Director will review 1157 referral packets to determine CCS on-going eligibility.
2. After CCS eligibility is determined, CSO will notify the BHO.

CCS ELIGIBLE DETERMINATION

BHO Responsibilities

1. Shall continue to provide CCS services at the BHO determined service level until the end of the ninety (90)-day HSH-CCS provisional enrollment transition period.
2. Shall continue collaboration and coordination of services with the QI HP.

CCS INELIGIBLE DETERMINATION

BHO Responsibilities

1. Shall continue to provide CCS services at the determined service level until the end of the ninety (90)-day HSH-CCS provisional enrollment transition period.
2. Shall continue coordination with the QI HP to evaluate members for all behavioral health services and housing navigation needs prior to the end of the ninety (90)-day HSH-CCS provisional enrollment transition period to ensure a seamless transition upon disenrollment from CCS.
3. At the end of the ninety (90)-day HSH-CCS provisional enrollment transition period, shall include members in the weekly CCS DIS-ENROLLMENT request list sent to MQD (HCSB) for CCS dis-enrollment. However, depending on the situation for each member, the BHO may also request URGENT CCS DIS-ENROLLMENT, at any time, as needed.

MQD (HCSB) Responsibilities

1. Shall review the dis-enrollment requests from the BHO.
2. If there are no issues with the information provided by the BHO, shall submit the request to have members dis-enrolled from CCS.

HAWAII STATE HOSPITAL (HSH)-COMMUNITY CARE SERVICES (CCS) PROVISIONAL ENROLLMENT TRANSITION CHECKLIST/COVERSHEET

***Complete this form and include with the HSH-CCS Transition Packet.**

DATE:		URGENT:	☐ YES	☐ NO
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MEMBER NAME:	
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FROM:	
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PH#:		EMAIL:	
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MEMBER HEARING or DISCHARGE DATE:	
Additional Info:	

INCLUDE THE FOLLOWING IN THE TRANSITION PACKET TO OHANA CCS:

- ☐ Completed HSH-CCS Provisional Enrollment Transition Checklist
- ☐ Completed HSH-CCS Provisional Enrollment Transition Consent Form
- ☐ Master Recovery Plan – *signed/dated*
- ☐ Medication list – *If not included in the Master Recovery Plan or Psychiatry note*
- ☐ History & Physical/Biopsychosocial Assessment – *most recent, signed/dated*
- ☐ Psychiatry note(s) – *most recent, signed/dated*
- ☐ Upon availability, copies of member's vital records (i.e., ID, birth certificate)
- ☐ Legal guardianship documents, if applicable

HAWAII STATE HOSPITAL (HSH) – COMMUNITY CARE SERVICES (CCS) PROVISIONAL ENROLLMENT TRANSITION CONSENT FORM

MEMBER LAST NAME	MEMBER FIRST NAME	DOB

The purpose of this form is to obtain consent and authorization for the provisional enrollment transition from Hawaii State Hospital (HSH) to Community Care Services (CCS) as follows:

- ☐ **YES** - I consent to CCS services and after discharge from HSH.
Please go to #1, 2 and 3 below.
- ☐ **NO** - I do not consent to CCS services after discharge from HSH.
Stop here. Please sign and date at the bottom.

After discharge from HSH and you qualify for Medicaid Services:

- If it is within six (6) months of disenrollment from your previous Medicaid Health Plan, you will be auto re-enrolled into the same Medicaid Health Plan you had prior to being at HSH.
- If it is more than six (6) months of disenrollment from your previous Medicaid Health Plan or you were not enrolled with a Medicaid Health Plan prior to HSH, you will be enrolled into Ohana Health Plan (OHP) to provide Medicaid services.

☐ Ohana Health Plan (*You will be enrolled in OHP even if you do not check this box*)

- If you **DO NOT** want your Medicaid services to be provided by OHP, please choose the Health Plan you want to be enrolled with. Please check only one (1) Health Plan below:

- ☐ Aloha Care
- ☐ HMSA
- ☐ Kaiser (Kaiser is only open to residents of *Oahu* or *Maui*. Residents of *Kauai*, *Lanai*, *Molokai*, and *Hawaii* island cannot enroll in Kaiser's Medicaid plan.)
- ☐ United Health Care

If you do not check off one of the boxes above, you will automatically be enrolled with OHP.

After the start of your chosen or assigned Health Plan services, if you decide you want a different Health Plan, please inform Med-QUEST Customer Service at 800-316-8005 of your new Health Plan choice within fifteen (15) days of the date of your enrollment choice notice. The new Health Plan will start on the first day of the second month after your call. Until then, you will stay with the Health Plan you are enrolled in.

In addition to the opportunity to change Health Plans after you first enroll, you are also able to request a change in your Health Plan at any time as long as you have been enrolled in the Health Plan you are leaving for at least twelve (12) months.

Member or Legal Representative or Authorized Representative Signature

Print Name

Date

***If signed by a Legal Representative, be sure legal representative/guardianship documents are present at the time of signature and attached with this document*

*** If signed by an Authorized Representative, be sure member consent for the Authorized Representative is verified by the member at the time of signature and attached with this document.*