Community Care services (CCS) Program RFI Responses (RFI-MQD-2021-010)

- **Collective Medical**
- **Community Mental Health Centers**
- **Ohana Health Plan**
- **Optum**
- **Waikiki Health Center**

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August 14, 2020

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Re: Collective Medical Response to Hawai'i Community Care Services (CCS) [RFI-MQD-2021-010]

To whom it may concern:

On behalf of Collective Medical (Collective) we are pleased to submit comments in response to the State of Hawai'i Department of Human Services Med-QUEST Division's Request for Information in preparation for Community Care Services' (CCS) re-procurement of a managed care or behavioral health organization. We commend the attention to efficiency, innovation, and patient outcomes in this RFI; we believe that by seeking this information, Hawai'i is on track to achieve an holistic and compassionate approach to behavioral health that will make the most of the state's resources and improve the lives of its most vulnerable populations.

Collective operates the largest real-time care collaboration network in the United States. Using unique technology, Collective unifies a patient's entire care team—including hospitals, primary and specialty care, post-acute care facilities, behavioral health providers, community service organizations, and health plans—to collaborate for the good of the patient.

Because Collective is not a managed care or behavioral health organization, we restrict our comments to the questions on which we have specific knowledge stemming from our years of work in the field of healthcare interoperability and information sharing.

1. What recommendations should MQD consider adopting that would increase standardization, reduce administrative burden, and maintain program integrity?

Behavioral health managed care carve-outs, although they can benefit patients through specialized care and services, also pose a risk of increasing fragmentation. Collective applauds MQD's acknowledgement of this challenge and its focus on alignment and standardization across CCS, QI and other parts of the delivery system.

One way to reduce administrative burden is to ensure that patient data is not siloed by program, particularly given that patients in the CCS program will receive services through both CCS and QI. Instead, payers and providers in both CCS and QI need to have the tools to be able to access critical data at the right point in time (in compliance with federal and state privacy laws) to gain a holistic view of the patient, assess their needs and risks, understand who is on the patient's care team, and reduce duplication of services. In concert with other programmatic efforts, Collective Medical recommends implementing healthcare interoperability technology solutions in order to achieve these objectives.

One example where an interoperability technology solution has been successful at reducing administrative burden is with the community-based palliative care team, Housecall Providers in Portland, Oregon, which relies on the Collective platform's real-time alerts, customized to address their needs. Housecall, a CareOregon provider, provides advanced care for patients at home. Their Medicare Independence at Home (IAH) program ensures quality care in the home by establishing six standards for home healthcare, including patient follow-up after hospital discharge, medication collaboration, and managing patient preferences for care.

Historically, case managers at Housecall Providers would spend hours a day trying to meet these benchmarks by calling around to different hospitals and facilities, looking for their patients. Using the Collective Platform, Housecall Providers was able to not only meet these standards but have more time to help more patients. Within the first year, Housecall Providers met all six key metrics, saving Medicare $1.8 million in care costs. Housecall Providers received 80% of those savings, totaling $1.2 million. Their practice has continually met these metrics, leading to $500K-$1.2 million in reimbursements each year.

Collective urges MQD to include in the CCS RFP a requirement or incentive for CCS and QI plans to implement an interoperable care coordination solution that enables data sharing among hospitals, ambulatory providers, and other post-acute care settings across the spectrum of behavioral health and medical services for the purpose of improved standardization and a more seamless experience for patients. The broad, deep data flowing from these providers and plans

should be delivered promptly and cleanly to bring attention to true needs without bogging down workflow. Collective would welcome the opportunity to talk further with MQD about additional technology-driven strategies to reduce administrative burden that could be applied to the CCS program.

Additionally, to the extent that MQD can generally align CCS and QI contract requirements, we expect that this would streamline administrative and compliance processes. This includes ensuring that providers of basic behavioral health services that are participating in both CCS and QI have the same or similar contractual requirements.

2. What strategies should MQD consider adopting that support movement along the continuum of value-based care/payment models?

Movement along the continuum of care in value-based behavioral health care must rely on robust, timely collaboration among providers, payers and community resources. Adopting a strategy that strengthens collaboration must include a data-sharing solution to empower each part of the care team with clear and timely communication, thereby facilitating decision-making about the most efficient, effective ways to meet the needs of patients.

Note that many EHRs and HIEs do not have the technological capability to share specific, consented information compliant with the Federal Confidentiality of Alcohol and Drug Abuse Patient Records Regulations— more commonly known as 42 CFR Part 2. This is one reason additional interoperability software solutions may be needed.

Organizations that have implemented the such solutions to serve behavioral health-related goals in value-based care have seen impressive results:

- Using Collective's real-time, ADT-based notifications, Aspire Health Alliance, a Medicaid health plan in Massachusetts with a dedicated Behavioral Health Community Partner program, has been able to raise patient engagement by 150 percent.
- Northwest Physicians Network (NPN)—an independent physician association in Tacoma, Washington, uses Collective's solutions to collaborate with Pierce County's Mobile Community Intervention Response Team and emergency services to increase efficiency and improve outcomes for patients with substance use disorders, mental health conditions and other complicating factors. This strategy has generated a 44 percent reduction in 911 calls, a 47 percent decrease in EMS transport, a 36 percent reduction in

ED visits, a 42 percent decrease in hospital admissions, and a 31 percent drop in observation stays.

Collective suggests MQD require all participants to use expanded interoperability solutions to support collaborations toward systemwide or plan-based goals—or both.

3. What strategies should DHS adopt that align incentives with the CCS and QI programs that improve outcomes, while better managing financial resources? Please suggest measures that would be effective and appropriate to include in the Performance Incentives for the CCS contractor. Include an explanation as to why these measures are suggested.

The most important strategy we can suggest to support any measure included in Performance Incentives is that each measure be supported by strong tools for sharing healthcare information and reporting on outcomes so that these measures can be accurately tracked and evaluated,. We do not suggest measures for CCS and QI but rather point to two key Medicaid managed care incentives below, with explanations for how a robust data sharing platform supports achieving each one and measuring its outcomes.

Any data sharing platform chosen for use by CCS, QI, or other plans and providers should be able to adapt to function on par with the descriptions below for any measure DHS decides upon.

1. *Follow-Up After Hospitalization for Mental Illness (FUH):* Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days and 30 days of discharge.

   How data sharing supports the measure: Depending on the state's specific approach to 42 CFR Part 2, the data sharing platform can notify the patient's health plan about appropriate details regarding the patient's encounter or admission. The platform must be able to adapt to state-specific requirements regarding 42 CFR Part 2. The real-time nature of these notifications greatly eases the requirement to follow up within 7 days. The platform should include reporting capabilities to facilitate documentation of compliance with the FUH measure.

2. *Follow-Up After Emergency Department Visit for Mental Illness (FUM):* Assesses emergency department (ED) visits for adults and children 6 years of age and older with a

diagnosis of mental illness and who received a follow-up visit for mental illness. Two rates are reported:

a. ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
b. ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

How data sharing supports the measure: A patient's health plan should receive notification from the data sharing platform as soon as a patient presents at the ED or receives a follow-up visit for mental illness. With no lag time in notification, it is not difficult for the health plan to meet the 7-day requirement. Any data sharing platform chosen for use should include reporting capabilities to facilitate documentation of compliance with the FUM measure.

As health systems implement these measures using robust data sharing and reporting, they also find opportunities to help individuals with behavioral health diagnoses or presentations to obtain appropriate care outside the ED, resulting in better management of their conditions, and to avoid hospital readmissions.

4. What specific activities should the BHO do and prioritize to meaningfully and proactively impact and facilitate such integration?

Data sharing and care coordination at the point of care are vital for the integration of BH with the broader healthcare system.

Suggested priority measures. We suggest that behavioral health organizations in Hawai'i focus on reducing unnecessary ED use and readmission rates as achievable, measurable goals with the support of a technology solution to improve communication and collaboration. This has proven successful in parallel situations in other states. As an example, Mid-Valley Behavioral Care Network (BCN) in Salem, Oregon, implemented the Collective platform to connect their case managers, psychiatrists, and therapists with members of the patient care team outside the network, targeting improvements in ED use and readmission rates. Having timely access to relevant data has not only helped BCN improve care for patients with patterns of high ED utilization, but has increased rates of patient follow-up within seven days by 11 percent. In Massachusetts, Collective notifications have proven to reduce readmissions by 4.8 percent statewide. Including care guidelines in the platform further reduces readmissions 12.8 percent.

Target populations. More specific measures may also be undertaken for defined population groups. When it comes to individuals with a history of threats, violence, or other security incidents in a healthcare setting, BH can be a contributing factor. A holistic approach has been shown to improve safety and security for providers and patients throughout the healthcare system, and BH patients identified for this kind of care can better obtain BH and non-BH medical care. Figure 1, below, shows one way this kind of collaboration might operate.

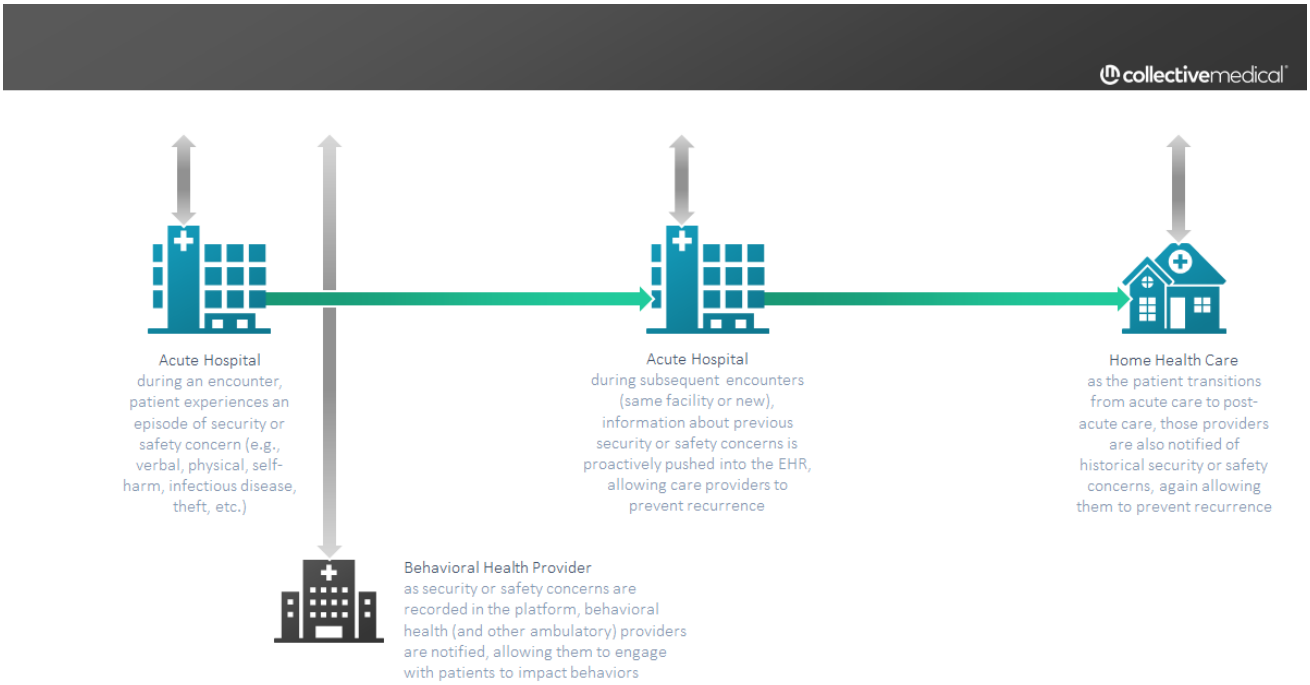

Figure 1: Interaction of BH with other providers collaborating using the Collective platform to assist a patient with a history of security incidents.

Providers at Torrance Memorial Medical Center in Southern California needed to find a way to better care for patients walking through hospital doors, particularly those with a history of violence. After Collective's solutions helped identify patients in need of additional attention, an interdisciplinary team of case managers, social workers, nurses, and physicians started meeting to discuss those patients, focusing on their needs and vulnerabilities as well as the safety of hospital staff. They created unified care plans that allowed providers to access insights wherever the patient went. Focusing on collaborative care plans not only helped staff address workplace violence, but also led to preliminary results showing a 57 percent decrease in ED utilization.

Another specific area for BHOs to target may be opioid misuse. The core components of Collective's Substance Use Disorder Coordination and Reporting functionality represent our approach to best practices for addressing this issue through data sharing solutions; these components are (1) hospital and community integration, (2) patient dashboard analytics and reporting, and (3) MAT workflow integration and coordination.

The chosen data sharing platform should be required to provide reports and dashboards that are customizable to the needs of the hospital, MAT clinic, BHO, health plan, community supports, and other care team members as needed. Using this kind of customization, the Collective platform, for example, has been used to successfully address opioid misuse in several locations.

Below are case studies of successful initiatives which could be adapted and applied to improve behavioral health outcomes for individuals with substance use disorders in Hawai'i:

- The SUD program at Hardin Memorial Hospital (HMH) in Kentucky, has used Collective's platform to connect to local SUD clinics such as Stepworks, a treatment and recovery center with five locations. The Stepworks care manager gets a real-time notification when one of their patients is in the HMH ED, which allows them to reach out to the ED social worker and meet the patient at the ED before opioids are given. Stepworks can intervene before the patient leaves the hospital, and in all but a few cases, these patients have chosen to re-engage in treatment.
- Rich data sharing has helped boost retention rates for medication-assisted treatment (MAT) programs for Bartlett Regional Hospital in Alaska, to achieve a 63.6 percent retention rate—15 percent higher than the national average.
- The Community Hospital of the Monterey Peninsula and other providers across Monterey County have implemented a care collaboration program using the Collective platform that has led to a 32 percent reduction in opioid deaths in Monterey County, a 59 percent reduction in ED visits, and a 50 percent decrease in the number of narcotic pills prescribed at the local primary care clinics.
- Virginia's Emergency Department Care Coordination (EDCC) program, launched in the summer of 2017, helps ED staff identify if a patient has been seen somewhere else, how they were treated, who their primary care provider is, and if they've had any controlled substances prescribed to them. Giving medical providers access to critical patient information in real time has helped decrease fatal opioid overdoses from 1,230 in 2017 to 1,213 in 2018. Additionally, all fatal drug overdoses in Virginia dropped from 1,536 in 2017 to 1,484 in 2018.

5. What are the best ways to align CCS with QI, Hawaii CARES, DOH-AMHD, DOH-CAMHD, Judiciary, and Public Safety programs?

Collective Medical recognizes that addressing the needs of the whole person is the best approach to caring for any health issue, but especially for behavioral health care. We advocate for the inclusion of community supports and other entities that affect social determinants of health in a patient's care team as much as possible. These agencies and programs need to share data with each other so that CCS plans and providers have access to social determinants of health data that inform care. We recommend that MQD establish or build upon data sharing mechanisms, processes, and platforms between these agencies so that no patient falls through the cracks.

We have seen successful in facilitating communication with non-healthcare entities to support a patient's healthcare experience; for example, in Oregon, the state HUD agency provides a list of Medicaid members who are on the waiting list for a housing voucher. This helps providers understand and support a patient who may be unsheltered or in an unstable housing situation. To follow up on this information, they may come up with strategies like more frequent check-ins from a care manager, a different plan for re-filling and storing medications, or increased attention to health risks that accompany the patient's situation.

We recognize different communities have different ways of managing the coordination of community-based care. In one innovative approach, the Mat-Su Health Foundation—a non-profit organization set up to support the health of the people of the Matanuska-Susitna Borough, Alaska (including the cities of Palmer and Wasilla as well as a large rural area)—was looking for a way to support its "High Utilizers of Mat-Su" (HUMS) program. Partnering with Community Based Care Solutions, a care coordination company based in Seattle, the foundation relied on improved communication through real-time Collective Notifications and collaborative care to track and help these patients, achieving a 61 percent reduction in ED visits and a 20 percent reduction in opioid use. This ultimately saved Mat-Su several million dollars in unnecessary care costs, and improved community satisfaction.

Collective would welcome strategic opportunities to discuss and innovate on this front in collaboration with MQD, CCS, and associated organizations.

13. Data and electronic health information exchange has been an ongoing discussion. What are your thoughts on how CCS can continue to play a role in data sharing and other related electronic health efforts?

We recommend that CCS ensure that all the providers and plans have data sharing platforms and tools, work with each other to promote common data sharing requirements and standards. It will be important to provide resources, support, and training to providers with limited health IT capabilities.

Our health plan customers find it extremely useful to receive a real-time notification when a patient they care for or a member of their care plan seeks care at a new location, especially if it is on a different care network or plan, rather than waiting for long-delayed claims data. Upon implementing a sophisticated interoperability solution with a large and growing network presence that reaches into other states, CCS may even benefit from knowing when plan members seek care outside Hawai'i. Non-BH providers will similarly be able to improve their responses to patients when they know what has been occurring with their patients who receive BH care through CCS.

We acknowledge that existing systems in use in Hawai'i provide electronic notifications (ENS) that overlap with part of our capabilities and recognize the value of those systems. It would be beneficial for DHS to work to expand upon current ENS capabilities by incorporating additional data sharing solutions.

We offer the table below to illustrate how a robust data sharing platform such as Collective's can accomplish this.

The Collective Platform Compared to Standard ENS Platforms		
Functionality	Collective Medical	Standard ENS
Accessible to all emergency room providers and case managers throughout the state for cross organizational care coordination	✓	
Accessible to all payers, behavioral health clinics, LTPAC, and primary care providers throughout the state for cross-organizational care coordination	✓	✓

Functionality	Collective Medical	Standard ENS
Curated insights summarizing disparate data sources: • ED admit, transfer, and discharge (ADT) • Inpatient / hospital ADT • Patient history • POLST advanced directives • Continuity of Care Document (CCD) • Claims data • Collaborative care plan • Security events • PDMP integration • Real-time analytics based on hospital/plan configured criteria	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓
Cross-organizational patient matching capability	✓	✓
Real-time analytics identify high-risk patients/target populations and alert providers only to those patients who require additional context or attention, eliminating 'notification fatigue'	✓	
Context-specific notifications embedded into existing workflows through the existing HER (e.g., ED tracking board) or clinical management system	✓	
Notifications with clinical content, curated and synthesized to meet the unique needs of acute, post-acute, and ambulatory care providers	✓	
Incorporation of ED or system-wide related security incidents into real-time analytics and provider notifications	✓	
Incorporation of collaborative care plans and care recommendations that can be consumed and contributed to by all stakeholders involved in a patient's care	✓	

Functionality	Collective Medical	Standard ENS
Configurability of notification mediums by stakeholder, either individually or by type (e.g., HER integration, secure [DIRECT] mail, SMS / text, email, web portal, network printer, or fax)	✓	
Customizable population-level dashboards and reports based on payer or facility	✓	

A platform like Collective's represents an important addition to a traditional health information exchange and an electronic health record system. We aim to collaborate with those who provide them to round out and enrich the data offering as well as ease the delivery, where possible, to the providers, payers and others who use the data to collaborate with each other. As HIE and EHR systems vary in their features and functionalities, we typically work with our customers and innovation partners to ensure they are receiving the parts of our offering they most need to reach their goals. A comparatively modest investment in Collective's solutions should boost the use and value of existing HIEs and EHRs—not supplant them.

Consider an HIE that provides patient record look-up, clinical alerts, and clinical summaries. A broader data-sharing platform such as Collective's should have the capability to enrich that content as follows:

- Patient record look-up
    - Comprehensive history of utilization from in and out of state
    - Ability to surface key patient attributes with unique, goal-driven flag or tag capabilities
    - Deployment of integrated provider workflow
    - Inclusion of detailed patient-specific care insights from collaborative care plans as documented by providers and payers on the network
- Clinical Alerts
    - Real-time, context-specific, predictive insights, at the point of care in workflow, to enable point-to-point collaboration across the spectrum
- Clinical summaries
    - Addition of detailed, user-generated, patient-specific care plans shared across the network, in workflow at the point of service

Figure 2, below, will help visualize how Collective can work in partnership with an HIE.

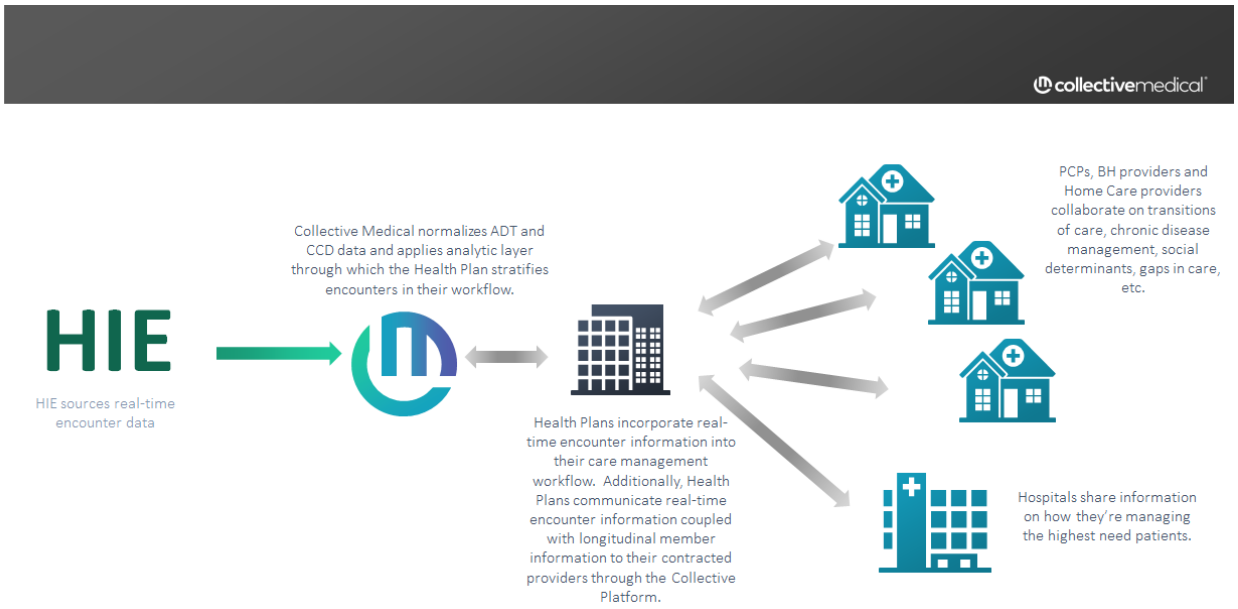

Figure 2. Collective rounds out and enriches the data provided by an HIE, boosting its value to providers and payers. For simplicity here, we show data flowing in one direction; in practice, Collective would connect directly with the HIE, health plans, and all types of providers.

Additional Input: Successful Statewide Implementation of Robust Data Sharing to Achieve Goals

Ensuring that patients with complex needs—often those who are dually eligible–are receiving the right care at the right time and in the right setting creates an all-around win: the healthcare system becomes more efficient and resilient, and patients experience improved outcomes. CCS and QI should be supporting the use of data sharing solutions that have a proven track record of supporting this goal in several use cases, for example:

- Frequent ED utilizers may need connections to primary care for management of chronic conditions, with the goal of reducing ED use.
- Frequent ED utilizers may need connections to community supports so that their non-healthcare needs can be met there, again with the goal of reducing visits to the ED.
- Patients at risk of hospital readmission can experience greater follow-up and support so that they can return to their best possible level of health in the least restrictive (and least expensive) care setting, with the goal of reducing readmissions.

Interoperability solutions such as those offered by Collective Medical can support these scenarios in three important ways:

1. Identify and surface the patients whose needs match the goals set in any of these situations
2. Provide opportunities for collaborative communication, such as Collective's unique Care Insights feature, where providers can add personalized, vital information about a patient to be shared with other members of the care team across the continuum of care
3. Provide reporting to responsible agencies with the metrics they've selected to measure each goal.

Any vendor providing such a solution should be required to provide robust onboarding and support so that the software implementation moves each participant forward with notifications, user interface, and reporting options aligned with chosen goals.

For example, the "ER is for Emergencies" program in Washington state chose Seven Best Practices as follows:

1. Track emergency department visits to reduce "ED shopping"
2. Implement patient education efforts to re-direct care to the most appropriate setting
3. Institute an extensive case management program to reduce inappropriate emergency department utilization by frequent users
4. Reduce inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care physicians and improving access to care
5. Implement narcotic guidelines
6. Track data on patients prescribed controlled substances by widespread participation in the state's Prescription Monitoring Program (PMP)
7. Track progress of the plan to make sure steps are working

In 2014, after only one year of the "ER is For Emergencies" program, the Brookings Institution evaluated and reviewed the results and found that, statewide, there was a 10 percent drop in total Medicaid ED visits year-over-year, a 24 percent reduction in ED visits with opiate prescriptions, and $34 million in savings.

In another example, Aspire Health Alliance runs a behavioral health program for Massachusetts Medicaid program, MassHealth. The program is opt-in only, which meant traditionally participation rates were averaging 10 percent. a robust data sharing solution in place, Aspire case managers receive real-time notifications and can follow-up with patients while in the ED,

instead of tracking them down post-discharge, leading to a 50 percent opt-in rate for behavioral health programs when patients are engaged in the ED, and an overall 35 percent participation rate.

Conclusion

In our ideal vision, CCS would participate with QI and as many other entities as possible to create a robust, active network of appropriately shared health information in Hawai'i, thereby facilitating a well-informed, highly interactive virtual interdisciplinary care team for any patient who needs it. Our experience shows this will save costs, improve experiences, and most importantly, create better health outcomes for the citizens of Hawai'i.

We appreciate the opportunity to submit our input in response to your Request for Information. Collective would welcome further discussion with you regarding lessons learned from our national network and ways to improve access, quality and outcomes for the individuals for whom you facilitate and provide care. Please do not hesitate to reach out using the contact information provided below.

Sincerely,

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CMHC Response to Community Care Services (CCS) [RFI-MQD-2021-010]

1.What recommendations should MQD consider adopting that would increase standardization, reduce administrative burden, and maintain program integrity?

CCS should not be allowed to mandate a secondary charting system for providers. They should be responsible to pull the information they need out of provider EMR via audits and chart requests. The requirement of Celltrax has been a huge burden on staff and most of the time celltrak has issues that we can't control so our documents are entered late which we get penalize on our score card. Keep the behavioral health services back to the QI plans for convenience for providers and members easy access to the plans. As providers, dealing with two different contracts that is being managed by MQD is a burden. Having to enter information in celltrak and in our EMR is not a best way to standardize. It creates more stress for our providers while we continue to provide quality service to Medicaid beneficiaries.

2.What strategies should MQD consider adopting that support movement along the continuum of value-based care/payment models?

Look at outcomes that show progress with the consumer. Such as psychiatric hospitalizations, treatment/recovery plans, etc…. Making the payments based on entering information into a CCS only program does not help the consumer or service provider, it only helps CCS to gather the data they need. MQD should measure quality of service via client outcome/results and not timeliness of submission of forms/contacts. How do you expect providers to participate in the value-based care/payment models if CCS requests too many documents for each CCS members? We get penalized for not entering or submitting the documents timely to CCS so I don't know how can we be part of the VB care if there are too many administrative burden to providers and with VB care/payments, I'm sure these will also requires more data to get measure in order to get the payment from MQD or CCS.

3.What strategies should DHS adopt that align incentives with the CCS and QI programs that improve outcomes, while better managing financial resources?

For services needing prior/service authorizations - Would it be possible to establish an initial amount of service and the program would need to request authorization if the client requires additional units. We need to supplemental documents that must accompany the authorization request is normally the behavioral health assessment, recovery plan and sometimes LOCUS. Too many requirements to get authorization for case management service which is needed for most of the CCS members.

4.What specific activities should the BHO do and prioritize to meaningfully and proactively impact and facilitate such integration?

One activity is to improved care coordination for patients requiring both physical and mental health services to improve the quality and outcomes and patient's daily lifestyle. This will enhance patient compliance with preventive care, which will also improve their chronic conditions and will be manage easily.

5.What are the best ways to align CCS with QI, Hawaii CARES, DOH-AMHD, DOH-CAMHD,Judiciary, and Public Safety programs?

To integrate the organizations the CCS carrier should have coordinators whose assignment is to facilitate information between the different entities. These coordinators would be responsible for making sure prior auths are done and forwarding to their administrators.

6.What considerations should DHS be aware of in relationship to CCS eligibility determination and services access? Are there any contractual changes that could be made to support improvements in this area?

CCS needs to be held accountable to have equal services on all islands. Currently CCS does not have their own in house level 5 teams on Kauai and Maui. This creates a disparity of care between the different islands. They should be held contractually to have equal services to all areas of service.

7.What new or existing key staff positions should the CCS BHO have in order to facilitate such alignment? Provide suggested qualifications for each of such positions discussed.

If CCS were to have their level 5 teams on all islands, they would have the positions and qualifications in place

8.Provide recommendations for a case management reimbursement model that would produce best case management practices and services for CCS members.

Fee for service with no exclusions or caps on service times per month. Capitated rate does not cover the amount of time necessary for a level 4 or 5 consumer. What does MQD consider to be the best-case management services? I work with very dedicated, and caring case managers. So I would like to know your definition of BEST CASE MANAGEMENT practice and services.

9.How should we structure reimbursement to incentivize providers to appropriately place members along the stepped care continuum? Fee for service and reimburse for med management consumers.

10. With the advent of COVID-19, what should be considered for CCS in the context of telehealth?

CCS should be more active in assisting their consumers with telehealth options. Mobile kiosks, a CCS monitored office their consumers can use would be two ideas. Many of the CCS clients do not have devices that can connect them to a tele-health appointment. What can CCS or MQD do to facilitate this? Since COVID-19 is going to be around for a while – this should be a priority. We noticed that after 2-3 months

clients were asking to “SEE” their doctor and were so happy when we arranged a tele-health appointment at our KIOSK.

11.Describe the components of CCS that work well or that you would recommend DHS keep and/or build upon. Provide detail.

Their staff are very polite and nice to work with. The CCS staff are knowledgeable, responsive and very professional. They are a pleasure to work with.

12.What recommendations or considerations should DHS be aware of in relationship to behavioral health crisis management and response? Describe what works well and what can be improved.

Please refer to Level 5 comments previously noted. Our community has been taught to seek and utilizes crisis services – crisis mobile outreach that is offered in our community. This service should be continued and expanded to offer assistance with RX refills when appropriate. Some clients go into crisis because they do not have the where-with-all or the funds to refill their medication.

We also need to have other health plans that are part of DHS to pay for the crisis service we provide to Medicaid beneficiaries.

13.Data and electronic health information exchange has been an ongoing discussion. What are your thoughts on how CCS can continue to play a role in data sharing and other related electronic health efforts?

CCS has never been functional in data sharing at a meaningful level for consumer concerns. CCS auditors cannot even access Celltrax and require service providers print out information for their use that is found in Celltrax.

Celltrak is a waste of time for everyone and it creates duplicate work for our staff. If CCS needs documentation for their audit, we can always print it from our EMR.

Response Submission for the
Community Care Services (CCS) [RFI-MQD-2021-010]
From the Department of Human Services
Med-QUEST Division

August 14, 2020, 2:00 p.m. Hawai‘i Standard Time (HST)

‘ohana health plan™

ORGANIZATION CONTACT INFORMATION

RFI submission must include the name, organization (if applicable), and contact information of the person/organization submitting the response.

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QUESTIONS FOR RESPONDENTS

STANDARDIZATION AND ADMINISTRATIVE IMPROVEMENTS

DHS supports increased standardization and reduced administrative burden at the DHS level, MCO/BHO level and the provider level in key areas such as quality assurance, quality improvement, billing, credentialing, prior authorization processes and tools, and other areas.
1. What recommendations should MQD consider adopting that would increase standardization, reduce administrative burden, and maintain program integrity?

Standardization in key operational areas can reduce administrative burden at the DHS, MCO/BHO, and provider levels, which enables greater focus on member care and service coordination. ‘Ohana supports standardization to reduce administrative burden, and we see opportunities in the following areas:

- **Standardized Referral Forms:** Ensure a consistent referral format across CCS and QI health plans that can be completed electronically to reduce the time it takes providers to complete these forms.
- **Standardized Provider Scorecards:** Enable providers through automated reports or dashboards to evaluate their service delivery and strategize ways to enhance program integrity and improve health outcomes.
- **Shared Learning Collaboratives:** Encourage health plans to provide training on referral workflows and evidence-based treatment models, share experiences with practice transformation implementations, and develop more efficient processes for referrals and reporting metrics.
- **Performance Measures:** Measure health plan performance according to indicators of positive health outcomes, rather than administrative benchmarks, to allow the MCO/BHO to focus on innovative programming that will help maintain program integrity and make participation in the CCS program easier for providers.

DELINEATING FINANCIAL RESPONSIBILITY

To reduce administrative burden for the MCO/BHO and providers, ‘Ohana recommends a more clearly delineated financial responsibility between the CCS and QI programs for services provided to members that aligns with program outcomes. This approach will reduce the administrative burden while maintaining the complex care coordination needed to deliver services to this highly specialized population.

Behavioral Health Foster Home placements for CCS members should be the responsibility and benefit of the MCO/BHO, giving more access to members with the most complex needs to specially trained foster home placements

STREAMLINING CCS ELIGIBILITY AND ENROLLMENT

In order to reduce administrative burden on DHS, the MCO/CHO, and providers, we recommend streamlined processes for eligibility determination and enrollment in CCS. We recommend reducing the CCS program referral form from three pages to one page, and requiring that it be accompanied by a comprehensive psychological evaluation.

INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTHCARE

DHS is interested in aligning incentives, strategies, and policies to create a health care system that better integrates the behavioral health services provided through CCS, and the physical and long-term services and supports provided by the QI MCOs.
2. What strategies should MQD consider adopting that support movement along the continuum of value-based care/payment models?

Providers enter the continuum at different starting points and with varying resources available. We recommend that MQD collaborate with physical health, LTSS, and behavioral health providers, CCS MCO/BHO, QI MCOs, and other stakeholders to identify a standard set of quality and cost efficiency measures. Standard approaches built around agreed upon measures can then be tailored for individual providers and provider types to best support integration.

In addition to encouraging health plan innovation through the procurement process, we recommend that MQD create mechanisms that encourage and support providers to move along the VBP continuum. This includes developing a statewide VBP roadmap, subsidizing investments in technology and infrastructure to prepare providers for assuming risk, and encouraging submission of data to state supported health information exchanges such as the Hawaii Health Information Exchange (HHIE). We also recommend that MQD convene an ongoing health plan and provider joint workgroup to discuss progress, identify barriers, develop strategies, and share best practices to support the delivery-system as a whole in advancing integrated value-based care.

3. What strategies should DHS adopt that align incentives with the CCS and QI programs that improve outcomes, while better managing financial resources? Please suggest measures that would be effective and appropriate to include in the Performance Incentives for the CCS contractor. Include an explanation as to why these measures are suggested. Health outcomes are optimal when physical healthcare and behavioral healthcare are integrated and addressed cohesively and in harmony.

‘Ohana supports aligned incentives that promote efficiencies in service delivery and improved outcomes for members served by the CCS and QI programs. We recommend that MQD, CCS and QI health plans, and providers agree on a core set of standard measures and performance goals that align with the goals of the HOPE Initiative and are based on nationally standardized measures when possible. Each health plan should have the flexibility to structure payment models with providers based on these standard measures depending upon a provider’s capabilities and ability to assume risk.

Based on our experience in serving members in both the QI and CCS program, we suggest that MQD consider the following process and outcomes measures that we believe directly impact health outcomes:

- Annual comprehensive health evaluation
- All cause readmissions
- ED utilization
- Inpatient utilization
- Routine outpatient psychiatrist or other behavioral health prescriber visits
- Medication adherence
- Connection to pro-social activities, including Clubhouse, supported employment, and PSR groups
- Initiation and engagement of SUD services
- Post-hospital follow-up
- Housing stability (number of months/year that the member is in stable housing and/or utilization of pre- and post- tenancy services for at risk members)
- Crisis service utilization
- Number of co-located providers (primary care physician within a behavioral health practice or behavioral health clinician within a primary care practice)

Additionally, we would like to advocate to retire the frequency of case management visits as a performance measure. We feel that the above suggestions will provide better insights to MQD as to the impact the CCS MCO/BHO is having on member health.

4. What specific activities should the BHO do and prioritize to meaningfully and proactively impact and facilitate such integration?

ʻOhana fully embraces a whole person approach that integrates member care to meet their physical, behavioral health, LTSS, and social needs. We suggest that MQD consider the following strategies to help the BHO meaningfully facilitate integration:

- Adopt focused strategies for addressing enrollees' social needs, which have a significant impact on their ability to engage in care and contribute to poor health outcomes and untreated behavioral health needs.
- Reimburse behavioral health providers for screening enrollees for physical health needs.
- Encourage providers to adopt a Collaborative Care model.
- Reimburse PCPs and specialists for participating in care planning.
- Encourage and support development of a common patient consent model among all healthcare providers in the community so that hospitals, PCPs, and behavioral health providers can effectively share physical and behavioral data through common, legally compliant, and secure exchange protocols.

PROMOTING A BEHAVIORAL HEALTH CONTINUUM

5. What are the best ways to align CCS with QI, Hawaii CARES, DOH-AMHD, DOH-CAMHD, Judiciary, and Public Safety programs?

As the only MCO that serves members through both the QI and CCS programs, ‘Ohana has unique insight into the benefits of alignment and the associated challenges. In our experience, increased alignment can be achieved through the following strategies:

- Align funding so that members can seamlessly access the services they need without having to meet separate eligibility requirements.
- Align benefits between CCS and DOH to allow CCS members to access Behavioral Health Group Homes and Hawaii State Hospital as needed.
- Establish a defined set of streamlined quality metrics that all MCOs and providers are working together to achieve.
- Establish a core set of screening and assessment tools to be used by all providers and systems.
- Develop standard processes for member referrals for close collaboration on transitions from the listed entities, including closed loop referrals and continued care coordination.
- Offer system-wide training on key topics such as Trauma Informed Care, Mental Health First Aid, and Recovery and Resiliency.
- Create a system of clinical support to increase providers’ capacity and comfort level with serving individuals with co-morbid needs and complex conditions.
- Develop standards and processes for information-sharing across providers and systems.
- Encourage enrollment alignment for members served by both the CCS and QI programs to promote whole person care.
- Execute statewide contracts for all systems of care, reducing member disruption if they move or their program eligibility changes.
- Hold regular meetings with stakeholders to collaborate to address system-wide issues and drive optimal health outcomes through promotion of best practices.

6. What considerations should DHS be aware of in relationship to CCS eligibility determination and services access? Are there any contractual changes that could be made to support improvements in this area?

ELIGIBILITY DETERMINATION

Eligibility determination for the CCS program could be simplified in order to best identify members in need of these critical services and provide treatment in a timely fashion. The current structure calls for a review and a determination within thirty days of receipt of referral from a QI health plan. This delay can be detrimental to members who are in need of special services quickly. It is our recommendation that the state consider automatic eligibility for members with the following diagnoses:

- Schizophrenia (F20.x)
- Schizophreniform Disorder (F20.81)

- Schizoaffective Disorder (F25.x)
- Delusional Disorder (F22)
- Bipolar Disorder (F30.xx, F31.xx)
- Major Depressive Disorder, Severe (F32.3, F33.2, F33.3)

Event-based eligibility could also be considered for automatic eligibility for CCS. These events could include multiple inpatient hospitalizations within a certain period of time. Co-existing substance use disorders and/or chronic comorbid physical and behavioral health conditions could also be considered to trigger automatic enrollment in the CCS program.

SERVICES ACCESS

Programmatic flexibilities for telehealth utilization allowed during the current public health emergency have increased access to services, but a limited cellular network continues to create a barrier to access for some members. If a member cannot access the right provider in their geographic area or via telehealth, we arrange for a flight which becomes costly, time-consuming, and difficult for members in need of care. Allowing for contracting with out-of-network clinics in extenuating circumstances is a potential solution to improve this situation.

7. What new or existing key staff positions should the CCS BHO have in order to facilitate such alignment? Provide suggested qualifications for each of such positions discussed.

We believe that the experience and expertise of the individuals filling key staff positions is as important as the roles that make up the structure. In order to best care for the SMI/SPMI population, the following roles must be filled with capable and specialized professionals: Medical Director, Executive Director, Financial Officer, Compliance Specialist, Data Analyst, a dedicated full-time Pharmacist, and Qualified Mental health Professionals as Team Lead Supervisors and Managers. We recommend employing a full-time treating psychiatrist working closely with a Certified Psychiatric Registered Nurse to ensure quality care in the critical task of medication management for CCS members. This collaboration supports stability in community-based settings, increases positive outcomes, and reduces costs.

In addition to these positions, we recommend dynamic staff in the following functional areas: Clinical Supervision and Support, Case Management, Member Relations, Provider Relations, Information Systems, Support Services, and Clerical. The Case Management staff plays a particularly important role in the care of members. This team should include a psychiatrist separate from the Medical Director.

REIMBURSEMENT CONSIDERATIONS

Currently, CCS has five service levels within a stepped care model, with level V being the most intensive service level. The current reimbursement system for the subcontracted community based case management (CBCM) agencies is a single per member per month (PMPM) payment for all service levels I – IV, with level V members receiving services directly from the CCS health plan.
8. Provide recommendations for a case management reimbursement model that would produce best case management practices and services for CCS members.

‘Ohana suggests a reimbursement model that provides a minimum per member per month payment to cover the cost of delivering services while giving providers the opportunity to earn financial incentives for improving member outcomes. Providers should have the opportunity to earn a performance bonus for meeting established quality performance metrics. They can leverage this additional funding to implement best practice approaches and deploy innovative strategies for improving member care and health outcomes.

‘Ohana further recommends that MQD consider reimbursing providers for leveraging CHWs and peer support specialists to support members in the community. Our affiliates in other states incorporate CHWs and peer support specialists as a viable and critical component of community-based care team. These models have shown promising results in reducing health disparities and increasing access to ongoing care.

9. How should we structure reimbursement to incentivize providers to appropriately place members along the stepped care continuum?

‘Ohana supports a reimbursement structure that considers the total cost of delivering care management services while rewarding providers for supporting members in achieving improved outcomes and decreasing their overall service level. The current reimbursement model does not account for the increased resources needed to support members in higher service levels. For example, members in higher service levels require additional face-to-face visits and are often involved in multiple systems and with several providers, including non-Medicaid providers critical to addressing social determinants of health. Comprehensive care of CCS members requires case managers to spend more time coordinating care and collaborating with community partners to arrange for services and supports.

To focus providers on delivering the appropriate level of care management based on the member’s needs, we recommend an approach that reimburses the provider based on the member’s service level and includes an incentive tied to the provider’s ability to advance the member to a lower service level. To reduce the likelihood that providers step members down to lower levels too soon, incentive measures should address potential indicators of emerging risk such as emergency department visits, inpatient admissions, and medication adherence.

‘Ohana is currently surveying Community-Based Case Management agencies to quantify the costs of delivering case management services by service level. Upon completion, we are happy to share the results with MQD to inform future reimbursement models.

RESPONDING TO THE PANDEMIC

10. With the advent of COVID-19, what should be considered for CCS in the context of telehealth?

The programmatic flexibilities that MQD has authorized in response to the COVID-19 pandemic helps members access needed services while minimizing disruptions in care. While these short-term solutions mitigate the immediate impacts of the pandemic, the long-term impacts on the CCS program will continue into the future. Consequently, ‘Ohana recommends that MQD continue allowing the following programmatic flexibilities after the public health emergency is lifted to best support providers and members:

- Flexibility with deadlines for conducting Behavioral Health Assessments and treatment plans
- Expanded service settings and scopes of service
- Expanded benefits and service limits which protect members’ health and safety

TELEHEALTH FLEXIBILITY

The telehealth flexibilities MQD has authorized in response to the pandemic enable more members and providers to adopt this channel of care. Consequently, ‘Ohana recommends that MQD permanently incorporate the flexibilities listed below:

- Flexibility on originating sites
- Expanded CPT codes for audio-only telehealth
- Waiving the established relationship requirement for telehealth check-ins/reassessments (Brief Virtual Check-In Visit)
- Telehealth for comprehensive health assessments
- Streamlining provider licensure and enrollment
- Expanding provider types who can deliver telehealth services

However, we urge MQD to allow health plans to resume former precertification, prior authorization, and other utilization management levers after the public health emergency to ensure that members receive the most cost-effective and medically necessary treatments while preventing costs from rising due to unnecessary utilization.

TELEHEALTH ADVISORY COUNCIL

We recommend that MQD convene the Telehealth Advisory Council to guide telehealth expansion. The Council can serve as a coordinating body for all health plans, providers, and community partners to standardize and simplify telehealth processes, such as pre-authorizations. In addition, the Council can spearhead efforts to establish Interstate Telehealth Compacts to grow the workforce of telehealth providers. Finally, in collaboration with health plans, the Council can organize an awareness campaign to promote telehealth to members and providers.

MISCELLANEOUS

11. Describe the components of CCS that work well or that you would recommend DHS keep and/or build upon. Provide detail.

'Ohana appreciates aspects of the CCS program that support our ability to provide quality care to members, including:

- **Shared electronic platform**. The use of a shared electronic platform and standardized clinical documents for contracted agencies has allowed for increased oversight and better monitoring to ensure the best care for members.
- **Monthly interagency meetings**. Connecting monthly with the QI health plans, state agencies, and other stakeholders is a best practice leading towards better outcomes for members. The presence of an MQD representative to provide feedback and monitor conversations is welcomed and appreciated.
- **Member advisory committee**. There is no better population to hear from on the performance of the BHO than the members themselves. Identifying member barriers and pain points helps focus efforts to improve access to care.
- **Internal prescribers.** Mandating agencies employ internal behavioral health prescribers is another welcome aspect of the CCS program.
- **Crisis hotline**. The 24/7 toll-free crisis hotline service is critical to ensure immediate access to care for members and resources for providers. This service is valuable to direct members to the nearest and most appropriate facility for care in the case of an emergency or crisis.
- **Assertive community outreach**. We believe strongly in assertive outreach to provide the flexibility needed to members in extenuating circumstances. If no contact has been made after one month, the member is referred back to the BHO by the provider and a collaborative process is put in place to contact the member in order to continue services. This is especially important for our most vulnerable members, including those who are homeless, have no access to transportation, and have language barriers. This approach ensures every effort is made to provide care to the individual before disenrollment, positively impacting member retention and engagement.
- **Internal Level V care coordination.** Providing case management services to Level V members internally provides the best care for the highest risk individuals.
- **On-site agency visits.** MQD on-site agency visits prompt productive feedback to the BHO. These touch points provide an added layer of oversight, help us identify needs, and strategize how to best work with each contracted agency.

12. What recommendations or considerations should DHS be aware of in relationship to behavioral health crisis management and response? Describe what works well and what can be improved.

It can be a challenge for health plans to properly deploy strategies designed to mitigate and control the effects of crisis situations with members. We recommend the following strategies to initial response and further management to ensure the care for members is both timely and successful across the continuum:

- **Training and support for first responders**. This approach is designed to equip law enforcement and emergency medical personnel with the training necessary to properly intervene when a person is in a behavioral health crisis. When partnering with local community resources, this creates a "no wrong door" approach and builds crisis resources into the community.
- **Training for the non-clinical workers.** Going beyond the clinical community, we see value in deploying training to the general population focused on behavioral health awareness and de-escalation techniques. Such programs would bring the issue to the forefront and prepare more community members to aid in crisis situations.
- **Telephonic support.** Be it through a 24-hour nurse line, text line, or innovative telehealth solutions, providing resources to avoid an emergency call and the need to transport to physical locations in order to receive help is beneficial to the member and will result in reduced costs.
- **Crisis education and training.** We strongly recommend crisis education trainings for staff members and providers alike. This will be helpful in changing the culture around crisis response with a unified approach and stresses its importance to the care of members.
- **Suicide care and prevention programs.** Supporting and implementing evidence-based programs like Zero Suicide.
- **ED diversion and intervention.** Providing a person-centered crisis facility, staffed with specialists and peers, would provide the member with the best chance to receive needed care in a non-emergency setting.

13. Data and electronic health information exchange has been an ongoing discussion. What are your thoughts on how CCS can continue to play a role in data sharing and other related electronic health efforts?

We agree with MQD's focus on data sharing as a way to enhance the CCS program. In our experience, leveraging technology to support data sharing promotes better partnerships, reduces unnecessary, counter-productive, and inefficient over-utilization of inpatient services, and results in improved outcomes for members.

STANDARDIZED DATA SHARING AND INTEROPERABILITY PROTOCOLS

To facilitate a streamlined data sharing process, we recommend that MQD support the creation of a workgroup with all health plans focused on data exchange and interoperability. The workgroup could be charged with identifying a shared format in which to exchange data and information that meets the US Department of Health & Human Services Office of the National Coordinator (ONC) for Health Information Technology standards. Identifying a consistent way to share data will reduce the burden on DHS and health plans from having to be able to receive multiple file types. MQD could encourage the adoption of industry standards for data exchange that include HIPPA compliant formats such as HL7 FHIR, HL7 CCD-A, and APIs that ensure data is exchanged securely and efficiently between stakeholders.

Additionally, in 2021, MCOs will be required to support interoperability standards as published by ONC. MQD may want to consider making this a focus area within the workgroup to support health plans as they progress towards addressing these anticipated standards.

PROVIDER ASSESSMENT, EDUCATION, AND INCENTIVES

MQD may want to consider surveying providers regarding their technology needs or leveraging a tool like the Integrated Practice Assessment Tool (IPAT) as published by the Health Resources and Services Administration (HRSA). The IPAT measures where providers fall on a scale for the integration between behavioral and physical health, which includes their technology integration capabilities. With more detailed provider capability information, health plans will be able to target their assistance regarding provider technology needs to support integration.

In our experience, in order to accelerate data sharing and the meaningful use of technology solutions, providers need to be educated on the benefits of adopting technology. Providers that utilize tools which offer them the ability to receive actionable information, displayed in a manner that they need (e.g. at the point of care), have the ability to relieve costly administrative burdens. CCS should encourage health plans to offer innovative methods for incentivizing providers to adopt technology. Strategies may include educating them on the associated benefits of adopting technology, providing technological assistance for the implementation of particular technology, such as ONC certified EHRs, or financially incentivizing providers to adopt certain best practices such as connecting to the Hawai'i HIE and use of Health eNet Community Health Record.

INTEGRATION WITH STATE SUPPORTED DATA SOURCES

We recommend that MQD continue to encourage health plans and providers to connect to the HHIE to enable hospital event notifications (e.g. Admission, Discharge and Transfer) sharing. Through referrals and more timely data, care teams are able to act promptly to improve member care. Additionally, there are benefits to adopting technology that has the ability to integrate with state registries like Hawaii's Prescription Data Monitoring Program (PDMP) and the Hawai'i Homeless Management Information System (HMIS) to ensure care teams have all of the necessary data to support their members.

MQD should continue to oversee health plan practices to ensure that data is being shared back with care teams, between health plans, as well as the State, in a format that is accessible and actionable. Members also benefit from secure data sharing by having easy access to their health care and care plan information through an electronic personal health record or secure member portal.

ADDITIONAL INPUT FROM STAKEHOLDERS

Stakeholders may write one page on other issues concerning the procurement to provide input to MQD.

'Ohana does not have additional input to offer at this time. We are happy to discuss these or other issues with MQD at any time.

State of Hawai‘i

Department of Human Services, Med-QUEST Division

Optum Response to:
Request for Information
No. RFI-MQD-2021-010 for
Community Care Services (CCS)

Redacted

Date
August 14, 2020

Contact
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August 14, 2020

Mr. Jon Fujii
c/o Eric Nouchi
Department of Human Services/Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707

Submitted via email: QUEST_Integration@dhs.hawaii.gov

Re: Community Care Services (CCS) [RFI-MQD-2021-010]

Dear Mr. Fujii:

Optum appreciates the opportunity to respond to the Community Care Services Request for Information released by the Hawai'i Department of Human Services, Med-QUEST Division. People who have SMI/SPMI deserve the best healthcare – healthcare that is easy to navigate, timely and allows for quality outcomes even during extraordinary times.

We share your commitment to improving integration with physical health, creating healthy communities and your continual effort towards system transformation. Should you have any questions or seek further information regarding our response, please do not hesitate to contact me at (808) 535-1036 or robbyn.takeuchi@optum.com.

Sincerely,

Robbyn Takeuchi
Behavioral Health Director
Optum

Confidential Information

Optum appreciates the opportunity to submit our response to the Request for Information (RFI) to seek information in preparation for a Request for Proposal (RFP) for the Community Care Services (CCS) procurement of a behavioral health organization (BHO). We have identified portions of our response that contain confidential, trade secret or proprietary information which should be protected from public disclosure under either the Hawaii Uniform Practices Act or Hawaii Uniform Trade Secrets Act to avoid frustration of a legitimate government function in protecting confidential commercial information and recommendations of prospective offerors. We respectfully submit reason statements for each item identified below to support our confidentiality declarations. Our RFI response consists of 1) a non-redacted confidential response and 2) a redacted version of our response for public distribution.

Redacted Item Section/ Question No.	Page Number	Detailed Reason
Standardization and Administrative Improvements Question 1	1	The response includes company confidential business information that if made public would likely cause substantial competitive harm to Optum as a prospective offeror by revealing information which may be included in an RFP proposal and negate our company's economic advantage over our competitors.
Integration of Behavioral and Physical Healthcare Question 2	2	The response includes company confidential business information that if made public would likely cause substantial competitive harm to Optum as a prospective offeror by revealing information which may be included in an RFP proposal and negate our company's economic advantage over our competitors.
Integration of Behavioral and Physical Healthcare Question 3	3-4	The response includes company confidential business information that is not known or available to the public and would cause substantial harm to our company's competitive position in the market, including as a prospective offeror by revealing information which may be included in an RFP proposal.
Integration of Behavioral and Physical Healthcare Question 4	4	The response includes company confidential business information that is not known or available to the public and would cause substantial harm to our company's competitive position in the market, including as a prospective offeror by revealing information which may be included in an RFP proposal.

Promoting a Behavioral Health Continuum Question 5	6-7	The response includes trade secrets and financial information that is not known or available to the public. Disclosure of such information would likely cause substantial competitive harm to Optum as a prospective offeror by revealing information which may be included in an RFP proposal.
Reimbursement Considerations Question 8	9	The response includes financial information that is not known or available to the public. Disclosure would likely cause substantial competitive harm to Optum as a prospective offeror by revealing information which may be included in an RFP proposal and negate our company's economic advantage over our competitors.
Reimbursement Considerations Question 9	9-10	The response includes financial information that is not known or available to the public. Disclosure would likely cause substantial competitive harm to Optum as a prospective offeror by revealing information which may be included in an RFP proposal and negate our company's economic advantage over our competitors
Responding to the Pandemic Question 10	11-12	The response includes confidential company information that is not known or available to the public and would cause substantial harm to our company's competitive position in the market, including as a prospective offeror by revealing information which may be included in an RFP proposal.
Miscellaneous Question 12	13	The response includes confidential company information that is not known or available to the public and would cause substantial harm to our company's competitive position in the market, including as a prospective offeror by revealing information which may be included in an RFP proposal.
Miscellaneous Question 13	13	The response includes confidential company information that is not known or available to the public and would cause substantial harm to our company's competitive position in the market, including as a prospective offeror by revealing information which may be included in an RFP proposal.

Standardization and Administrative Improvements

(Limit response to 1 page)

1. *What recommendations should MQD consider adopting that would increase standardization, reduce administrative burden, and maintain program integrity?*

Increasing the efficiency and integrity of Hawai'i's Medicaid behavioral healthcare delivery system will improve the effectiveness of services provided to beneficiaries enrolled in Community Care Services (CCS) as well as the satisfaction of those beneficiaries, their families, network providers, the BHO, and other stakeholders. Among the steps that the Department of Human Services (DHS) Med-QUEST Division (MQD) should consider are:

- Encourage consistency among MCOs and the BHO. The need to comply with varying requirements of state Medicaid programs and multiple managed care organizations (MCOs) is one of the most frequent concerns of providers. [redacted].
- Remove barriers to improving efficiency. Currently, Managed care provides oversight for many provider requirements and regulations that were previously the responsibility of the Medicaid Agency. Removing or reducing duplicative oversight requirements (i.e. limiting their application to service delivery outside a managed care plan), can benefit both providers and beneficiaries. To the maximum extent possible under federal law, barriers to sharing clinical information between treating providers also should be minimized.
- Align performance targets and incentives. MQD could establish one or more priority areas each contract year for MCOs, the BHOs and their provider networks. Establishing, monitoring, tracking—[redacted]—complementary performance indicators will improve outcomes and promote collaboration between providers, MCOs, and the BHO.
- Invite stakeholder input. Stakeholder participation can increase engagement in Managed Care Plans. People who work with or are served by the CCS program offer valuable suggestions based on their direct experience receiving, providing or coordinating with CCS services. Incorporating and implementing appropriate stakeholder recommendations will increase support for the CCS program and achievement of DHS' goals. Cross-functional stakeholder work groups that address specific challenges and barriers impacting service delivery also can identify effective ways to improve overall healthcare services and outcomes.

[redacted]

Integration of Behavioral and Physical Healthcare

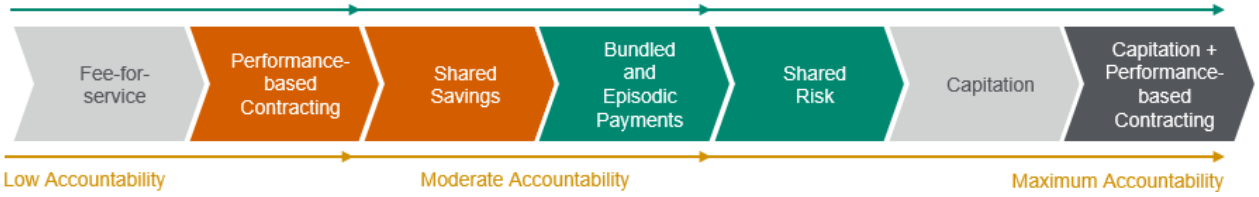
(Limit response to 4 pages)

2. What strategies should MQD consider adopting that support movement along the continuum of value-based care/payment models?

Consistency is key in supporting MCOs, the BHO, and network providers to better integrate care and implement value-based care/alternative payment models. Using the same terminology, setting common goals, and establishing complementary performance targets are critical, especially in a delivery system in which every beneficiary is served by at least two managed care entities, and many providers contract with multiple entities. Flexibility to innovate also is important in enabling providers and managed care entities to move along the continuum of integrated healthcare. Some strategies that MQD might consider are:

[redacted] to build a shared understanding of the concept of value-based care and the points in the continuum. Managed care organizations offer a wide variety of models with different reimbursement strategies and basic provider requirements, such as a minimum caseload and electronic medical records.

Optum typically uses a graphic such as the one below to illustrate opportunities for providers to contract for more clinical and financial/administrative responsibility.



As providers take on a broader role, the focus of the managed care organization also changes. MCOs and the BHO will spend more time reviewing data to identify utilization trends and outliers among providers and members. Providers should be given additional supports to meet goals/needs and expand provider-led integration efforts.

[redacted]

3. What strategies should DHS adopt that align incentives with the CCS and QI programs that improve outcomes, while better managing financial resources? Please suggest measures that would be effective and appropriate to include in the Performance Incentives for the CCS contractor. Include an explanation as to why these measures are suggested.

To continue to improve outcomes and better manage financial resources, MQD should continue its foundational comprehensive quality management program. Operated collaboratively by MQD and its MCOs and BHO, the program incorporates national

standards of care and is in compliance with federal requirements and MQD's quality strategy.

[redacted]

Performance Area	Priority Addressed/ Explanation	Applicable to
[redacted]	Preventive care	BHO and MCO*
[redacted]	Integration of physical and BH care	BHO
[redacted]	Coordination between MCO and health plan	MCO and BHO
[redacted]	Integration of BH and physical health care	BHO and MCO**
[redacted]	Integration of BH and physical health care	BHO and MCO
[redacted]	Integration of BH and physical health care	BHO and MCO

[redacted]

[redacted]

Health outcomes are optimal when physical healthcare and behavioral healthcare are integrated and addressed cohesively and in harmony.

4. What specific activities should the BHO do and prioritize to meaningfully and proactively impact and facilitate such integration?

As part of its administration of CCS, the BHO can impact and facilitate the integration of physical and behavioral healthcare in several ways. Some may require delegation of additional responsibility by MQD, but all require that MQD actively encourage and/or incent the cooperation of the QI MCOs.

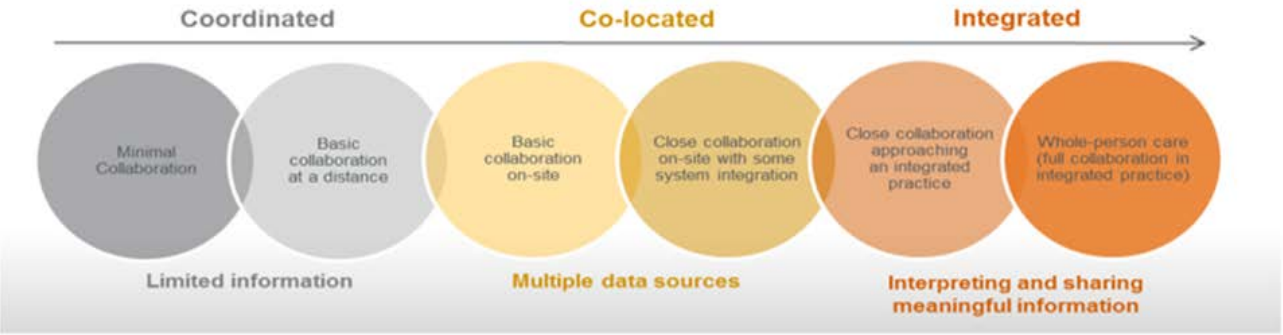
Some of the activities the BHO could undertake through a Service Level Agreement between the BHO and MCOs include:

Primary Physicians

Lead Influencers

85%	of patients with a mental health and/or substance use disorder visit a primary physician at least once in a 12-month period
75%	of individuals who die by suicide have contact with a primary physician within a year of their death, and 45% have contact within one month
20% to 30%	of patients with psychological issues inform their primary physicians about their concerns
70%	of primary care visits are related to psychosocial issues

Source: Association for Behavioral Health and Wellness, Health Integration in the Era of the Affordable Care Act, July 2015.



Integration of physical and behavioral healthcare also would be strengthened by implementing suggestions in several other responses, particularly #12.

Promoting a Behavioral Health Continuum

(Limit response to 5 pages)

5. What are the best ways to align CCS with QI, Hawai'i CARES, DOH-AMHD, DOH-CAMHD, Judiciary, and Public Safety programs?

Collaboration across state agencies and funding streams improves efficiency and effectiveness of service delivery to individuals and families who are using a wide array of resources. Some of the steps that MQD could take to expand alignment of CCS with QI, Hawai'i CARES, DOH-AMHD, DOH-CAMHD, Judiciary and Public Safety are:

- Ensuring that CCS enrollees have access to AMHD benefits when those benefits are not covered by Medicaid, such as psychosocial rehabilitation and clubhouse services.
- Clarifying financial responsibility for overlapping conditions. MQD should work with the MCO and BHO contractors to identify those diagnoses and conditions for which allocating payment responsibility has been difficult. Diagnoses related to dementia and Traumatic Brain Injury (TBI) with a co-occurring Serious Mental Illness have been frequent examples. MQD should then ensure that development of capitation payments, contracts and policy documents reflect those decisions.
- Implementing processes with the MCOs and BHO to ensure that incarcerated individuals are enrolled with an MCO and CCS (as appropriate) prior to discharge so they have access to physical and behavioral healthcare services as soon as they return to their communities.

[redacted]

- Expanding the scope of the CCS program to include funding for all Medicaid and non-Medicaid public sector mental health and substance use services; enroll and serve all Hawai'i residents who require and qualify for those services through CCS.
- Ensuring more effective coordination on behalf of individuals whose eligibility for services moves from Medicaid to non-Medicaid delivery systems.

[redacted]

6. What considerations should DHS be aware of in relationship to CCS eligibility determination and services access? Are there any contractual changes that could be made to support improvements in this area?

Overall, the current eligibility process is efficient and seems to be working well. It allows for effective oversight and collaboration between the BHO and MCOs. It could be improved by:

- Allowing behavioral health providers to bill for case management-type activities required to assist members with the CCS application process
- Allowing behavioral health providers to provide case management support to individuals for two weeks while they are awaiting eligibility determination
- Allowing young people who have been receiving behavioral health treatment the option of enrolling in CCS at age 16 or 18 to support them as they transition to the adult behavioral health delivery system

7. What new or existing key staff positions should the CCS BHO have in order to facilitate such alignment? Provide suggested qualifications for each of such positions discussed.

State Medicaid agencies often establish minimum requirements for the number of positions, staff qualifications and other details related to managed care operations. Leveraging continuing advances in technology, managed care entities have developed more efficient and effective ways to meet many contract requirements. Therefore, we encourage MQD to clearly describe the task(s) or responsibilities incorporated into CCS contract and allow organizations responding to the Request for Proposals (RFP) to explain how they will meet those expectations. Specifying requirements for recovery-oriented positions, such as peer support specialists, and designating functions that must be provided in Hawai'i ensures that all proposals comply with a consistent staffing approach. Peer support services should also be included as a CCS-reimbursable service.

Reimbursement Considerations

(Limit response to 2 pages)

8. Provide recommendations for a case management reimbursement model that would produce best case management practices and services for CCS members.

[redacted]

The case management level would drive:

- A minimum number of contacts with each individual, each month; telehealth visits would be allowed, but a minimum number of face-to-face meetings also would be required (post-COVID)
- Frequency of treatment team meetings and treatment plan reviews with the individual

Caseload limits for staff that are proportional to the intensity of need/assigned case management level of individuals assigned to the case manager's individual caseload should continue. Several states have adopted models that define allowable caseload size for case managers serving individuals with varying service intensity needs. [redacted]

9. How should we structure reimbursement to incentivize providers to appropriately place members along the stepped care continuum?

Creating incentive programs requires a dual focus: [redacted]

Responding to the Pandemic

(Limit response to 2 pages)

10. With the advent of COVID-19, what should be considered for CCS in the context of telehealth?

Any BHO seeking to manage the CCS program should offer a free platform to support the expansion of telehealth for members and providers. Optum has been encouraging consumers and families to take advantage of telehealth for several years. We have provided equipment and technical assistance and adapted clinical and reimbursement policies to motivate providers to offer tele-behavioral health. In most of our contracts—both commercial and public sector—more providers and members are working together telephonically or over the internet than ever before. This is especially true in remote areas. Technology is the most efficient way to connect clinicians with people who need their services.

Although we generally find that Medicaid beneficiaries have a smart phone or a computer and internet access, we have identified some QI plan members who lack access to the equipment necessary to take advantage of telehealth. Telehealth is particularly important for those who have SMI/SPMI, so the CCS contractor should verify that each beneficiary who wants to use telehealth treatment services can do so. If other programs that provide technology to low-income individuals are insufficient, MQD may want to develop strategies for ensuring telehealth access for all CCS enrollees.

In addition to enabling communication between a provider and a member, technology also is creating a wide array of applications that can support an individual maintain his or her own health and wellness. [redacted]

On the administrative front, today's visual conferencing systems allow healthcare providers to collaborate in treatment teams and administrative work groups. Real-time sharing of clinical information has been spurred by federal grants for health information exchanges (HIEs) and electronic health records (EHRs). The CCS contractor should be an active participant in all Hawai'i's efforts to improve access to healthcare through telemedicine and other emerging technologies.

[redacted]

[redacted]

Miscellaneous

(Limit response to 3 pages)

11. Describe the components of CCS that work well or that you would recommend DHS keep and/or build upon. Provide detail.

Our comments in response to this question have been included in other RFI responses.

12. What recommendations or considerations should DHS be aware of in relationship to behavioral health crisis management and response? Describe what works well and what can be improved.

Beneficiaries with SMI/SPMI have frequent interactions with the crisis system. Coordination between the crisis providers and the BHO and provider case manager (if known) should occur at regular frequency during a crisis episode. Once a call is made to the crisis line on behalf of a CCS beneficiary or by the CCS beneficiary and the crisis situation has not been resolved via the crisis counselor and requires the next level of intervention, a case manager is required to respond within 1.5 hours. [redacted]

Many states have successfully instituted Medicaid policies, covered services and billing practices to allow the hiring and training of Peer Support Specialists as para-professionals while extending the behavioral health workforce. [redacted]

13. Data and electronic health information exchange has been an ongoing discussion. What are your thoughts on how CCS can continue to play a role in data sharing and other related electronic health efforts?

At a minimum, [redacted]

Additional Input from Stakeholders

(Limit response to 1 page)

Stakeholders may write one page on other issues concerning the procurement to provide input to MQD.

One of the major challenges during a procurement in which there is an existing contractor is to provide enough information to ensure a level playing field among all bidders. Some of the key elements in this process include:

- Providing access to the most current contract, including any amendments or updates
- Providing an electronic data book that includes CCS enrollment and utilization of all covered services
- Continuing in the style of this RFI: simple, direct questions and clear page limits
- Responding to bidders' questions as promptly as possible and allow bidders to request clarifications of MQD responses
- Scheduling enough time between RFP release and proposal submission to allow bidders to research the current delivery system as well as respond to the specific RFP questions
- After MQD's selection is announced, providing access to all proposals and evaluators' scoring so bidders that were not selected can determine how they could have improved their responses. Offering a debriefing session to those bidders not selected provides an additional quality improvement opportunity for them.
- Setting the PMPM payment(s) for the CCS program and include that information in the RFP. This approach will allow MQD to select the winning bidder based solely on the quality, responsiveness and innovative aspects of its proposal as well as the bidder's financial stability and references.
- Including in the RFP the specific type of licensing and business requirements a bidder must have in order to be considered qualified for an award and which will subsequently be required under the ensuing contract. For example, is a TPA license a requirement to bid or contract? Publishing such information in the RFP will provide clarity and should benefit MQD by attracting more qualified bidders.

Alternative Procurement Approach

As alternatives to a standalone BHO, Hawai'i could consider other plan designs to ensure special attention to persons with SMI/SPMI that would require coordination with PH and BH care, and also integration of care coordination, pharmacy, services and supports.

One alternative design would be a vertically integrated SMI/SPMI plan that includes all physical, behavioral, dental, and vision services and is only offered to plans that receive a QI state/county/island-wide award. Other characteristics and benefits could include:

- Continuing referral to DOH for SMI/SPMI determination
- Giving members choice of at least two health plans
- Easing administrative complexity and reducing administrative cost
- Providing a comprehensive approach to care coordination across PH and BH services

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QUEST Integration (QI) [RFI-MQD-2021-008] input from:
Waikiki Health, 277 Ohua Avenue Honolulu, HI 96822
Contact person: Phyllis Dendle 808 537-8443

QI- RFI input:

1. QI health plans should not vary by region and we should keep the current plans we have. If an individual moves to a different region and unable to find a PCP due to insurance plan/region restrictions, this will inconvenience the patient. This delay in getting the patient connected to care can cause increased costs.
2. Quality improvement programs should be the standardized for each payer. The quality measures and submission process (ie. coding vs faxing) should be the same.
    a. Could QI health plans also obtain some of their quality data via Hawaii Health Information Exchange? This would help with closing gaps/decrease outreach to FQHCs. (reduce administrative burden)
3. Service Coordination should include assistance with Housing and providing smart phones to the patients. If we are trying to treat patients on a holistic level, housing also needs to be addressed (ie. Maslow's Hierarchy of Needs). Without housing/shelter (social) needs beings addressed, it is difficult to address complex health needs of our patients. Furthermore, due to COVID, Service Coordinators can only complete their 'visits' via telehealth. Many eligible quest patients are unable to obtain services without access to a phone (and/or minutes).
    a. Service Coordinators should have standing orders to assist with addressing quality measures (ie. provide/mail FOBT kit).
4. Services through different programscan cause fragmentation in care. Regular meetings to coordinate care is essential. This will prevent duplication and also promote better outcomes.
5. Integrated care is essential for holistic care for the patient. This is something that is practiced at Waikiki Health.
6.
7. The State should pay for population health management platforms that is integrated with the clinics EMR (example: Azara). MQD could get the data from here to reduce administrative burden and costs incurred by the clinics.
8. -
9.
10. Expand/Promotetelehealth
    a. MQD can help expand and promote telehealth by providing smart phones/minutes to our QI patients without phones. This becomes a barrier to care, if they lack access. Phones could be issuesby a FQHC Care Coordinator or Payer Service Coordinator

b. Telehealth should also reimburse enabling services (ie. care coordination, CHW).

Care and Service Coordination (Questions 3 & 4)

- If CCS is in place, then what more is HOPE supposed to accomplish? Is this program specifically for people with *physical* health needs? All plans offer case management, but why does only one offer special case management for those with special behavioral health needs? It seems that MedQuest sees that its services are not reaching all who can benefit, and instead of improving current programs, they created a new one. Our program agrees that every plan should have a program like CCS. Case management should be standardized, as well; it sounds like HOPE is the first step.
- If a patient has special health needs, they should not have to race to switch plans because their auto-assigned one will not bridge them to services they need.
- If mental health programs from Quest directly involved AMHD, patients would lose trust in service providers. To improve patient outcomes and retain patients, Quest should use Ohana Health Plan's CCS as a model for their own. If the goal is to expand these services to children too, it would not make sense to involve CMHD anymore than AMHD is involved with the adult program.
- Waikiki Health draws parallels with HOPE in programs such as Waiwaiola. Do the two programs inform each other? We are noticing a lack of transparency that both sides would benefit from administratively, leading to better patient outcomes.
- Patients are seeing too many providers to prove to linked stated agencies that they are disabled.
- Proving you are disabled is an obstacle. Generally, you are only considered disabled if you are terminally/chronically ill or receive SSI/SSDI. People with mental health challenges are the last to get help.
- There are not clear lines when it comes to the term *disabled*. A person that can seem fully-functioning could be receiving SSDI for the past fifteen years and automatically be eligible for special services, while a person who is clearly struggling with their health but not receiving SSDI may take months to get approved for extra help.

10. Provide smart (and minutes) phones to CCS clients so that they can complete telehealth visits.