Response to the Request for Information (RFI)

Community Care Services (CCS) [RFI-MQD-2026-001]

Emailed to: QUEST_Integration@dhs.hawaii.gov

Submitted by: ‘Ohana Health Plan
Scott J. Sivik, Plan President & CEO
Phone: 808-421-8587
Email: scott.sivik@centene.com

Responses Due: September 15th, 2025 2:00 p.m. HST

QUESTIONS FOR RESPONSES
Standardization and Administrative Improvements

(Limit response to 1 page)
MQD supports increased standardization and reduced administrative burden at the MQD 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?

INCREASING STANDARDIZATION AND REDUCING ADMINISTRATIVE BURDEN

'Ohana Health Plan ('Ohana) supports simplifying and aligning Community Care Services (CCS) processes that benefit member care, provider experience, and program efficiency while allowing space for lessons learned and best practices from managed care organizations (MCOs). After 17 years of experience serving members in Med-QUEST Division (MQD) programs, including 12 years as the CCS Behavioral Health Organization (BHO), Ohana understands local practice patterns and the availability of State resources. We offer the suggestions below to **improve quality, reduce administrative burden,** and **prevent waste** in the Hawai'i Medicaid program.

Convening an Administrative Processes Workgroup to Promote Efficiency

An **administrative processes workgroup** would identify processes across both QUEST Integration (QI) and CCS MCOs for alignment, meet regularly, and report to MQD. Their tasks would simplify referrals, enrollment/credentialing, claims/billing, and prior authorization (PA) processes with single provider/member forms (e.g., Billing Quick Reference Guides, PA Lists, Referral Indicators, Enrollment Files) that capture the same or similar information across MCOs. Their projects would align with **State priorities** and **reduce administrative burden**:

- Define payment rules for behavioral health (BH) versus physical health claim coding and billing. These rules would delineate financial responsibilities for the complex care coordination needed to deliver services to a highly specialized population. For example, billing responsibility when a shared member visits the emergency department (ED).
- Suggest standardizing covered PA services, recommending a frequency/process for updates, and decreasing the variation in PA requirements.

Simplifying Eligibility and Enrollment through Coordinated Referrals

BH data sources show that there are fewer members with a serious mental illness (SMI) enrolled in CCS than are eligible.[1] **A simple, standard referral process based on specific regulated criteria** would promote consistent and cost-effective CCS referrals. Members would receive the intensive BH services they need to achieve better managed mental health outcomes. We suggest:

- MQD creates a **list of qualifying events** requiring QI MCOs to submit a CCS referral. Indicators would include any psychiatric inpatient admission, three (3) or more ED

[1] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010 and 2017-2019 pg 32.

visits in relation to BH, ongoing interaction with law enforcement, and all members on prescribed long-acting injectables (LAI) for a serious mental illness.

- Enhanced supports, training, and resources would help facilities and community providers in the MQD delivery system identify individuals who would benefit from CCS case management. We suggest **shared learning collaboratives** and a **direct provider referral process** where providers refer members for CCS enrollment directly to the State.

Integration of Behavioral and Physical Healthcare

(Limit response to 4 pages)
MQD is interested in aligning incentives, strategies, and policies to create a health care system that better integrates the behavioral health services provided through the CCS program, and the physical and long-term services and supports provided by the QI MCOs.

'Ohana has served the Community Care Services (CCS) population for the past 12 years and agrees with Med-QUEST Division (MQD) that integrated physical and behavioral health (BH) services produce the best outcomes for individuals with serious mental illness (SMI). We look forward to continuing our partnership with MQD to serve this population with respect, dignity, and culturally competent care.

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

We support MQD's efforts to promote value-based care in the CCS and QUEST Integration (QI) programs. We believe that value-based care will lead to better outcomes for members, and we will invest in the processes, people, and technology needed to move this priority forward in the CCS program.

3. What strategies should MQD 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 BHO. Include an explanation as to why these measures are suggested.

To improve outcomes while effectively managing financial resources, Med-QUEST Division (MQD) should prioritize integrating behavioral and physical health benefits at the payer level. This model enables a single managed care organization to coordinate care across the full continuum, aligning incentives and accountability for both Community Care Services (CCS) and QUEST Integration (QI) populations.
Integrated benefits at the payer level allow for:

- **Unified case management** that reduces fragmentation and ensures smoother transitions between levels of care
- **Shared data infrastructure**, enabling real-time insights into member needs and outcomes
- **Aligned financial incentives** that reward whole-person care and reduce duplicative or unnecessary services
- **A simplified system** that reduces administrative burden for providers

'Ohana recommends that all CCS members are aligned in receiving all health care - physical and behavioral health services - from the CCS BHO. If the current bifurcated CCS and QI payer structure is maintained, we recommend aligned measures and incentives for members with an SMI diagnosis across both programs. This approach is only successful if the CCS BHO has full access to the necessary data, including claims, utilization, and quality. This structure supports the use of performance incentives that reflect shared goals across CCS and QI to promote consistency in MQD expectations and outcomes. Aligning incentives across CCS and QI programs will also lead to less

administrative burden for providers in value-based contracts, as it will help them focus on the same measures across payers.

Health outcomes are optimal when physical healthcare and behavioral healthcare are integrated and addressed cohesively and in harmony.
4. What specific activities should the CCS BHO prioritize to meaningfully and proactively impact and facilitate such integration?

As stated in our response to Question Three, we believe the most meaningful strategy to effectively integrate physical and behavioral health care for Community Care Services (CCS) members is to integrate benefits at the payer level. Within the current structure, however, the following are specific activities that the CCS Behavioral Health Organization can prioritize to facilitate integration:

- **Establish Joint Governance Structures.** Create shared leadership forums with QUEST Integration (QI) plans to align strategy, performance goals, and accountability for integrated care delivery.
- **Implement Shared Care Coordination Models.** Develop cross-functional teams that include CCS and QI representatives to collaboratively manage high-risk members.
- **Align Quality and Performance Metrics.** Align CCS and QI incentive measures to promote shared accountability and reduce siloed efforts.

Promoting a Behavioral Health Continuum

(Limit response to 5 pages)

5. What are the best ways to align the CCS program with the QI program, Hawai'i CARES 988, DOH-AMHD, DOH-CAMHD, DOH – Hawaii State Hospital (HSH), Judiciary, and Department of Corrections and Rehabilitation?

ALIGNING COMMUNITY CARE SERVICES (CCS) WITH OTHER PROGRAMS

'Ohana Health Plan ('Ohana) has 12 years of experience working together with State agencies, community partners, and other managed care organizations (MCOs) as the Community Care Services (CCS) Behavioral Health Organization (BHO). We collaborate with State agencies to align our goals and create processes that support one another. **We believe that the Department of Human Services (DHS) should continue to award the CCS contract to a single MCO with local decision-making and proven experience in serving members with serious mental illness (SMI).** This approach enables State agencies to develop effective solutions quickly with the CCS BHO, without needing permission from outside Hawai'i or waiting for a health plan to gain expertise. For instance, we have partnered closely with the Department of Health (DOH) to establish a shared vision for addressing homelessness. 'Ohana has committed resources to the shared vision of supporting those unhoused within the CCS and QUEST Integration (QI) programs.

6. What considerations should MQD 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?

CONSIDERATIONS FOR ELIGIBILITY AND ACCESS TO SERVICES

SAMHSA estimates that 5.4% of Hawai'i adults have a Serious Mental Illness (SMI), meaning over 21,000[2] adult Medicaid members are likely eligible for the Community Care Services (CCS) program, more than double the number enrolled in the CCS program today. 'Ohana recommends these actions as ways the Med-QUEST Division (MQD) can enroll more eligible members in the CCS program to improve their health:

- Enrolling all Medicaid members with SMI diagnoses into the CCS program so that they can receive the case management (CM) and behavioral health (BH) services needed to improve their health by:
  - Creating a **list of qualifying events** requiring QI MCOs to submit a CCS referral. Indicators would include any psychiatric inpatient admission, three (3) or more ED visits in relation to BH, ongoing interaction with law enforcement, and all members on prescribed long-acting injectables (LAI) for a serious mental illness.
  - Requiring QI MCOs to submit the 1157 form received from providers for qualifying members to MQD promptly
  - Allowing **providers to submit the 1157 form directly to MQD** rather than through a QI MCO to prevent delays in assessments
  - Educating health facilities and community organizations about referrals to the CCS program

[2] SAMHSA report: https://www.samhsa.gov/data/sites/default/files/reports/rpt53158/adults-with-smi-and-children-with-sed-prevalence-in-2023.pdf. The over 21,000 members is a calculation from the most recently reported Medicaid enrollment numbers from MQD at 392,906 as of 9/8/2025.

To help CCS members access physical health, BH, and Social Determinants of Health (SDOH), we suggest that MQD enroll members with the CCS MCO for both CCS and QI-covered services. Our data shows that members who have their QI and CCS benefits aligned get better care, have better health outcomes, and stay more engaged in CM than those with unaligned benefits. To support these changes, MQD should consider updating CCS contract sections 4.14 and 9.3. The QI MCO contracts may also need updates to reflect new referral protocols and processes.

7. What are the key considerations and potential impacts of the new authorities, under the 1115 Waiver, listed below, on the CCS program.
a. Community Integration Services Plus
b. Contingency Management
c. Pre-Release Medicaid Services for Justice-Involved Individuals

CONSIDERATIONS OF 1115 WAIVER AUTHORITIES ON THE CCS PROGRAM

Community Integration Services (CIS) Plus

CMS has approved Hawai'i's 1115 Waiver for the Community Integration Services (CIS) Plus program, creating new opportunities for Community Care Services (CCS) members beyond tenancy support and pre-tenancy planning. These expanded options will help CCS members find stable housing and improve community living. 'Ohana suggests that Med-Quest Division (MQD) and managed care organizations (MCOs) hold informational meetings for providers and community members to explain the new services, who is eligible, what types of providers can participate, billing codes, and how to make referrals to MCOs.

Contingency Management

Members with stimulant and opioid use disorders will have access to new contingency management services. To make this effective, we suggest the following steps:

- Organize information sessions for MCOs, providers, community organizations, and advocacy groups to explain the purpose and goals of contingency management
- Train eligible providers to ensure consistent implementation of the model
- Define member eligibility, the referral process, allowable incentives, and guidelines for enrollment and disenrollment
- Develop an easy evaluation and reporting plan that uses simple measures to reduce the administrative workload for providers

Pre-Release Medicaid Services for Justice-Involved Individuals

The Department of Human Services' (DHS) new 1115 Waiver will help improve care for justice-involved CCS members. It will ensure they receive CM services before release, get a 30-day supply of their prescription medicines, access medication-assisted treatment (MAT), and connect to primary care, BH, and peer support services. We believe these changes will improve the transition process for CCS members as they move out of jails and prisons.

We recommend that DHS assist the CCS BHO in building relationships with jails and prisons to make data sharing and support for CCS members easier. We also suggest that MQD:

- Provide a list of CCS members admitted to jails or prisons whose benefits MQD suspends
- Provide a list of Medicaid-eligible members with SMI for in-reach at least 90 days before the scheduled release from a jail or prison
- Creating data sharing protocols for the transfer of carceral health records for CCS members once they enroll in the CCS program

8. What are the key considerations and potential impacts of the new authorities, under the 1115 Waiver, listed below, on the CCS program. In relation to our CCS members and the homeless population, what would be your approach and plan for addressing the goals outlined in the Executive Orders issued on July 24, 2025, regarding the initiative to End Crime and Disorder on America's Streets?

APPROACH FOR ADDRESSING GOALS OF THE EXECUTIVE ORDERS

At 'Ohana, we believe housing is health care. We partnered with the Department of Health (DOH) to create a caring approach for people without houses, ensuring they receive the right support when needed. To implement this approach, 'Ohana has expanded housing options for Community Care Services (CCS) members.

To further support the shared vision between DOH and 'Ohana and address the Executive Orders, we recommend:

- Streamlining processes between the Hawai'i State Hospital (HSH), Med-Quest Division (MQD), and the CCS program to facilitate immediate care and support upon discharge for CCS members experiencing homelessness, such as:
  - Implementing provisional CCS enrollment to ensure immediate support at discharge
  - Identifying HSH discharges with special placement needs to match them to appropriate community resources (e.g., members with traumatic brain injuries or criminal records)
- Using emergency powers and administrative actions for innovative solutions:
  - Revising the 1147 process to allow members with serious mental illness (SMI) to achieve the level of care necessary for long-term services and supports in nursing homes and other care placement options, along with case management support
  - Pursuing a CMS waiver to allow payment to institutions for mental diseases (IMD) beyond 15 days to increase available treatment beds
  - Amending the 1157 process to allow fast-tracking of QUEST Integration (QI) program members with SMI into the CCS program for expanded housing options
- Reviewing state-owned properties that private partners could lease to set up fully staffed step-down care units
- Clarifying the Office of Health Care Assurance's role for launching housing options for CCS members under Hawai'i's Clean and Sober Living law

Reimbursement Considerations

(Limit response to 2 pages)
Currently, the CCS program has five service levels within a stepped care model, with level 5 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 1 – 4, with level 5 members receiving services directly from the CCS BHO.

9. Provide recommendations for a case management reimbursement model that would produce best case management practices and services for CCS members.
This response intentionally left blank. 'Ohana has no input to provide.

10. How should the reimbursement model be structured to incentivize CCS providers to appropriately place members along the stepped care continuum?

RECOMMENDATIONS FOR REIMBURSING CASE MANAGEMENT (CM)

'Ohana's Community Care Services (CCS) program focuses on providing case management (CM) based on each member's needs. We match the stepped care level to the severity of their situation, ensuring members receive the support they need without using more resources than necessary. Members move between different care levels as their needs change. Our CM assignment system honors the member's choice of CM entity, with community-based case management (CBCM) agencies providing services for members assigned to levels 1-4. At the same time, 'Ohana supports the highest acuity members in level 5. This approach has allowed us to establish effective practices and achieve important quality outcomes in case management.

We suggest some CCS CM reimbursement model updates based on our extensive experience in Hawai'i and nationwide. These updates support our key recommendations for MQD:

- Continue contracting with a **single CCS Behavioral Health Organization**
- **Integrate behavioral health and physical health benefits** into a single CCS plan
- **Enroll all eligible members** in the CCS program

Our recommendations also support **NCQA CM accreditation standards**.

- Replace administrative CM metrics for meetings with members with NCQA CM measures that show quality CM and positive member results. For example, CBCMs could track the creation of individualized treatment plans and plan monitoring, which MQD and 'Ohana can confirm through regular chart audits.
- Implement a quality withhold for CBCM payments to align with value-based payment initiatives. A quality withhold would focus CBCM activities on HEDIS and other performance measures known to improve outcomes and reduce costs. We also recommend that these performance measures be aligned across QUEST Integration and CCS programs, so all payers are focused on the same goals.

Inquiry on the Integration and Utilization of Telehealth Services

(Limit response to 5 pages)
11. Please address the following questions:
a. How can the CCS BHO ensure choice, without outside influence, for in-person vs. telehealth services for CCS members?
b. In most cases, in-person care is considered more optimal for the SMI population. Beyond rural locations and member preference, please explain how telehealth can be more advantageous than in-person care for CCS members.
c. How can the BHO optimize telehealth platforms to ensure high-quality, continuous care, support long-term integration and support for providers?
d. What quality assurance measures should be implemented to evaluate the effectiveness of telehealth in CCS services?

ENSURING MEMBER CHOICE FOR SERVICES

Since 2013, Ohana Health Plan ('Ohana) has been the sole Behavioral Health Organization (BHO) for the Community Care Services (CCS) program. We provide specialized care for individuals with serious mental illnesses (SMI), ensuring they receive the coordinated support they need in environments that best suit them.

'Ohana recommends a **person-centered communication approach** to support CCS members in choosing in-person or telehealth services. Communication with members should be clear and accessible at every interaction to help them make informed decisions about services. We advise that CCS BHO staff are trained to ask about and respect members' preferred ways to communicate, understand their cultural and language needs, and use interpreters when necessary. Upon enrollment and at least once a year, the CCS BHO should provide information about both in-person and telehealth services and how to access them through various channels to help members make informed choices. The CCS BHO should provide culturally responsive materials that are inclusive, gender neutral, easy to understand, and available in multiple languages.

To ensure all members can choose telehealth services equitably, the CCS BHO should help members access the necessary technology, like Wi-Fi and smartphones or tablets. We suggest offering training and support on this technology to improve members' digital health literacy.

IMPROVING MEMBER OUTCOMES THROUGH TELEHEALTH

Our clinical and community teams address the medical, behavioral, and social needs of CCS members. We meet members where they are, whether on the street, in a shelter, or at home. Based on this experience, we agree that in-person care is the optimal way to meet the unique needs of this population. We believe in-person care should remain a priority for high-risk, complex, or unstable cases. When in-person care is not possible, due to factors like geography, provider shortages, and transportation, telehealth is the best option to provide care.

We also see the value in a hybrid model that allows telehealth and in-person visits for more flexibility and access. CMS encourages states to explore telehealth options to

improve access to care. In a 16-month study, participants who received behavioral health (BH) services via telehealth preferred it over in-person visits. They also had higher completion rates, attendance rates, and more treatment visits[3]. These results indicate virtual BH care could provide similar or better outcomes than in-person treatment. We suggest the following reasons why telehealth could be more advantageous than in-person care for CCS members:

- Customized care plans that combine virtual check-ins with in-person therapy when needed
- Expanded access to providers, increasing availability
- Fewer transportation issues
- Lower stigma around mental health treatment since care is in members' homes
- More convenience for members
- More inclusiveness for marginalized groups, like racial minorities and non-binary individuals, who face barriers in traditional settings
- Providers can see members in their home environment, offering a better context for treatment
- Quick response during crisis events
- Shorter wait times for appointments

OPTIMIZING TELEHEALTH PLATFORMS

'Ohana has provided telehealth services since 2013 to ensure CCS members can access care anytime, anywhere. We identify qualified telehealth vendors and regularly analyze their utilization and performance to ensure they meet members' needs. This experience helps us recommend the following ways for providers and vendors to optimize telehealth platforms:

- Collect feedback from members on platform needs and effectiveness
- Design workflows that integrate telehealth into daily operations
- Ensure functionality at low internet speeds
- Ensure platforms are ADA-compliant and accessible to people with disabilities
- Ensure the system connects with electronic health records, scheduling systems, remote monitoring devices, and billing platforms
- Follow HIPAA guidelines
- Improve user experience by offering support in multiple languages, larger text, and screen readers
- Make navigation simple and easy for smartphones and tablets
- Offer 24/7 tech support
- Offer interfaces and clear instructions in multiple languages
- Provide training and support for users
- Use culturally relevant visuals and examples
- Use different ways to communicate, like chat, video, and messaging
- Use secure platforms with end-to-end encryption

[3] Waite MR, Diab S, Adefisoye J. Virtual Behavioral Health Treatment Satisfaction and Outcomes Across Time. J Patient Cent Res Rev. 2022 Jul 18;9(3):158-165. doi: 10.17294/2330-0698.1918. PMID: 35935523; PMCID: PMC9302910.

EVALUATING THE EFFECTIVENESS OF TELEHEALTH THROUGH QUALITY ASSURANCE

We regularly assess patterns and trends and identify barriers that affect care quality. As part of our effective CCS Quality Improvement program, we track and analyze telehealth utilization and service delivery and gather feedback from external sources. We use this internal and external data to assess the effectiveness of telehealth in managing BH. Our successful history informed the following recommendations for quality assurance measures that evaluate the effectiveness of telehealth in CCS services:

- Assess clinical quality measures, like patient outcomes, adherence to guidelines, and diagnostic accuracy
- Evaluate technical performance
- Measure member and provider satisfaction through surveys, advisory committees, and/or special focus groups
- Monitor for the most common diagnoses to help expand and evaluate telehealth services
- Perform audits for privacy and security to confirm HIPAA compliance and protection of data during transmission
- Track claims to trend utilization and assess costs and quality
- Analyze scheduling and response times to evaluate access to care

Miscellaneous

(Limit response to 3 pages)

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

BEHAVIORAL HEALTH CRISIS MANAGEMENT AND RESPONSE

For the past 12 years, 'Ohana Health Plan ('Ohana) has responded to individuals experiencing a behavioral health crisis as the Community Care Services (CCS) Behavioral Health Organization (BHO). A timely response to crisis situations can be lifesaving. We understand that CCS members are more likely to experience a crisis than the general population and have taken steps to improve the crisis system. To optimize crisis response, we need to reduce duplication of efforts and streamline the responsibilities of stakeholders in this important effort. Close collaboration and integration between the CCS BHO and the Hawai'i CARES 988 line is needed. **Identifying a single source responsible for intake, referral, and follow-up would help eliminate duplication, streamline the response, and get these individuals the long-term help that they need.**

Additionally, crisis services need to be linked to long-term solutions. We recommend a process that includes follow-up with everyone experiencing a crisis, regardless of their current enrollment status, and determining the best next step in their recovery. If this step is not required, these individuals are more likely to continue to relapse into crisis, and the cycle continues.

13. What are your thoughts on how the CCS BHO can utilize CCS data to analyze health outcome? How can the CCS BHO and QI health plans integrate data to ensure whole person health care.

UTILIZING DATA TO ANALYZE HEALTH OUTCOMES

After serving Community Care Services (CCS) members for 12 years, we know how important it is to use data to track health results and measure progress. We suggest that Med-QUEST Division (MQD) use simple, outcome-focused measures instead of the current administrative timelines and time-based metrics used to assess performance. New outcome-focused measures should look at things like stable housing, hospital and crisis visits, how well symptoms are managed, if people take their medicine regularly, and overall quality of life. Tracking these results will help the CCS Behavioral Health Organization (BHO) and the Department of Health – Adult Mental Health Division (DOH-AMHD) work together better and make sure care continues smoothly for people in Hawai'i.

ALIGNMENT TO BEST ACHIEVE WHOLE PERSON HEALTH FOR MEMBERS

To best measure the whole-person health, the CCS BHO needs total utilization, medical costs, and quality measures data for each member. As the current CCS BHO, 'Ohana does not receive this data from QUEST Integration (QI) health plans for shared members receiving their physical health services through another health plan. We

recommend that all CCS members are aligned in receiving all health care, physical and behavioral health, from the CCS BHO.

If physical and behavioral health services remain unaligned for members in the CCS BHO, we highly recommend that MQD implement stringent requirements for QI plans to track and report all members with a serious mental illness diagnosis and be held accountable for transparently communicating this information. If members are not properly referred to the CCS BHO, they are put at risk of their behavioral health deteriorating. We recommend a clear list of qualifying events for when an individual needs to be referred to CCS, including:

- A serious mental illness (SMI) diagnosis
- Any psychiatric inpatient stay
- Three (3) or more Emergency Department visits in relation to a behavioral health diagnosis within six months
- Ongoing interaction with law enforcement or emergency services
- Prescription for a long-acting injectables (LAI); excluding those with traumatic brain injury or cognitive impairment

These qualifying events are in addition to the current qualifications in the CSS contract for individuals to be referred to and enrolled in the program to ensure they receive the care they need and deserve.

14. What recommendations or considerations should MQD be aware of to prevent Fraud, Waste, and Abuse of the CCS program?

PREVENTING FRAUD, WASTE, AND ABUSE IN THE CCS PROGRAM

'Ohana has a strong Fraud, Waste, and Abuse (FWA) program and works closely with the Medicaid Fraud Control Unit. We intimately understand the importance of detecting and eliminating FWA from the Community Care Services (CCS) program, as we have done over the past 12 years. The FWA process can be improved with the move to a single managed care organization serving CCS members for both physical and behavioral health services. This change would provide the CCS BHO with full access to all medical claims and utilization data for each member and lead to better FWA results.

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.

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