COVID-19 Hospital Assistance Partnership Program (HAPP)
Medicaid Hospital Care Transitions Initiative (HCTI)
State of Rhode Island

Medicaid Hospital Care Transitions Initiative (HCTI)
Program Terms and Conditions

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1 Background

To participate in Phase 2 of the Hospital Assistance Partnership Program (HAPP), eligible applicants must also participate in the Medicaid program's Hospital Care Transitions Initiative (HCTI), including through execution of a one-year contract on or before January 15, 2021 with a state-approved vendor to implement a "Specialized Transitions Team" focused on discharges to community care.

HCTI is specifically intended to support the hospital discharge planning process for Rhode Islanders in need of intensive post-acute or long-term care using person centered practices that promote choice, home and community-based (HCBS) options, and focused care planning. One of the key barriers to greater utilization of HCBS options is the availability of timely information and support for arranging these solutions. HCTI will provide timely, proactive support to Rhode Islanders to promote understanding of HCBS alternatives to institutional congregate care settings that are associated with a higher risk of COVID-19 exposure. Timely hospital discharges are critical to ensuring that hospital capacity is free to address the public health emergency. Additionally, patients who can be discharged to home, rather than congregate care settings, are better able to mitigate the impact of the public health emergency based on the inherent risk presented in congregate care settings.

This **Medicaid HCTI Program Terms and Conditions** document provides additional information and further specification of the requirements for participation in HCTI.

2 Hospital Eligibility Criteria

Hospitals are eligible to participate in the Hospital Care Transitions Initiative (HCTI) if:

a. Hospital is a short-term acute care hospital
b. Hospital had at least 2,000 Medicare enrolled 65+ hospital admissions in CY 2018[1]
c. Hospital is part of a Medicare ACO

3 Participating Hospital Requirements

3.1 HCTI Hospital Requirements

Hospitals that meet the above criteria, and that participate in HAPP Phase 2, must agree to abide by the following requirements:

a. Hospital commits to executing a one-year contract on or before January 15, 2021 with a state-approved vendor to implement a "Specialized Transitions Team" focused on discharges to community care, in accordance with the terms specified in Section 4: State-Approved Vendor Requirements.
b. Hospital commits to meeting the following HCTI program requirements:
    i. Provide a single point of contact/ project lead for HCTI implementation. The project lead shall coordinate the training, implementation and reporting for this project.

[1] This requirement will be assessed based on data from the RI Department of Health Hospital Discharge Dataset – accessed via web query, *Hospitalizations among Rhode Island residents in 2018*, https://health.ri.gov/data/hospitalization/discharge/

ii. Provide an office/workspace for the Specialized Transitions Team co-located or appropriately located to support the hospital's Discharge Planning Team. Facilities provided must include the following and/or substantially equivalent supports: workspace, parking, access to space suitable for meeting with families/patients, internet access, access to printer/copier/fax.
iii. Establish a process for regular communication between the Specialized Transitions Team and the hospital's Discharge Planning Team.
iv. Provide a daily list of admitted patients who would benefit from Specialized Transitions Team support to the team. Hospital EMR access may be necessary, depending upon agreed upon workflows.
v. Require the hospital's Discharge Planning Team to participate in State-specified training process.

3.2 Program Expenditure Requirements

Participating hospitals are required to dedicate a budget of at least $28.26 per Medicare enrolled 65+ hospital admission to fund the Specialized Transitions Team.[2]

Hospitals are expected to spend funds provided under HAPP in accordance with CRF guidelines and HAPP program guidance. All HCTI program expenditures may be applied for through the HAPP program for consideration.

Note that as specified in the HAPP Phase 2 Grant Guidance memo, projected costs associated with establishing the infrastructure and contracts required to participate in HCTI that participating hospitals intend to incur before December 30, 2020 may be included in calculating Operating Expenses for Strategic Initiatives ("Net New Strategic Costs").

4 State-Approved Vendor Requirements

A Specialized Transitions Team is defined as a group of healthcare professionals located on site at a hospital (or elsewhere in support of the onsite team) to assist Medicare/Medicaid eligible individuals with options to receive rehabilitation services at home rather than in a congregate care setting where they have a much higher risk of COVID-19 exposure.

The state-approved vendor will be selected by the facility and pre-approved by the state. The required terms for the state-approved vendor to provide a Specialized Transitions Team to support HCTI are as follows:

1. **The Specialized Transitions Team shall support and integrate with the existing hospital discharge planning staff** to supply additional resources to enable the more time-consuming logistical work of coordinating and obtaining home services to be focused upon complex patients to enable them to transition directly home rather than typical process of transitioning first to a nursing facility, with potential exposure to COVID-19, and then home.

[2] This requirement will be assessed based on data from the RI Department of Health Hospital Discharge Dataset – accessed via web query, *Hospitalizations among Rhode Island residents in 2018*, https://health.ri.gov/data/hospitalization/discharge/

2. **The Specialized Transitions Team shall provide education to Medicare and/or Medicaid eligible patients** about the available options to receive rehabilitation in their home with the appropriate home and/or community-based care services as an alternative to entering a nursing facility for post-acute care. Patient education shall be based upon:
   - **Benefits Counseling**- Provide in-depth expertise and assistance with both Medicare and Medicaid benefits, including copay and cost sharing implications for different service needs under Medicaid FFS, Medicaid/Medicare Managed Care, Medicare Advantage Plans, Medicare FFS; coordinate with the POINT as needed to clarify benefit assessments. If the patient could benefit from Medicaid LTSS services, provide a clear overview of the different options for receiving care at home or in a home-like setting.
   - **Application Assistance** - Provide in-depth expertise and assistance with Medicare and Medicaid eligibility considerations. Work with patients to identify the primary payer for at home services. If a patient is potentially Medicaid eligible, the HCTI vendor will provide the State with the necessary paperwork to ensure that Medicaid eligibility is aligned with the patient's current requirements. Additionally, the HCTI vendor will work with the DHS Medicaid Eligibility team to establish shared business processes/protocols to ensure that potentially Medicaid eligible patients receive needed supports.
   - **Service Coordination** - Work with home care providers and community supports organizations to seek to ensure that caregivers are in place immediately upon discharge, and that plans are communicated clearly and effectively to the patient. The HCTI vendor will bring an established relationship with home and community-based provider organizations. including home health agencies, adult day centers, and assisted living organizations If a patient already has a case manager through a community organization, the HCTI vendor will connect with that organization prior to discharge and make sure they have the documentation they need to adjust care accordingly post discharge. The HCTI vendor should not duplicate any work of an existing case management agency. If a patient is seeking to enroll in a self-directed program post-discharge, or needs habilitation services, ensure appropriate referrals are made prior to discharge to expedite the process for program enrollment.
   - **Supports** - Work closely with patients to identify and address personal barriers to home/community-based care. Coordinate with Ocean State Center for Independent Living (OSCIL) to facilitate expedited access to DME and home modifications, as needed. Coordinate with the Medicaid Office of Community Programs for potential enrollment into Personal Choice, Independent Provider Program and Shared Living.

3. **The Specialized Transitions Team shall** include the following team members, without limitation:
   - Clinicians (e.g. RNs or other persons with clinical licenses) who are trained and able to interact with hospital clinicians, to address medication management issues and to coordinate follow up appointments as needed,
   - Social Workers who are trained and able to work with patients with complex medical needs to address such needs and any barriers to receiving care in their home,
   - Community Health Workers (CHWs, whether certified or on the path to certification) who are representative of the community being served and trained to connect with patients, identify patients' goals, and provide the non-clinical support necessary to achieve those goals,
   - Managers, supervisors, or other personnel (regardless of job title) with supervisory duties over staff working on the scope of work described in this agreement,

- Subject matter experts who can provide training or other technical support or services to help carry out the scope of work described in this agreement (e.g. expert on Medicare benefit rules, data/analytic support, project management support, etc.),
- Other personnel necessary or desirable to carry out the scope of work described in this agreement.