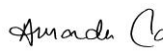




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July 2021

TO: Managed Care Entities and PACE Organizations Participating in MassHealth

FROM: Amanda Cassel Kraft, Acting Assistant Secretary for MassHealth 

RE: **Discharge Planning to Support Members Experiencing or at Risk of Homelessness**

Overview

MassHealth is working in coordination with the Department of Housing and Community Development (DHCD), the Interagency Council on Housing and Homelessness (ICHH), and other departments within the Executive Office of Health and Human Services (EOHHS) to better align expectations for Acute Inpatient Hospitals (AIHs), Freestanding Psychiatric Hospitals (PIHs), and emergency shelters in order to decrease the number of people who are discharged from healthcare facilities directly to homeless shelters. This initiative is an outgrowth of the [Commonwealth's Olmstead Plan](#), which included a specific strategy for EOHHS to *support homelessness prevention and more effective discharge planning efforts across populations*. To assist discharging hospitals and shelters, DHCD, ICHH, and MassHealth have developed new tools and guidance, all of which are available on a new website: [Helping Patients who are Homeless or Housing Unstable](#).

Contemporaneous with this bulletin, MassHealth is publishing companion bulletins for its participating AIHs and PIHs describing discharge planning procedures designed to enable AIHs and PIHs (together, "hospitals") to identify MassHealth members (Members) experiencing or at risk of homelessness in a timely fashion after admission and ensure that such members have access to the post-hospital care (including an appropriate place to live) or services that they need. This bulletin sets forth MassHealth's expectations for Accountable Care Partnership Plans (ACPPs), Managed Care Organizations (MCOs), Senior Care Organizations, One Care plans, and the MassHealth behavioral health vendor (collectively "managed care plans") and Program for All-inclusive Care for the Elderly (PACE) organizations in supporting these efforts.¹

In addition to discharge planning procedures required by their contracts with EOHHS and other EOHHS guidance, managed care plans and PACE organizations must incorporate the discharge planning procedures set forth in this bulletin into their discharge planning and transitions of care protocols with network hospitals.

This bulletin is effective on and after September 1, 2021.

¹ One Care plans and SCOs should first follow guidance provided by Medicare on discharge planning. SCOs must follow the requirements in this bulletin as they relate to protocols with hospitals serving the SCOs' Medicaid-only enrollees.

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MassHealth may update managed care plan and PACE organization contracts to reflect the requirements set forth in this bulletin as necessary in the coming months.

Definitions

- **A Member Experiencing Homelessness** is any member who lacks a fixed, regular, and adequate nighttime residence and who:
 - has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or
 - is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.
- **A Member at Risk of Homelessness** is any member who does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.

Discharge Planning Procedures for Members Experiencing or at Risk of Homelessness

The planning procedures that follow are designed to enable hospitals to identify members experiencing or at risk of homelessness in a timely fashion after admission and ensure that such members have access to the post-hospital care or services that they need, including an appropriate housing setting. Effective September 1, 2021, managed care plans and PACE organizations must include these procedures in their discharge planning and transitions of care protocols with network hospitals.

Discharge Planning Activities at the Time of Admission

Managed care plans and PACE organizations must require network hospitals to contact them at the time of admission in order to collaborate in identifying resources to assist with the housing situation of members experiencing or at risk of homelessness. Additionally, managed care plans and PACE organizations must ensure that the following discharge planning activities occur at the time of admission:

- At the time of admission, and as part of its general discharge planning processes, each hospital must assess each admitted member's current housing situation. At a minimum, the hospital must assess whether such member is experiencing or at risk of homelessness. To aid in this assessment, hospitals must also ensure that their discharge planning staff screen admission data, including but not limited to age, diagnosis, and housing status, within 24 hours of admission. For any member determined by the hospital to be experiencing or at risk of homelessness, the hospital must commence discharge-planning activities no later than three working days after the member's admission unless otherwise required to commence such activities at an earlier time following admission.

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- To assist in the discharge planning process for each member experiencing homelessness or at risk of homelessness, the hospital must, to the extent consistent with all applicable federal and state privacy laws and regulations,² invite and encourage the following persons to participate in or otherwise contribute to such member's discharge planning activities: the member; the member's family members, guardians, primary care providers, behavioral health providers, key specialists, Community Partners, case managers or other representatives, emergency shelter outreach or case management staff, or care coordinators; and any other supports identified by the member. For any such member who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Massachusetts Rehabilitation Commission (MRC), the hospital must, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage designated staff from each such agency to participate in such Member's discharge planning activities.
- The hospital must determine whether any non-DMH-, non-DDS-, or non-MRC-involved member experiencing or at risk of homelessness may be eligible to receive services from some or all of those agencies. For any such member, the hospital must, within two business days of admission, and to the extent consistent with all applicable federal and state privacy laws and regulations, offer to assist the member with completing and submitting an application to receive services from DMH, DDS, or MRC, as appropriate. Please click the following links to obtain additional information about the process of applying to receive services from [DMH](#), [DDS](#), and [MRC](#).
- The hospital must determine whether any member experiencing or at risk of homelessness has any substance use disorder. For any such member, the hospital must contact the DPH-sponsored [Helpline](#) ((800) 327-5050), the statewide, public resource for finding substance use treatment, recovery options, and assistance with problem gambling. The Helpline's trained specialists will help the member understand the available treatment services and their options.
- For any member experiencing homelessness who is expected to remain in the hospital for fewer than 14 days, the hospital must contact:
 - The emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge; or
 - If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the local emergency shelter to discuss the member's housing options post discharge.
 - The names and contact information for emergency shelters is available via <https://hedfuel.azurewebsites.net/iShelters.aspx>.

Assessing Discharge Options

Managed care plans and PACE organizations must ensure that options for discharge are assessed as follows:

- Hospitals must ensure that their discharge planning staff are aware of and utilize available community resources to assist with discharge planning for members experiencing homelessness or at risk of homelessness. For example, hospitals must provide regular

² To the extent that any applicable federal or state privacy law or regulation requires member consent as a prerequisite to any activity described in this bulletin, the hospital must seek such consent.

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training to discharge planning staff on available resources and/or up-to-date resource guides. Various resources are available on [Helping Patients who are Homeless or Housing Unstable](#).

- Hospitals must make all reasonable efforts to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose behavioral health condition would impact the health and safety of individuals residing in the shelter. For such members, hospitals should seek placement in more appropriate settings, such as DMH community based programs or skilled nursing facilities. EOHHS has established a [website](#) to assist hospital discharge staff when helping members with skilled nursing or other long-term care needs. This website also includes information about EOHHS's new [Long Term Care Discharge Support Line](#).
- For certain members, discharge to an emergency shelter or the streets may be unavoidable. For example, certain members may choose to return to the streets or go to an emergency shelter despite the best efforts of the hospital. For these members, the hospital shall:
 - Discharge the member only during daytime hours;
 - Provide the member a meal prior to discharge;
 - Ensure that the member is wearing weather appropriate clothing and footwear;
 - Provide the member a copy of their health insurance information;
 - To the extent clinically appropriate and consistent with all applicable laws and regulations, provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications;
 - If the member is to be discharged to an emergency shelter:
 - Provide at least 24 hours advance notice to the shelter prior to discharge;
 - Provide the member with access to paid transportation to the emergency shelter;
 - Ensure that the shelter has an available bed for the member. In the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the hospital should delay discharge until a bed is available. In these cases, the hospital may bill the managed care plan or the PACE organization at the Administratively Necessary Day (AND) rate for each such day on which the member remains in the hospital.

Tracking and Reporting Discharge Planning Activities:

Managed care plans and PACE organizations must ensure the following discharge planning tracking and reporting activities:

- Hospitals must document in each member's medical record all efforts related to the discharge planning activities described above, including options presented to the member and, if applicable, the member's refusal of any alternatives to discharge to the streets or emergency shelters.
- Hospitals must track discharges of members to local emergency shelters or the streets in a form, format, and cadence to be specified by MassHealth.

Available Resources

As part of the collaborative effort with DHCD and ICHH, MassHealth has jointly developed a Discharge Planning Toolkit – a series of guidance documents and technical assistance products. The section below provides an overview of these tools, all of which incorporate the protocols described

above. Managed care plans and PACE organizations are encouraged to review these resources and share them with their network hospitals.

All of these materials can be accessed online at a new website: [Helping Patients who are Homeless or Housing Unstable](#). This website includes resources, information, and a support line to assist hospital staff in placing members who are experiencing or at risk of homelessness.

- ***Housing Tool for Housing Discharge Staff***

Housing resources, particularly during the COVID-19 pandemic, can be challenging to navigate. This online decision tree can help guide hospital discharge staff when working with a member experiencing or at risk of homelessness by providing specific action steps tailored to the individual's unique situation. A short companion video provides instructions for using the Housing Tool.

- ***DHCD Letter to Individual Emergency Shelter Providers***

This newly released letter outlines DHCD's expectations and requirements for homeless providers that operate emergency shelters for homeless individuals with regards to communicating and collaborating with provider hospital discharge staff. Highlights of the letter include reminders that emergency shelters may not place geographic/community of origin restrictions on access, may not refuse entry to individuals taking prescribed medications, including opiates, oxygen, and benzodiazepines. In addition, DHCD guidance encourages shelters to be prepared to receive and be receptive to inquiries from provider hospitals who may have an individual who previously resided in shelter by sharing information about the individual's housing history and any other support systems they may have (family, friends, case managers, housing leads, etc.).

- ***ICHH Letter to State Agency Stakeholders***

This letter from ICHH provides the context for the renewed focus on the intersection between facility discharges and homelessness.

- ***Reporting Form for Inappropriate Discharge to Adult Individual Shelter***

To develop more robust information related to discharges from facilities into shelters, DHCD, in consultation with ICHH and MassHealth, have developed a Discharge Reporting Form for shelters to complete for any situations in which an individual may have been inappropriately discharged from a hospital to a shelter. This information will help guide future policy discussions. This information will help guide future policy discussions and inform hospital practices.

- ***Finding Alternatives to Shelter: A Discussion Guide for Hospital Discharge Staff and Shelter Realities***

These documents are helpful tools during discharge to identify possible housing solutions other than shelter. *Finding Alternatives to Shelter: A Discussion Guide for Hospital Discharge Staff* provides examples of specific prompts and questions to help facilitate an in-

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depth iterative conversation between discharge staff and a member about possible housing options during discharge. *Shelter Realities* provides clear information about things for a member to consider before choosing to discharge to shelter, including space configurations (e.g., beds, privacy, storage), and operations (e.g., rules around daytime hours, time limits).

- ***How to Obtain Identification Documents***

A useful fact sheet that hospital discharge staff can refer to in assisting members in accessing key identification documents

- ***Homeless Support Line for Discharge Staff***

EOHHS currently operates a Homeless Support Line for Discharge Staff for hospitals to call when they have exhausted all potential placement options, including speaking with a local shelter. Support Line staff aid with troubleshooting benefits issues, connecting with resources not known to the facility, and coordinating with state government partners to address the individual's needs.

- ***EOHHS Long Term Care Discharge Support Line***

EOHHS currently operates a Long Term Care Discharge Support Line for provider hospitals to assist staff from provider hospitals and other settings, who are working with members in need of facility-based long-term care post discharge.

In addition, training opportunities will be forthcoming over the summer and fall.

MassHealth Website

This bulletin is available on the [MassHealth Provider Bulletins](#) web page.

[Sign up](#) to receive email alerts when MassHealth issues new bulletins and transmittal letters.

Questions

If you have any questions about the information in this bulletin, please contact the MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

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