May 20, 2026

The Honorable Marvin L. Abney
Chairman, House Committee on Finance
RI House of Representatives
By Email To: HouseFinance@rilegislature.gov

Re: **Governor's Budget Amendment #16**
Hospital Care Transition Initiative (HCTI)
Duals Care Management Program (CMP)

Dear Chairman Abney:

Governor's Budget Amendment #16 eliminates funding for two successful RIPIN programs, the Hospital Care Transition Initiative (HCTI) and the duals Care Management Program (CMP). EOHHS terminated the CMP contract in February, and the program has already closed down. **The HCTI program is still operating, and we strongly urge this committee to sustain funding for it.**

Hospital Care Transition Initiative (HCTI) ($500,000 all-funds, $250,000 GR)

HCTI embeds RIPIN staff into South County, Kent, Miriam, and Rhode Island Hospitals' discharge teams to help vulnerable older patients discharge safely to home. This innovative approach saves the State money by avoiding long term skilled nursing facility (SNF) stays before they start, while also meeting the desires of most patients and their loved ones to receive care at home. **A long terms SNF stay costs the State more than $65,000 on average**. HCTI supports about 500 discharges annually and **75% of patients are home within a few weeks of discharge.** If even one in ten of these patients would have otherwise needed a long SNF stay, that **would reduce Medicaid expenditures by $1,750,000, a return-on-investment of nearly 4-to-1.**

We **strongly disagree** with the GBA's (and EOHHS's) assertion that the program is no longer eligible for Medicaid match, or duplicative with other programs. This program first starting drawing matching funds in FY25, and **we worked closely with EOHHS in July of 2024 to align the scope of work with federal Medicaid matching guidance**. In fact, large sections of the scope of work are quoted directly from matching guidance that is still effective and available on the CMS website. EOHHS has not shared with us any analysis of how they reached a new conclusion or offered any attempt at mitigating potential concerns. Further, the program is not duplicative. Neither hospital discharge teams nor other care management resources provide the same targeted support as HCTI. Please find attached a separate memo that we recently provided to EOHHS outlining these points in more detail.

The participating hospitals support the program, as indicated in the attached letter they recently sent to Secretary Charest at EOHHS. Brown's School of Public Health is currently completing an academic evaluation of the program's effectiveness. **We strongly urge the committee to sustain funding for this program.**

Care Management Program (CMP) ($1,981,424 all funds, $990,712 GR)

CMP provided care coordination to very high-risk Medicare-Medicaid duals to help them remain in the community and avoid long SNF stays. EOHHS terminated this contract in February 2026 and we ceased program operations, closed out client cases, and eliminated positions or reassigned staff. **We are not seeking to revive this program for FY2027.**

Though we are not seeking to revive this program, it is still important to correct some inaccuracies for the record. First, this program's services could not be provided through managed care organizations because the program never served managed care enrollees. Our scope of work specifically limited the program to Medicare-Medicaid duals who were not enrolled in Neighborhood's managed care plan for duals. Out of 40,000 duals in Rhode Island, only about 12,000 are enrolled in Neighborhood's duals plan. And providing care management support to Medicaid enrollees is clearly a permissible Medicaid matchable activity. The program was terminated for spurious reasons, but that's now in the past.

Conclusion

Unfortunately, the ship has sailed for CMP. Despite its inclusion in the FY2026 budget, EOHHS terminated the program in February with three weeks' notice. After exploring other options to sustain the program, we worked quickly to shut the program down as responsibly as possible. Some program staff were retained to support our growing Conflict-Free Case Management (CFCM) program.

HCTI is still operating, still helping patients every single day. Until last Friday, the program had been included in the Governor's proposed budget for FY2027. **We look forward to partnering with the legislature to sustain this important work**.

Thank you for your attention to this issue, and please do not hesitate to reach out if we can be helpful.

Sincerely,

/s/

Samuel Salganik, JD
Executive Director
Salganik@ripin.org

Enclosures: HCTI One-pager
RIPIN May 19th letter to EOHHS about HCTI
Letter from Participating Hospitals to EOHHS

RIPIN

HOSPITAL CARE TRANSITIONS INITIATIVE (HCTI)

Helping Vulnerable Older Patients Discharge to Home

WHAT IS HCTI?

The **Hospital Care Transitions Initiative (HCTI)** is an EOHHS-RIPIN partnership to **help patients discharge to the community** and **avoid long skilled-nursing facility (SNF) stays.**

- **HCTI is cost-effective**: A long SNF stay costs the State more than $65,000 on average.
- **It's what patients want**: The vast majority of patients want to be home.

THE RIPIN MODEL

RIPIN **embeds staff** into hospital discharge teams.

→

RIPIN staff connect with patients and families while inpatient, and follow the patient into the community with multiple home visits over several weeks.

→

RIPIN helps patients set up home care and other supports, **preventing long-term SNF stays** before it's too late.

PROGRAM FUNDING

- Launched in 2021 with federal funds
- Funded in FY2025 and FY2026 at $500,000/year (50% general revenue, 50% Medicaid matching funds)
- Removed from FY27 proposed budget in GBA #16 (submitted May 15th)

75% of our patients discharge successfully to home

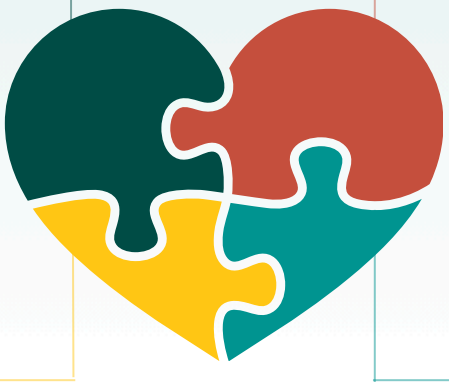
HCTI FOUR KEY PRINCIPLES

SUPPORT PATIENTS & CAREGIVERS

RIPIN provides extra support to patients and caregivers beyond that which the hospital can easily provide.

BUILD RELATIONSHIPS

RIPIN builds relationships in the hospital, then follows-up with patients right after discharge to ensure smooth transitions.



RIPIN coordinates with and uses other care management resources when available, adequate, and appropriate.

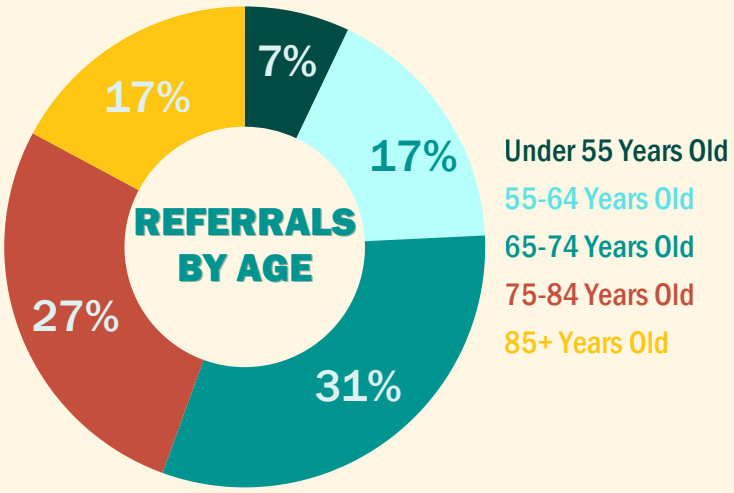
SERVE AS CARE MANAGEMENT OPTION OF LAST RESORT

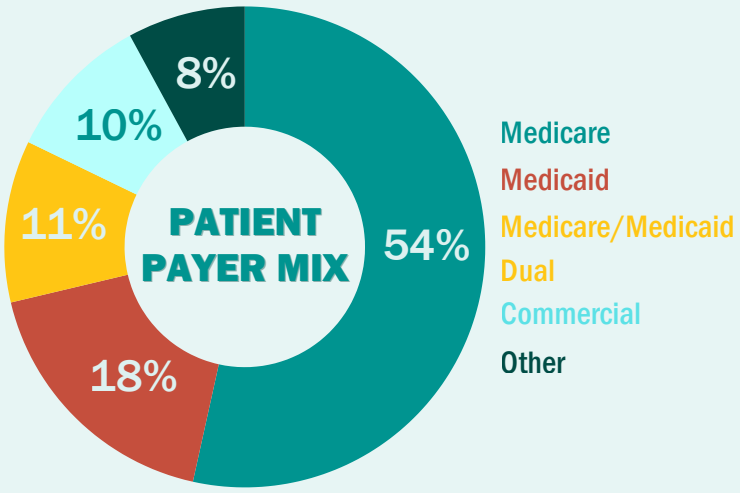
RIPIN supports patients who are ready to leave the hospital but not ready to go home through a discharge to another setting and then later to home.

NOT LENGTHENING A PATIENT'S HOSPITAL STAY

KEY PROGRAM DATA

- ✓ Supported more than 2,000 discharges since 2021
- ✓ Now supporting about 50 discharges per month
- ✓ Embedded in four hospitals: Rhode Island, Miriam, Kent, and South County
- ✓ Evaluation by Brown School of Public Health in progress





RIPIN
PERSONAL SUPPORT BUILT ON PERSONAL EXPERIENCE

401.270.0101
www.ripin.org
hcti@ripin.org

May 19, 2026

Ms. Kristin Sousa
RI Medicaid Director
RI Executive Office of Health and Human Services (EOHHS)
By email to: Kristin.Sousa@ohhs.ri.gov

Re: **Hospital Care Transition Initiative (HCTI) and Medicaid Administrative Match**

Dear Kristin:

On May 1, 2026, you emailed to inform us that our Hospital Care Transition Initiative (HCTI) contract "will not be Medicaid matchable moving forward (at the conclusion of the current term)," despite the program's funding being included in the Governor's FY27 proposed budget. On May 15, 2026, the Governor submitted Governor's Budget Amendment #16 removing this funding from the FY27 budget, stating that the program is "no longer eligible for Medicaid match," and that "comparable Medicaid-eligible services will continue to be provided through managed care organizations."[1]

We strongly disagree with that assessment. HCTI is a Medicaid and LTSS screening, application support, and coordination program. The HCTI scope of work was significantly revised in July 2024 to align with Medicaid matching guidance on No Wrong Door systems that is still effective. Most of the patients served are not in managed care plans, and they do not offer comparable services to their enrollees. We look forward to working with you and your team to gain an understanding of how you reached your conclusion. If legitimate concerns remain, we look forward to working to mitigate them.

Federal guidance on Medicaid administrative claiming is clear that "[f]ederal funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid."[2] The table below summarizes some areas where language in our contractual scope of work aligns with language in federal guidance on Medicaid administrative claiming.

Language from our SOW	Language from Matching Guidance[3]
… engaging in a conversation with the individual and/or their family or caregivers about preferences, strengths, needs, and available resources to determine initial interest in and potential eligibility for Medicaid / LTSS…	Engaging in a conversation with individuals, families or groups about preferences, strengths, needs, and available resources to determine initial interest in and potential eligibility for Medicaid.

[1] See Governor's Budget Amendment #16, at https://omb.ri.gov/sites/g/files/xkgbur751/files/2026-05/GBA%2016%20-%20Amendments%20to%20FY%202027%20Appropriations%20Act%20%2826-H-7127%29.pdf.
[2] See *No Wrong Door System and Medicaid Administrative Claiming Reimbursement Guidance*, available at https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/no-wrong-door-system-and-medicaid-administrative-claiming-reimbursement-guidance (accessed May 12, 2026).
[3] See *No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance*, available at https://www.medicaid.gov/medicaid/downloads/no-wrong-door-guidance.pdf (accessed May 12, 2026); see also *NWD Medicaid Administrative Claiming Workbook* (June 2021), available at https://nwd.acl.gov/pdf/NWD%20Medicaid%20Claiming%20Workbook%20FINAL%20July%202021.pdf (accessed May 11, 2026).

Section 1(c)(i)	*No Wrong Door Reference Document, p12*
… a discussion of the pros and cons of applying for Medicaid in light of the individual's preferences, support system, resources, needs, and any other factor the individual wants to address. *Section 1(c)(ii)*	Discussing the pros and cons of applying for Medicaid relative to an individual's preferences, support system, resources, needs and any other factor the individual wants to address. *No Wrong Door Reference Document, p. 13*
Providing in-depth expertise and assistance with Medicaid and Medicaid LTSS applications *Section 1(c)(iii)*	Assisting individuals or families in gathering information related to the Medicaid application and eligibility determination for an individual *No Wrong Door Reference Document, p. 14*
Referring to, coordinating with, and monitoring Medicaid LTSS home care providers and community support organizations… *Section 1(c)(iv)*	Making referrals for and coordinating the delivery of Medicaid services (includes acute, primary, mental health and LTSS). *No Wrong Door Reference Document, p. 14*
… participate in, coordinate, and present ongoing training which enhances the quality of screening, one-on-one person-centered counseling or other components of Medicaid eligibility processes. *Section 1(c)(v)*	Participating in Medicaid related training which enhances the quality of screening, one-on-one person-centered counseling or other components of the Medicaid eligibility processes. *No Wrong Door Reference Document, p. 15*
…establish protocols for maintaining documentation, internal processes, quality oversight, and policies related to the provision of Medicaid LTSS, health care services, and other supports that may assist an individual to remain in their community, return to the community, or otherwise enhance the person's quality of life, as well as working with State and other partner agencies to improve the coordination and delivery of services, and perform collaborative activities with other agencies to provide services. *Section 1(c)(vi)*	…establishing and maintaining documentation, internal processes, quality oversight and policies related to the provision of Medicaid LTSS, health care services, and other supports that may assist an individual to remain in the community, return to the community, or otherwise enhance the person's quality of life, as well as working with other partner agencies to improve the coordination and delivery of services, and performing collaborative activities with other agencies to provide services. *No Wrong Door Reference Document, p. 16*

It is no coincidence that the scope of work is modelled on federal matching guidance. After full federal funding expired in 2024, the legislature allocated general revenue funding in the FY2025 enacted budget for this program if matching funds could be secured. In July of 2024, RIPIN and EOHHS collaborated to ensure that the program and its scope of work aligned with matching guidance. Since that time, EOHHS has been drawing down matching funds for this program, and we are not aware of any CMS challenge to these claims.

Our understanding is that you have concerns about the extent to which this program interacts with patients before they become eligible for Medicaid. But federal guidance recognizes this is a necessary and inherent aspect of any screening and application program. For example, under a section describing fully matchable activities, the guidance includes, "activities that inform Medicaid eligible or potentially Medicaid eligible individuals about Medicaid" and "engaging in a conversation .

. . . to determine initial interest in and potential eligibility for Medicaid."[4] Clearly, having interaction with some non-Medicaid individuals is not an absolute bar to Medicaid matching.

We also understand that you may have concerns that this program is duplicative, either with services provided by hospital discharge teams or by other case management resources in the community. This is incorrect. Hospital discharge teams do not follow patients after discharge to make sure they have the resources in place to remain at home safely (or to get home in the first place if they discharged to a nursing home). EOHHS developed this program because of an acknowledgment that hospital discharge planners are under enormous pressure to process discharges quickly, and that nursing homes often provide the discharge path of least resistance. The State Medicaid program bears the costs of long nursing home stays, not hospitals. Though hospitals do support discharge planning, they often do not have the resources or incentives to support a community discharge plan in many borderline cases. HCTI fills that gap, removing some structural barriers to getting patients discharged to home, at great advantage to those patients and to the State. HCTI also stays with patients post-discharge in a manner totally different from hospital discharge teams. If a patient discharges to a nursing home, HCTI stays with them to help them get home. And for patients who discharge to home, HCTI follows up for a brief period to make sure appropriate home-based services are in place.

Other care management resources outside of the hospitals (e.g. conflict-free case managers) simply do not have the tools, systems, or relationships to know when their patients are hospitalized and to coordinate with discharge teams at the pace necessary to have an impact. For example, conflict-free case managers (CFCMs) contact patients on a monthly basis, so it is easy to miss a major health change like a hospitalization. And when our HCTI staff identify through the provider portal that a patient has CFCM services, they have to contact DHS to get information about which CFCM agency is involved, a process that does not happen quickly enough to support the discharge planning process. The State's Nursing Home Transition (NHTP) and Money Follows the Person (MFP) programs only serve patients post-discharge, and only those who already have Medicaid, so cannot support LTSS screening and applications to help non-Medicaid patients get home from a nursing home. Managed care plans do not have the presence in hospitals to support the discharge process, and only one managed care plan – a plan that serves a small minority of patients – has any ability to help a patient or family initiate LTSS services.

Further, with respect to duplication, our scope of work requires us to "coordinate the services [we provide] with the hospital discharge planning team to prevent duplication." The scope specifically states:

> *When a person already has a case or care manager through a community organization, State agency, provider, and/or health plan, and a plan of care, the Specialized Transitions Team must facilitate a warm transfer that includes any documentation about clinical status and/or needs, goals and preferences necessary to adjust services post-discharge. The services the Specialized Transitions Team provides in such circumstances wrap around or inform rather than duplicate the work of existing case managers in these circumstances.*

[4] Id. at 13 (emphasis added).

As this language requires, we regularly make warm referrals to the NHTP, MFP, CFCM, or other programs that might be available to support patients. The reality is that there are many patients whom these programs cannot serve. Many of these programs are also not structured to operate on the timelines required to support discharge planning.

HCTI is a successful program that helps prevent long nursing home stays by intervening at the most critical point in the process – at the time of hospital discharge. HCTI embeds RIPIN staff into the discharge planning teams at the Miriam, Rhode Island, Kent, and South County Hospitals. We received more than 700 referrals last year, and roughly 75% of the patients we support are in a home or community setting within a few weeks after discharge. The average long term nursing home stay costs Medicaid more than $70,000, so this program is cost effective if it prevents even a small number of such stays. We are currently working with the Brown School of Public Health on an academic evaluation of program impact, focusing on measures like long term nursing stays, hospital readmission, and post-discharge outpatient follow-up.

We look forward to working with you and your team to understand and mitigate your concerns regarding this program's eligibility for Medicaid administrative matching. Thank you for your attention to this issue.

Sincerely,

Samuel Sagalnik, JD
Executive Director
Salganik@ripin.org

CC: Richard Charest, EOHHS Secretary
Dan Connors, EOHHS Chief of Staff
Matt Stark, Medicaid Managed Care Oversight Director

May 19, 2026

Richard R. Charest
Secretary, RI Executive Office of Health and Human Services
By email to: richard.r.charest@ohhs.ri.gov

Re: **Hospital Care Transition Initiative (HCTI)**

Dear Secretary Charest:

As participating hospitals in the Hospital Care Transition Initiative (HCTI), we write to express ongoing support for the program. Since 2021, HCTI has been a collaborative effort between RIPIN and our hospitals to help high-risk older patients discharge safely to the community with support, with the goal of reducing long stays in skilled nursing facilities (SNFs).

Though many of these patients do not have Medicaid (yet), they are often the types of patients at risk of joining Medicaid after a long stay in a SNF, at great expense to the State. RIPIN offers resources and supports, including remaining engaged with patients for a few weeks post-discharge – and these resources are truly impactful for many patients and caregivers. This program strives to reduce long-term SNF stays by stopping them before they start, saving Medicaid money and helping patients meet their goals. We understand that RIPIN is collaborating with the Brown School of Public Health on a formal program evaluation, which we look forward to reviewing.

The program is included in the Governor's FY27 budget request, but RIPIN's current contract expires on June 30, 2026. We look forward to collaborating with EOHHS and RIPIN staff to ensure smooth and continuous operation of this important program.

Signed:

Brown Health

Care New England

South County Health

CC: Samuel Salganik, RIPIN
Kristin Sousa, RI Medicaid Director