Brief

Healing After the Hospital: Medical Respite Care

Updated July 18, 2022

Related Topic: Health

Patients discharged from the hospital often require continued recuperative care to ensure they heal and recover. Patients experiencing homelessness, however, may not have a safe location to go to where they can rest and manage their conditions and medications after a hospital stay.

Medical respite presents a safe, transitional housing option for people experiencing homelessness to use during recovery. Medical respite programs are growing rapidly as an opportunity to support the health needs of people experiencing homelessness and to address high health care costs associated with hospital readmissions. The number of medical respite programs nearly tripled in the past decade, from 38 in 2011 to 133 in 2021.

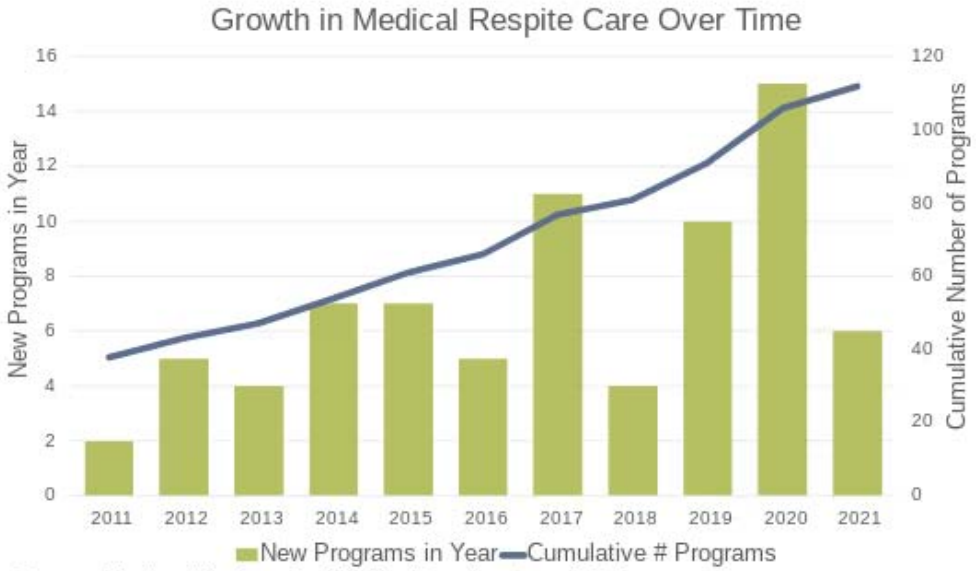
What Is Medical Respite?

Medical respite care, often also referred to as recuperative care, offers acute and post-acute medical care for people experiencing homelessness. Medical respite provides people experiencing homelessness a safe place to manage a chronic condition and get help finding permanent housing.

Based on the Standards for Medical Respite Programs developed by the National Health Care for the Homeless Council, medical respite programs include:

- Safe and quality accommodations.
- Quality environmental services (e.g., hazardous waste handling, disease prevention and safety).
- Timely and safe care transitions to medical respite care.
- High-quality post-acute clinical care.
- Care coordination and wraparound services.
- Safe and appropriate care transitions from medical respite to the community.
- Quality improvement.

Medical respite care differs from caregiver respite, skilled nursing facilities, nursing homes, assisted living facilities, hospice care and supportive housing programs. Instead, medical respite is meant to provide a safe healing environment for people experiencing homelessness, equivalent to recovering at home.



Source: National Institute for Medical Respite Care (2022)

Outcomes

While research on health outcomes and cost effectiveness for medical respite care is sparse, data from medical respite providers indicates:

- People who spend time in medical respite care spend less time in the hospital, are less likely to be readmitted to the hospital and are more likely to use primary care.
- Medical respite care is often less expensive than other forms of residential health care, such as hospital inpatient care and skilled nursing facilities.

In addition, current research suggests medical respite care may reduce unplanned inpatient hospitalizations and stays and emergency room admissions and stays, while increasing the likelihood of housing security for participants through structured partnerships and pathways.

A 2018 study found that hospitals, particularly those in non-Medicaid expansion states, could save money by funding medical respite programs that avoid preventable hospital readmissions due to wounds not healing or medication not being taken or stored properly.

Funding

Medical respite programs are financed through a variety of mechanisms, including funding from hospitals, private donations, state and local governments, Medicaid or managed care organizations, federal agencies (the Health Resources and Services Administration, for example) and others.

Three primary funding sources—hospital, Medicaid and state/local government—are outlined below.

Hospital

While most medical respite programs are not run by hospitals, nearly two-thirds of programs across the country receive funding from them. There are a variety of sources for medical respite funding within hospitals, including community benefit resources, operations funding and contributions from a hospital's foundation or charitable arm.

Medicaid

The outcomes of medical respite care—including decreased hospital stays, medically appropriate care and safe hospital discharge planning—present an opportunity for state Medicaid programs as vested stakeholders in the cost and quality of health care services for enrollees. Even so, medical respite programs face many barriers when securing Medicaid funding for services. Stand-alone facilities operated by nonprofits that do not directly provide clinical care are not usually licensed by the state or recognized as Medicaid providers. Medicaid is prohibited from paying for rent or room and board, except in certain medical institutions, which limits the services that may be reimbursed within medical respite programs.

States have navigated these challenges in various ways, including implementing Medicaid waivers to provide medical respite care to individuals experiencing homelessness and operating through managed care organizations to address housing and other social determinants of health.

Medicaid Waivers

While federal law sets minimum standards related to Medicaid-eligible groups and required benefits, states may apply to the Centers for Medicare & Medicaid Services for formal waivers that provide additional flexibility to design and improve their Medicaid programs.

Under federal rules, medical respite cannot be counted in medical loss ratios (or the percentage of revenue a health plan spends on medical care), which disincentivizes health care organizations from paying for medical respite care. To address this issue, some states have implemented Medicaid waivers to allow plans to pay for medical respite care and other housing supports for homeless beneficiaries as medical expenses in their medical loss ratio.

- Utah implemented a Section 1115 Medicaid waiver for medical respite in 2021, after the Legislature enacted HB 34. The bill created a three-year pilot program to add medical respite as a covered benefit for Medicaid beneficiaries who lack housing.
- Kentucky enacted SJR 72 in 2022, directing the department of health and human services to apply for a Medicaid waiver to provide supportive housing, medical respite care and supported employment for individuals with severe mental illness.

Managed Care Organizations

As of July 2019, MCOs provided care for 7 in 10 Medicaid beneficiaries across the U.S., and MCO coverage has continued to grow during the COVID-19 pandemic. States are increasingly contracting with MCOs to serve more medically complex beneficiaries, including providing services to address social factors that drive health outcomes.

- California implemented the California Advancing and Innovating Medi-Cal through an extension of the state's 1115 demonstration and Medicaid managed care section 1915(b) waivers. By including medical respite as a benefit under community supports, managed care organizations may contract with medical respite providers.

State Appropriations

Approximately 43% of medical respite programs receive funding from local and state government appropriations. Public health, social services and behavioral health agencies looking to improve the health of chronically ill people experiencing homelessness may offer annual grants to support medical respite care.

- Washington appropriated (SB 5693) over $1.5 million in 2022 for medical respite care for individuals with behavioral health needs who do not require hospitalization but are unable to provide adequate self-care for their medical conditions.

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Medical respite post-hospitalization for adults experiencing homelessness

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Abstract: Nurses provide care in various settings and advocate for vulnerable populations. Recognizing the need for follow-up care after hospitalization and mobilizing necessary resources are part of caring for patients, including those experiencing homelessness. This article discusses how one community coalition assessed gaps in care that might be met by establishing medical respite in the community.

Keywords: community assessment, homelessness, medical respite

Case example

Mary was hospitalized for diabetes and acute bilateral lower extremity cellulitis. Her blood glucose levels were elevated, with an admission A1C of 13%.

Prior to hospitalization, Mary resided in a homeless shelter. After 10 days in the medical-surgical unit receiving I.V. antibiotics, analgesics, and twice-daily sterile dressing changes, the discharge planner could not place Mary in a skilled facility for further care due to a lack of personal finances and health insurance. In addition, family members were unwilling to take her in because they lived out of state and felt incapable of helping with managing her diabetes and performing Mary's frequent requisite dressing changes.

Rather than being dismissed to the street or a homeless shelter ill-equipped to provide for her needs, Mary was discharged to a medical respite facility for adults experiencing homelessness. There, she would

receive assistance with medication administration, dressing changes, and learning how to care for herself from nurses and other healthcare professionals. Nursing support in the respite setting while transitioning Mary from the hospital to self-care at home or in a shelter would include helping her achieve glycemic control to prevent the long-term complications of diabetes.

Introduction

Medical respite care facilities, often called recuperative care, provide "acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from physical illness or injury on the streets but are not ill enough to be in a hospital."[1] Patients at these facilities benefit from an interprofessional approach to providing care and resources.[1]

Approximately 116 medical respite facilities have been established in 38 states, mostly in urban areas with greater homeless populations. However, many geographical regions in the US remain underserved.[2] Medical respite traditionally provides 1 week to 2 months of daily health monitoring and appropriate-level care in a safe and supportive environment. During this time, patients receive the care necessary for recovery and are connected with essential services, such as case management, disability, and housing.[3]

This article describes how one community coalition of academic nurse consultants assessed community needs when no medical respite care was available. The nurses identified healthcare service gaps for adults with serious health issues post-hospitalization that might be met by establishing medical respite in the community. As a result of this collaboration, a pilot medical respite program was implemented in the community.

Homelessness

In 2022, the National Alliance to End Homelessness reported that 580,466 people experience homelessness each night in the US.[4] Sixty-one percent of people experiencing homelessness reside in shelters that provide a place to sleep, meals, and programs to help them receive services to overcome obstacles contributing to their homelessness.[4] The remaining individuals experiencing homelessness live unsheltered in areas including sidewalks, subway trains, vehicles, and parks.[4]

Health concerns for individuals experiencing homelessness are complex and often go untreated or undertreated, resulting in poor health outcomes. Those unsheltered individuals experience premature mortality, averaging 12 years earlier than their housed counterparts.[5] Rates of depression and substance use disorders are significantly higher among those experiencing homelessness than the general population. Similarly, rates of diabetes, hypertension, HIV infection, and hepatitis C virus infection follow this trend.[5] Exposure to communicable diseases, harmful weather extremes, and violence may be greater due to homelessness. It can exacerbate health conditions as well as contribute to new pathology.[5] The COVID-19 pandemic added a burden to this already vulnerable population.[6]

Barriers to care

EDs often become the primary source of healthcare for individuals who are homeless due to a lack of insurance and the inability to pay for healthcare services. Persons experiencing homelessness have increased ED visits.[7] The annual number of ED visits is 42 per 100 persons in the general population, compared with the rate of 203 ED visits per 100 homeless persons.[7] Therefore, transitional care from ED visits and hospitalizations to independent self-care is vital.

Transportation to follow-up appointments with care providers may not be available following hospitalization, and the individual may rely on public transport, such as city buses. Those who are unemployed are financially limited and may not be able to access or afford medications without health insurance from an employer.

Homeless residential shelters may not be able to provide higher-level healthcare.[8] Many shelters do not employ nursing personnel. They expect that individuals will be independent in their activities of daily living (ADL) while residing at the shelter and manage any wound dressing changes, medication administration, and ambulation without assistance. Older adults experiencing homelessness may have more chronic illnesses and require assistance that the shelter cannot provide.[9]

Post-hospitalization health needs

At hospital discharge, adults experiencing homelessness need a respectful and understanding approach to care, housing assessments, communication and coordination, support for after-care, complex medical care and medication management, and basic needs and transportation.[10]

In areas without medical respite care, providers from hospitals and community-based agencies may coordinate the services needed for persons experiencing homelessness for appropriate care and recovery after an ED visit or hospitalization.[11] Service providers have reported remorse and frustration at the lack of processes and care provided to these individuals after discharge; similarly, individuals experiencing homelessness reported stress and uncertainty about post-hospitalization care.[11]

Nurses' role

Nurses are integral in coordinating and transitioning care through hospitalization and discharge. In a medical respite facility, nurses determine qualifications for admission and discharge, establish and coordinate care, provide wellness

checks, ensure that medications are appropriately administered, monitor for adverse reactions, and teach patients how to care for themselves.

Positive outcomes from recovering in medical respite facilities include reduced hospital admissions, shortened hospital lengths of stay, decreased frequency of ED admissions, and increased use of primary care services.[2]

Complex healthcare needs are common among people experiencing homelessness. Nurses can teach individuals to care for themselves, connect them to resources, and offer support during this process.

Starting a community coalition

In a community located in the midwest region of the US, no respite care was available, and hospitalized patients who were homeless experienced prolonged lengths of stay due to the inability to discharge promptly to appropriate level facilities. Hospitals were not financially compensated for this extended care; homeless shelter personnel admitted individuals into their facilities without the licensed personnel to provide the requisite levels of care.

The coalition conducted a qualitative study to assess community needs, describe current realities, and identify healthcare service gaps for adults experiencing homelessness. The coalition observed three distinct groups of participants to gain broad perspectives of those impacted by this lack of resources: adults experiencing homelessness, hospital discharge planners, and shelter staff.

Three perspectives

An Institutional Review Board at a Midwestern private university approved the study. The setting was an urbanized region of 4,346.3 square miles with approximately 972,195 people.[12]

Demographic results, group 1 (N = 20)

Age	Range: 29-70 years Mean age: 50 years
Gender	Male: 70% Female: 30%
Race	Non-Hispanic White: 55% Hispanic: 5% Black American: 25% Native American: 15%
Highest level of education completed	Middle school: 15% High school/GED: 50% College education: 35%
Number of times homeless	First time: 35% Multiple times: 65%

The area has eight residential homeless facilities, three federally qualified health centers, and other supportive service agencies to address the homeless population's needs. Descriptive statistics and summarizing key points from the transcripts were used to identify gaps in care.

Participants

The first group consisted of guests at a homeless shelter who had been hospitalized or received care in an ED the previous year. The shelter facility staff recommended these participants to the investigators as meeting inclusion criteria. Participants were selected after an interview. Before the interview, the investigator presented the purpose of the study as well as the risks and benefits of participating, answered questions, and obtained written informed consent. The shelter staff then introduced each participant to the two RN academic faculty and provided a quiet place for the interview.

A convenience sample of 20 adults participated in semistructured interviews with the investigators. Interviews were recorded with permission and transcribed verbatim. In addition to basic demographic information, participants were asked about their health status, including their ability to perform activities of daily living, such as eating, dressing, toileting, and bathing; their ability to walk; sensory impairment; the presence of pain; history of falls; and problems with depression, anxiety, and other mental health concerns. Participants were also asked to describe their difficulties or supports when caring for themselves after hospital discharge.

The second group of participants consisted of hospital discharge personnel. The investigators contacted directors of the hospital discharge departments at several metro hospitals to request permission to send an electronic survey about the discharge of patients experiencing homelessness to their discharge personnel and social workers. Once the hospital's permission had been obtained, participants were emailed a link to the survey. The survey consisted of five questions from the National Health Care of the Homeless Council: (1) How often do you encounter patients who are experiencing homelessness? (2) What gender are the patients who are experiencing homelessness? (3) How often is the discharge delayed due to homelessness? 4) Where are patients experiencing homelessness typically referred to at discharge? and (5) What do you perceive as the biggest gaps in the community related to homelessness?[1] The

Health questions, group 1 (N = 20)

Symptom	Number of participants (%)	Participant comments
Difficulty walking	17 (85%)	• unsteady gait • lower limb and toe amputations • diabetic neuropathy • degenerative joint disease • knee pain • instability, open foot wound, stroke
Poor vision	18 (90%)	• corrective lenses • cataracts • glaucoma • eye injury • retinopathy • poor night vision
Fatigue/ exhaustion	15 (75%)	• shortness of breath • heart failure • COPD • heavy work assignment • night shift • difficulty day sleeping • chronic back pain • blood glucose level fluctuations
Daily pain	19 (95%)	• musculoskeletal pain • neuropathic pain • headaches • phantom pain
Falls in the past 3 months	13 (65%)	• shortness of breath from heart failure • weakness • hemiparesis from stroke • tripping over feet • falling over furniture • falling in the bathroom • falling due to meds • falling on ice • falling during a seizure • daily falls or falls several times each month
Inability to independently perform ADL	4 (20%)	• dressing • carrying food trays • laundry • showering • navigating stairs • toileting • personal hygiene
Anxiety/ depression	9 (45%)	• anxiety/nervousness • inability to control worry • depression • hopelessness
Mental/ behavioral health issues	18 (90%)	• chronic depression • post-traumatic stress disorder • paranoia, bipolar disorder • attention-deficit/hyperactivity disorder • nightmares

(Continues)

participants returned the survey through the electronic system upon completion.

The third group consisted of homeless shelter staff interviewed by the investigators. The homeless shelter directors in the midwestern community were participants in the coalition and were asked electronic email by the coalition directors to participate in the study. The researchers followed up on any who volunteered to be interviewed. The homeless shelter directors in the midwestern community were asked through electronic mail from the coalition directors to participate in the study and were interviewed about the experience of receiving guests from healthcare facilities. The interviews were recorded with permission and transcribed verbatim. Participants were allowed to complete the questions via an electronic survey link if preferred for convenience. The survey consisted of five questions from the National Health Care for the Homeless Council: (1) Over the past six months, have shelter guests come to your facility with health illnesses and injuries? (2) How many guests had just received medical care? (3) Did the individuals come with the necessary medications and medical supplies that were needed when they were admitted? (4) Were the individuals independent in their ADL? and (5) How much time do you think individuals might have benefited from a medical respite program had there been one in the community?[1]

Results

Difficulties posthospitalization

Twenty adults experiencing homelessness were interviewed. They reported 25 hospitalizations and over 50 ED visits in the year before the study. The mean age of these participants was 40 years old. The majority were male, non-Hispanic White, had a high school education,

Health questions, group 1 (N = 20) *(Continued)*

Dentition issues	15 (75%)	• edentulism • broken teeth • tooth extractions • cavities • inherited bad teeth • methamphetamine • dental disease • limited access • dental care access

and had been homeless on multiple occasions (see *Demographic results, group 1*).

Participants reported being hospitalized for health conditions including heart failure, lung and kidney cancer, hypertension, chronic obstructive pulmonary disease, diabetes, wound infections, COVID-19 pneumonia, complications from HIV infection, bipolar disorder, posttraumatic stress disorder, depression, anxiety, paranoia, and substance use disorders. Most participants reported experiencing difficulty walking, poor vision, physical fatigue and exhaustion, daily pain, falls within the past 3 months, mental health and behavioral issues, and dental issues. Reports of anxiety and depression (45%) represented many symptoms of those experiencing homelessness (see *Health questions, group 1*).

Participants were also asked about the difficulties and support they had in caring for themselves after being discharged. They described the inability to remember and follow discharge instructions; an inability to perform dressing changes using a clean technique; a lack of support from others; and a lack of supplies, equipment, and/or medications. They often returned to the ED when they experienced a further exacerbation of symptoms. Several participants described the social support they received (see *Participant descriptions of social support*).

Discharge difficulties

Twenty discharge planners from three hospitals participated in the electronic survey. Fifteen participants (75%) reported encountering patients experiencing homelessness one or more times each week. Half (50%) of the patients identified as male, and the other half (50%) as female.

Participants reported that hospitals have difficulty discharging patients who are homeless if there are any ongoing health needs or a need for follow-up services due to the lack of health insurance or inability to pay. Discharge is often delayed, and the hospital stay is prolonged when individuals could not be admitted to skilled or long-term-care facilities as needed. If there is a delay in discharge, the hospital bed is not available for another ill patient. Discharge planners reported community service gaps as a lack of shelter beds and shelters capable of caring for patients with medical needs, skilled care facilities, transportation, and mental health resources.

Participant descriptions of social support

"I did okay because I ended up going back to the shelter. If I didn't go there, then I would not have had none of it. I would have ended up not having my medicine or anything."

"When I'm not here (in the shelter) or places like this, I kinda don't really care about myself. Especially on my foot 'cause I was here last year, and I was taking good care of it here, but once I left, I stopped taking care of it because I didn't have the supplies I needed and also because I kinda just didn't want to. And then it got a lot worse. As soon as I got back here, I started taking care of it again and it just got better. But being here we got a bed, and we're around people. It's just more of a want to do it because I'm here."

Difficulties for shelters

Five shelter staff from three residential homeless shelters volunteered to participate in the study. Shelter staff reported that guests have arrived at shelters following hospitalization without notice and that admission to the shelter may not always be appropriate for the guests' needs. For instance, guests lacked medications and durable medical equipment. They were not always able to perform ADL, and the shelters generally did not have trained staff to meet these needs. Furthermore, palliative, hospice, and long-term care beds were sometimes needed for guests and were not available. In addition, shelter staff reported that guests often needed mental health and substance use services, which they could not provide.

Shelter staff reported that 1 to 3 weeks of medical respite before admission to the shelter would likely be adequate to regain strength and increase their ability to perform ADL.

Discussion

The results of this study are consistent with the literature reporting that adults experiencing homelessness frequently experience disease processes and adverse symptoms and may use ED services to meet these needs due to lack of insurance and inability to pay for healthcare

services.[4] Because individuals are not receiving consistent care in a primary care setting, diseases may exacerbate until hospitalization is required. Continued recovery time is often needed after a hospital stay and the individual experiencing homelessness may lack resources and assistance with self-care. Discharging to a safe, appropriate place where further follow-up and recovery can occur may be difficult for discharge planners to accomplish. Residential homeless shelters are often not equipped or staffed to care for individuals with complex health needs.

Four of the themes identified by Canham et al.[10] are especially noteworthy regarding the current study.[10] "Communication/coordination" described a lack of coordination between hospitals and housing services which impacted the anxiety and recovery of the persons experiencing homelessness. The authors also reported that shelters sometimes received discharged patients unexpectedly arriving at the shelter without advanced notification, so shelters could not provide appropriately for the individual's needs. In the current study, the shelter staff communicated with providers, social services, and skilled nursing facilities to find the most satisfactory location for the individual to meet their needs. This was beyond the scope of the role of shelter personnel.

"Supports for After-Care" was described as identifying a need for immediate and long-term support for individuals with medically complex needs.[10] In the current study, shelter staff reported a lack of available services such as mental health services, addiction treatment, supportive housing, and resources for the individual beyond immediate needs for medications and medical equipment.

"Complex Medical Care and Medication Management" described the lack of instruction available for shelters to assist guests recently discharged from a hospital, the lack of medications and medical equipment, and the lack of staff qualified to provide this care.[10] In the current study, shelter staff reported a lack of nursing personnel and equipment to perform dressing changes, monitor blood glucose levels, and ensure an adequate supply of medications was available for guests.

"Basic Needs and Transportation" described the needs of clothing, food, money, housing, and transportation to assist the person experiencing homelessness with recovery.[10] Transport was especially needed to get individuals to their destination due to weakness from the hospital stay and the necessity of follow-up appointments.[10] Consistent with Canham et al.,[10] discharge planners and shelter staff in the current study reported that shelters had similar difficulties in providing appropriate placements, transport, and assistance in completing applications for additional resources.

CONCLUSION

Individuals experiencing homelessness may have health concerns that often go untreated or undertreated, resulting in poor health outcomes. This study contributes to a better understanding of the healthcare service gaps for individuals experiencing homelessness when medical respite care is unavailable. These perspectives also inform nurses of the complexity of the problem so they may better advocate for these patients and assist with necessary care transitions. ■

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The authors have disclosed no financial relationships related to this article.

DOI-10.1097/01.NURSE.0000918524.41501.98

ISSUE BRIEF

Health Centers Improve Health Outcomes with Medical Respite Care

June 2022

Community health centers [also known as federally qualified health centers (FQHCs), or simply health centers] are the backbone of the health care safety net. Not only do health centers have a fundamental mission to deliver comprehensive primary care with integrated access to behavioral health, dental care, and supportive services (case management, outreach, etc.), they also strive to reduce health care disparities and improve health outcomes in underserved communities. In 2020, health centers served nearly 29 million people—and of these, almost 1.3 million people were reported to be experiencing homelessness.

People experiencing homelessness (PEH) often have high rates of chronic and acute medical conditions, behavioral health issues, and needs for supportive services, and they incur disproportionately high rates of emergency department (ED) visits and inpatient hospitalizations. PEH also experience significant barriers to engaging in primary care, which leads to more acute care utilization—largely in health care settings not equipped to address their underlying, interdisciplinary needs. In addition, because PEH often lack a safe place to recover once they are ready for discharge, patients who are homeless often experience longer stays in the hospital at greater expense to public systems. Those patients not needing a higher level of care—such as at a skilled nursing facility—are often discharged to a homeless shelter (or to the street) but still require ongoing post-acute care. Finally, initiating medications for opioid use disorder (MOUD) is much more difficult absent a safe, stable environment.

Lack of housing and the inability to rest and recuperate means this population also experiences poorer health outcomes and higher rates of ED/hospital re-admissions. Further, homeless services providers (such as shelters) are not trained or staffed to provide medical care and generally cannot accommodate illnesses, injuries, or post-operative care. To help address these gaps in care, medical respite care programs offer a solution to meet medical needs for this vulnerable group.

The purpose of this issue brief is to describe medical respite care programs, illustrate how health centers can fulfill mission and add value to their community by adding a medical respite care program, outline both the advantages and challenges to such an expansion, and offer action steps for health centers to consider. As the larger health care system increasingly focuses on addressing social determinants of health (such as the lack of housing) through innovative care approaches, HRSA-funded health centers play an important role as a key health care partner in communities across the nation.

Medical Respite Care (aka Recuperative Care[1])

Medical Respite Care

Provides people experiencing homelessness a safe space to recuperate from illness/injury post-hospitalization:

- Medical care & case management
- Help with documentation & benefits
- Medication & disease management skills
- Housing assessments & search preparations
- Ongoing care plan development & care coordination

Medical respite care is also known as "recuperative care." HRSA defines recuperative care as "short-term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate hospitalization, but would be exacerbated by their living conditions (e.g., street, shelter or other unsuitable places)." The National Institute for Medical Respite Care estimates there are ~130 medical respite care programs in the United States operated mostly by small, non-profit organizations (with only 36 of these programs operated by a health center). The most recent assessment of programs found most are based in a homeless shelter or a stand-alone facility with fewer than 20 beds where the median length of stay is 28 days. About half of these programs offer onsite clinical services (medical providers, nursing, social work), and nearly all provide supportive services (case management, peer support, etc.). Note that some clinical services could be offered on-site at a respite program while the majority of care could occur off-site at the health center (or other outpatient venue).

The combination of clinical and supportive services together with a short-term residential component like medical respite care has been shown to reduce ED and hospital re/admissions, improve engagement in care and health outcomes, improve care coordination and care transitions, and reduce overall system costs. (Find more information about medical respite care here.)

Medical respite care programs meet the short-term needs of patients experiencing homelessness, as well as offer an appropriate, cost-effective solution for both hospitals and insurers given the lack of safe discharge options. These programs also add value to health centers as they engage more vulnerable patients in care.

There are different models of medical respite care to consider, and health centers have options in how they incorporate medical respite care. The most common approach is to partner with a homeless shelter and identify a few staff positions to provide case management and/or clinical services to patients at the shelter. Other approaches involve different venues for care, as well as varying breadth and depth of services offered and the frequency of service delivery. (The State of Medical Respite Care offers more information about how programs operate and what services are provided.)

[1] Note: 'recuperative care' and 'medical respite care' are interchangeable terms though 'recuperative care' is the term used in the Public Health Services Act, the authorizing law for health centers.

Advantages to Adding a Medical Respite Care Program to Health Center Operations

Medical respite care programs offer five key benefits to health centers:

Maximizes funding opportunities: Medical respite care has not always been well funded or considered reimbursable; however, there are various funding strategies to explore. Hospitals are key financial partners, as are homeless shelters, who can use HUD funding to pay for beds, staffing, and other program costs. The rise in value-based payments and accountable care organizations (ACOs) has also changed the financing landscape. Now, Medicaid and managed care organizations (MCOs) increasingly cover interventions designed to address social determinants of health—like medical respite care—though health centers in states not expanding Medicaid to single adults will be more limited on this option. Importantly, health centers may bill at their usual encounter rate for every eligible visit, which can generate significant revenue depending on the patient population served. Further, states may allow flexibility for billing nursing care (or other type of staff) if it is fulfilling a physician-directed medical plan, which can extend reimbursement potential.

> "We include medical respite care in our costs of care and we bill our PPS rate for every encounter. Even with the cost of 24-7 nursing staff, we are able to break even. It's definitely not a money-loser for us."
> *~ Kim Depres, CEO, Circle the City, Phoenix, AZ*

> "There's a level of acceptance that we don't need to focus on traditional return on investment as the only primary objective with medical respite because of a long-term shared understanding that the service provides other forms of value."
> *~ Jordan Wilhelms, Central City Concern, Portland, OR*

While reimbursement is clearly important, those interviewed for this brief caution against relying on billable revenue and return on investment as the sole factors that determine whether a health center engages with a medical respite care program. They cite other, non-financial factors that demonstrate how medical respite care programs add value (which are outlined below), as well as note that health centers should be determining services based on patient need rather than earned revenue.

Adds value for health center as an organization: Medical respite care programs add value to health centers because they fulfill mission, going beyond minimum standards to extend services to a patient population that is chronically marginalized in the health care system—and often not engaged in care as a result. The program connects patients to primary care, behavioral health, support services, and housing (as often as possible), and staff actively seek to build relationships based on trust and respect. Not only does this care model bring new patients to the health center, but it also retains those patients for ongoing care after the medical respite care stay ends. **Importantly, the stability offered through the residential component helps improve health center outcome measures, such as those for vaccines/immunizations, cancer screenings/preventive care, control of diabetes and hypertension, and connections to primary/specialty care.** For those in ACOs, outcome measures such as hospital lengths of stay and 30-day readmission rates are also positively influenced by medical respite care.

> "FQHCs need to adopt medical respite because the population they serve needs a different option to healing that doesn't exist currently. There has to be a gap-filler, and medical respite is that filler."
> *~ Miriah Nunnaley, Colorado Coalition for the Homeless, Denver, CO*

For health centers who host medical residents (or other clinical roles), medical respite care programs offer an opportunity to expose students to a social medicine curriculum on rotations and orient them to issues of homelessness earlier in their clinical training. Health centers that are part of public health departments ("public entities") report an easier experience collaborating more seamlessly across the entire system, making care coordination more successful.

"We are part of a hospital ACO with a capitated budget and a shared savings contract—when the hospital saves money on length of stay and re-admissions, we all benefit."
~ Rhonda Hauff, CEO, Yakima Neighborhood Health Services, Yakima, WA

Adds value for the community and to community partners: Interventions that improve the conditions of homelessness are of high value in any community. Hospitals greatly benefit from the reduced lengths of stay and re-admissions rates as well as the safe discharge venues that medical respite care programs offer them. Homeless services providers, like shelters, benefit when high-needs clients with health conditions can receive needed care that shelter staff are not trained or able to provide. Partnerships with homeless shelters are particularly advantageous for medical respite care programs because they can maximize the roles that both partners play—with health centers providing staff and services, and shelters providing beds, facilities, and oversight (though this is just one programmatic approach of many).

Adds value for clinicians: Medical respite care programs offer clinicians (and the entire care team) a better way to deliver services, and they experience greater job satisfaction as a result. This is especially true if a health center can refer patients directly to respite (rather than needing a hospital referral). Being able to have a dedicated space to refer complex patients with intensive needs so they can stabilize and receive care in a way that is not possible in a traditional health center setting is incredibly rewarding. The extra time to work with patients gives a great opportunity to evaluate functionality and ongoing needs, coordinate care, establish a patient relationship, and develop a longer-term care plan. Those interviewed for this brief cite improvements in connecting clients to primary and behavioral health care, initiating medications for HIV or opioid use disorder (MOUD), performing cancer screenings/treatment, as well as having needed time to adjust insulin regimens for those with diabetes. Connecting patients to longer-term treatment programs and/or permanent housing placements is also very fulfilling. Beyond the provision of services, clinicians routinely describe greater satisfaction in being able to gain patient trust, work with a team to deliver holistic care, improve the dismal experience of homelessness (even if temporarily), and see patients improve and become more stable.

"As a doc, you get a unique perspective from spending more time with patients in an MRC than a 30-minute visit in the clinic allows—you get a better sense of their day to day function."
~ Sara Jeevanjee, MD, Valley Homeless Healthcare Program, Santa Clara, CA

"We treat people with dignity and respect, and often they then say, "I want you to be my doctor." As a provider, it is very rewarding to know I've earned someone's trust."
~ Tyler Grey, MD, Health Care for the Homeless, Baltimore, MD

Adds value to patients: Medical respite care offers the clearest value to patients, who benefit directly from the services and stability that the program offers them. Not only are they able to get their identification and other documentation, but they are able to rest and recuperate from their illness or injury, and have time to focus on their care plan and next steps instead of needing to prioritize basic needs such as safety and a place to sleep and eat. Medical respite care programs also offer more autonomy in medical decision-making and engage patients as partners in the process, establishing more trust and dignity than is usually experienced in other health care system interactions. Those health centers with Consumer Advisory Boards or those seeking patient input on needed health center improvements may find that patients experiencing homelessness want these types of programs to help them improve their quality of life.

> "Our nurse practitioner would get bus tokens and put patients on the bus so they could ride for the day to get off their feet. MRC solved that, and was a direct response to the expressed needs and desires of the patients we serve."
> *~ Rhonda Hauff, CEO, Yakima Neighborhood Health Services, Yakima, WA*

Health Center Requirements: Aligning Medical Respite Care with Mission & Compliance

In order to continue providing comprehensive, culturally competent, high-quality care, health centers are regularly evaluated for compliance with a range of requirements that are outlined in HRSA's Health Center Program Compliance Manual. These requirements form the foundation of the Health Center Program and support the core mission of health centers' innovative and successful model of primary care. Six areas in the compliance manual most directly align with a medical respite care program (see Table 1).

Table 1. Aligning Medical Respite Care with Health Center Requirements

Health Center Requirement	Health Center Program Compliance Manual	Connection to Medical Respite Care
Needs assessment Chapter 3	The health center must assess the unmet need for health services in the catchment (or proposed catchment) area of the center based on the population served, with the option to include an additional focus on a specific underserved subset of the service area population.	Community needs assessments often cite a gap in services for people experiencing homelessness when they are discharged from hospitals and/or need a safe place to recuperate from illness/injury.
Required and additional health services Chapter 4	Health centers must provide a set of required services. Those services most likely to be delivered in a medical respite care setting include: • General primary care • Screenings • Immunizations • Substance use disorder services (for Health Care for the Homeless grantees only) • Case management • Eligibility assistance • Health education	There is a strong overlap between core health center services and medical respite care services. While a number of health centers have added 'recuperative care' to their scope of service, several health centers interviewed for this issue brief indicated they did not have to add recuperative care because the approved list of required services

Health Center Requirement	Health Center Program Compliance Manual	Connection to Medical Respite Care
	• Outreach • Transportation • Translation However, health centers also have the option to add additional services—**with 'recuperative care services' expressly listed as allowable services**—"that are appropriate to meet the health needs of the population served by the health center involved."[2] Details of the services offered by the health center are listed on Form 5A as part of a health center's scope of health center project.	already included the services being provided in recuperative care. For health centers serving a high number of patients experiencing homelessness, medical respite care may constitute services appropriate to meet patients' health needs. Note: not all services offered by a health center need to be available at every service site, thereby giving medical respite care programs more flexibility to tailor care at a specific location.
Accessible locations and hours of operation Chapter 6	Required services must be available and accessible in the service area of the health center promptly and in a manner that ensures continuity of service to the residents of the center's catchment area. Details of a service site are generally included on Form 5B, which lists the details for each approved service site, or on Form 5C, which lists other health center activities.	Service sites for medical respite care can be identified as permanent, seasonal, mobile van, or intermittent.
Coverage for medical emergencies during and after hours Chapter 7	Health centers already are required to have provisions for promptly responding to patient medical emergencies during the health center's regularly scheduled hours, as well as arrangements for responding after hours.	Medical respite care programs offer an additional route to providing 24/7 coverage for particularly vulnerable patients.
Continuity of care and hospital admitting Chapter 8	Health centers must provide the required primary health services of the center promptly and in a manner that will assure continuity of service to patients within the center's catchment area (service area), as well as develop an ongoing referral relationship with one or more hospitals.	Medical respite care programs often are based on contracting with partner hospitals so there is a safe discharge option for patients, and an expressed goal to improve coordination of care.
Collaborative Relationship Chapter 14	Health centers must make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the service area, local hospitals, and specialty providers. They are also required to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments.	Medical respite care programs specifically fulfil this requirement given their ability to reduce ED visits, extend needed service provision to a vulnerable group, and establish relationships with area hospitals (and other types of providers who might refer to the program).

[2] Note: 'recuperative care' and 'medical respite care' are interchangeable terms though 'recuperative care' is the term used in the Public Health Services Act, the authorizing law for health centers.

Challenges to Adding a Medical Respite Care Program to Health Center Operations

There are challenges to adding any type of service to health center operations. While the pressure to accept referrals and manage higher acuity patients for medical respite programs is a common challenge, three issues may affect health centers more specifically:

Unifying work culture across teams: Depending on the model of care, staff at medical respite care programs will develop their own team culture, which may feel separate from the care teams at traditional clinic locations. This may be particularly true if the model uses 24/7 staff at a separate location. It may be more challenging to supervise 24/7 staff or back-fill medical respite care staff with staff from other areas of the clinic. It may also be that non-respite care staff misunderstand the care model and/or the purpose of the program within the organization. Clinicians at health centers that directly refer patients to medical respite may be tempted to place those with especially high needs because skilled care/nursing home care is unavailable.

Strategies to mitigate:

- Regularly include medical respite care issues and/or program information in staff meetings, Board of Directors meetings, or other events so that the purpose and value of medical respite care is broadly understood.
- Plan trainings or events at a time when more medical respite care staff can attend so they feel connected to the larger agency.
- Determine how medical respite care staff interact with staff at the main clinic sites so it is clear where the clinical leadership resides and how decision-making occurs for patient care.
- Support cross training among sites so more providers understand medical respite care operations and service delivery approaches. This approach should help facilitate smoother care coordination between the health center and the medical respite care program.
- Identify clear clinical criteria for program admission and only make exceptions when arrangements have been made to ensure safety and quality of care.

Managing the finances: Managing multiple funding sources is likely needed to cover all medical respite care program costs, which is not unlike health center financing in general. Most financing partnerships (e.g., with shelters, hospitals, or others) require time spent managing the relationship and the grant/contract to ensure continuity of operations. If Medicaid is being used to finance medical respite care services, negotiating with managed care plans, establishing billing rates, and managing contracts can be an added administrative task. There may also be times when MCOs do not authorize a medical respite care stay for a patient, which can pose a challenge for the clinical team.

> "For health centers going into value-based care, recuperative care decreases costs of care, helps you perform under those contracts, and takes better care of patients."
> *~ Jeff Norris, MD, Father Joe's Villages, San Diego, CA*

Strategies to mitigate:

- Fold the administrative requirements for medical respite care into routine financial operations for the health center.
- Adopt a uniform contracting approach across MCOs for medical respite care.
- Use volunteers or other community resources to add "hands on deck."

Overseeing additional facilities: Assuming responsibility for a 24/7 short-term residential program, such as hiring and overseeing kitchen, housekeeping, or overnight staff, may be new for a health center if it is not already operating such services. Staffing and technical support (especially for the electronic health record) also needs to be available at times when other health center operations might be closed.

Strategies to mitigate:

- Partner with a shelter/housing operator who can take on these responsibilities (if they are not already)
- Start with a medical respite care program that requires fewer 24/7 staff (or positions such as housekeeping) if this is a barrier to moving forward (e.g., collaborating with a shelter provider who will already have these services in place).
- Train medical respite care staff in managing the environment of care to ensure it is a safe, therapeutic space.
- Develop policies and protocols for emergencies and/or after-hours needs.

> "Our CEO had less heartburn over a shelter-based program than a stand-alone one because we just had to provide the medical component to what the shelter was already doing."
> *~ Brandon Cook, New Horizon Family Health Services, Greenville, SC*

Ten Action Steps to Consider

Leaders at nine health centers that incorporate medical respite care into their operations were interviewed for this policy brief. Their programs range from five to 125 beds, and they use a varying combination of staff. Some dedicate one to two staff that only deliver case management and support services at an offsite location, while others have dozens of staff working at a stand-alone, full-service facility dedicated only to medical respite care. Most employ a middle approach that uses a combination of clinical and support staff. When asked what action steps they would recommend to health centers looking to add medical respite care, they offer the following advice:

1. Ask health center patients who are homeless about their needs for recuperation from illness and injury.
2. Consult staff at local hospitals and homeless shelters about the recuperation needs of people experiencing homelessness, and what type of services are needed.
3. Identify potential partners among other homeless/community service organizations (such as shelters).

4. Identify a possible venue (or space within an existing venue) to locate a medical respite care program.
5. Identify what funding sources are available from state Medicaid, managed care partners, hospitals, homeless services providers, public health authorities, and philanthropic organizations.
6. Identify appropriate staff (to include security, if appropriate) who could be dedicated to a medical respite program, and train them on harm reduction, trauma-informed care, de-escalation, and other relevant skills.
7. Start small and with the model that costs the least, even if that means providing services via telehealth.
8. Name a champion for the medical respite care program within your health center.
9. Meet regularly with hospital discharge staff because they identify the patients needing referral to medical respite care.
10. Ask for technical assistance from the National Institute for Medical Respite Care.

Conclusion

Interventions that address the social determinants of health—like the lack of housing—are increasingly being funded through insurers, hospitals, and community partners like homeless services providers. Medical respite care programs, which provide a post-acute care venue for people experiencing homelessness to rest and heal from illness or injury, bring a number of organizational advantages to health centers and are appropriate and effective models of care. As health centers continue to grow their role in underserved communities, they should consider adding medical respite care programs to their scopes of service.

"We recognize our patients have been left behind by the system and the lack of trust requires this need to create a culture of 'I care for you, I'm going to provide services in a unique and different way.' If you already care for homeless folks, it makes sense to create an MRC program."
~ Omar Marrero, Boston Health Care for the Homeless Program

This activity is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,967,147 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Washington State Health Care Authority
Report to the Legislature

Statewide Medicaid Benefit for Medical Respite Care

Issues Informing Benefit Design and Implementation

Engrossed Substitute Senate Bill 5092, Sections 211(69) and 1210(75), Chapter 334, Laws of 2021

January 15, 2022

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Statewide Medicaid Benefit for Medical Respite Care

Acknowledgements

This report was contracted to the National Health Care for the Homeless Council and authored by Barbara DiPietro, PhD, Senior Director of Policy. John Gilvar of Gilvar Consulting offered additional assistance developing this report.

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Executive Summary

Background: ESSB 5092 (2021), Sections 211(69) and 1210(75) directed the Health Care Authority (HCA) to develop an implementation plan to incorporate medical and psychiatric respite care as statewide Medicaid benefits. This plan includes a description of medical respite care nationally and in Washington State; feedback from interested stakeholders (to include hospitals, Medicaid managed care organizations, federally qualified health centers (FQHC), organizations providing medical respite care, consumers, and Tribal members; an analysis of the cost-effectiveness of providing medical and psychiatric respite care benefits for Medicaid enrollees; strategies for successful community partnerships with homeless services providers; and additional issues to consider moving forward.

Medical Respite Care: A National Model: People experiencing homelessness (PEH) have high rates of chronic and acute medical conditions, behavioral health issues, and needs for supportive services. As a result, this population also experiences high rates of emergency department (ED) and inpatient hospitalizations. Lack of discharge options and other factors lead to high re-admission rates and poor health outcomes for this vulnerable population. To help address these issues, medical respite care (MRC) programs offer acute and post-acute medical care for PEH who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. These programs provide short-term residential services (often in a shelter or transitional program) coupled with support services and access to medical care. There is a nationwide need for MRC programs because of the lack of affordable housing and the significant health care needs of PEH. As of January 2022, there were nearly 120 MRC programs nationwide. While these programs vary significantly in their scope and intensity of services, they share the same defining characteristics and ensure quality of care through national standards that can be applied to any program model.

Medical Respite Care in Washington State: There are eight known MRC programs in Washington State that use different models of care, and additional programs are in various stages of development. Most programs are based in homeless shelters (or other congregate settings) and offer a package of supportive services daily such as care transitions and coordination/medical case management, outreach, medication management, care plan development, education, connections to health care providers, enrollment in benefits, assessment of behavioral health care needs, crisis stabilization, and housing assessments/referrals. In many of these programs, most medical and behavioral health treatment services are provided by FQHCs or other community health care providers. Two of these eight MRC programs in Washington State currently receive Medicaid reimbursements through either a per diem rate, or a fixed case rate (with an annual or bi-annual cap per person). An additional program in King County takes a novel approach to helping people experiencing homelessness with an acute need for psychiatric stabilization but without a co-occurring acute medical condition necessitating on-site intensive medical care.

Feedback from Listening Sessions with Stakeholder Groups: Listening sessions were conducted with MRC program staff, FQHC staff, hospital discharge planners, managed care organizations, homelessness services providers, consumers, and Tribal council members. They offered perspectives related to the following areas:

- Barriers to Higher Levels of Care
- Aspects of a Statewide MRC Medicaid Benefit:
    - Value of MRC programs
    - Advantages of a statewide benefit
    - Services to include in a statewide benefit
    - Payment model
    - "Psychiatric respite care"
    - Separate programs for serious behavioral health conditions
- Strategies for Successful Implementation/Partnerships with Homeless Services

Cost Effectiveness Analysis: For the past several years, HCA has been engaged in an informal demonstration to test a strategy for providing MRC to Medicaid patients enrolled in a Managed Care Organization (MCO). There are several approaches to conducting a comprehensive cost-effectiveness analysis and understanding the full cost of MRC. One approach is to compare the cost of MRC to the administrative day rate in a hospital. However, the encounter rate is not the sole factor in determining cost-effectiveness as there are additional factors that should be considered when making a cost-effectiveness assessment including:

- Reduced cost of averted hospital re/admissions
- Reduced cost of hospital lengths of stay
- Value of improved health outcomes and connections to care, especially as they pertain to behavioral health and substance use
- Value of providing care in a less restrictive setting

Further analysis is necessary to estimate the impact of MRC on these additional factors in Washington State. Research conducted on the financial impact of MRC programs on hospitals and insurers in Connecticut and Florida found MRC programs reduced the hospital length of stay by 2 days, reduced subsequent emergency department visits by 45%, and subsequent inpatient admissions by 35%, offsetting $1.81 in hospital costs for each dollar invested in MRC.

Moving Forward: The Centers for Medicare and Medicaid Services (CMS) have encouraged states to consider how to address social determinants of health in their Medicaid plans. Incorporating MRC into the state's

Medicaid plan as a statewide benefit with federal funding contribution can be accomplished in different ways, to include through a new or existing 1115 demonstration waiver or 'in lieu of' services available through managed care. Benefits could be added as a 1915 (i) state plan amendment, but the requirement for institutional level of care is less likely to be a successful strategy for MRC. State-only funding would offer additional flexibility. Washington State policymakers will need to weigh the advantages and drawbacks of various Medicaid authorities, noting that some options would be limited to enrollees in managed care. Importantly, requirements for cost-neutrality should recognize and include the value of the broader connections to care, the impact on inpatient/emergency department utilization, and improvements in client health and well-being. State policymakers might also consider start-up funding, guidance to providers, and other factors that would better facilitate program development and expansion moving forward.

Washington State Health Care Authority recognizes the benefits of a statewide MRC service, and is proposing it as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

Medical Respite Care: A National Model

People experiencing homelessness (PEH) have high rates of chronic and acute medical conditions, behavioral health issues, and needs for supportive services. As a result, this population also experiences high rates of emergency department (ED) and inpatient hospitalizations. In addition, because they often do not have a safe place to recover once they are ready for discharge, patients who are homeless often incur longer stays in the hospital at greater expense to hospitals and insurers. Those discharged to a homeless shelter (or to the street) who require ongoing care after an acute hospitalization often are not able to manage post-acute conditions, hence having poorer health outcomes and higher rates of ED/hospital re-admissions. Further, homeless services providers (such as shelters) are not trained or staffed to provide medical care and cannot accommodate illnesses, injuries, or post-operative wound care.[1]

To help address these issues, medical respite care (MRC) programs offer acute and post-acute medical care for PEH who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.[2] These programs provide short-term residential services (often in a shelter or transitional program) coupled with support services and access to medical care. The range of services can vary widely depending on the program, but at the most basic level, programs provide care coordination/care plan development, case management, nursing care, medication and disease management, care transitions and connections to medical and behavioral health care as well as primary care and/or specialty care, connections to benefits (such as insurance, food assistance, identification, etc.), and connections to housing assessments. Importantly, MRC programs are generally intended for clients able to manage their own activities of daily living (ADL) such as bathing, dressing, eating, etc.) and are not a substitute for higher levels of care such as skilled nursing facilities or nursing homes.

Medical Respite Care

Provides people experiencing homelessness a safe space to recuperate from illness/injury post-hospitalization:

- Medical care & case management
- Help with documentation & benefits
- Medication & disease management skills
- Housing assessments & search preparations
- Ongoing care plan development & care coordination

[1] Research demonstrating MRC outcomes can be found at Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care (March 2021).

[2] Note: MRC is also called recuperative care, and is different than "caregiver respite," a term used in the long-term care community to refer to short-term relief for caregivers.

Health care systems benefit from MRC programs because they offer a safe hospital discharge option for individuals without housing, lower hospital lengths of stay, reduce readmission rates, improve health outcomes for a vulnerable population, stabilize patients with unmet chronic disease care management and care coordination needs, and lower overall costs. Patients benefit from MRC programs because these venues offer a safe space to recuperate and stabilize from illness; connections to medical care, case management, and support services; and help with developing an ongoing care plan.[3] MRC programs that can take referrals from non-hospital partners [e.g., shelters or health care providers, such as federally qualified health centers (FQHC)], may be able to avoid a hospital admission altogether.

There is a nationwide need for MRC programs because of the lack of affordable housing and the significant health care needs of PEH. As of January 2022, there were nearly 120 MRC programs nationwide. While these programs vary significantly in their scope and intensity of services, they share the same defining characteristics and ensure quality of care through national standards that can be applied to any program model. COVID-19 responses, which emphasized alternate care sites, only heightened the need for MRC and further illustrated the importance of connecting vulnerable people to the post-acute care services normally provided in one's home.

Several states have been using Medicaid and/or managed care to finance medical respite care. Currently, California is in the process of implementing a statewide optional benefit through its CAL-Aim plan, while other states are currently in the process of considering and/or seeking approval to do so (Michigan, Minnesota, New York, North Carolina, and Utah).

[3] Research demonstrating MRC outcomes can be found at Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care (March 2021).

Medical Respite Care in Washington State

There are eight known MRC programs in Washington State that use different models of care, and additional programs are in various stages of development. Most programs are based in homeless shelters (or other congregate settings) and offer a package of supportive services daily such as care transitions and coordination/medical case management, outreach, medication management, care plan development, education, connections to health care providers, enrollment in benefits, assessment of behavioral health care needs, crisis stabilization, and housing assessments/referrals. In many of these programs, most medical and behavioral health treatment services are provided by FQHCs or other community health care providers.

Two current programs illustrate the wide range of MRC approaches and services in Washington. Yakima Neighborhood Health Services, an FQHC, operates an MRC program that offers all these supportive services plus onsite nursing and behavioral health care, with traditionally billable services provided at its nearby FQHC sites. By contrast, the Edward Thomas House in Seattle (operated by Harborview Medical Center) provides an array of more intensive clinical and case management services through a stand-alone facility. It's onsite medical and behavioral health teams provide care 24 hour/7-days a week, including intensive medical and behavioral health case management, which enables it to serve patients who are more acutely ill, those requiring IV antibiotic treatments, and/or have more complex care needs, including acute behavioral health needs.

Across the spectrum, Washington MRC programs employ teams of service providers that vary depending on the program model. For more basic programs focused primarily on supportive services, teams typically include a case manager, outreach worker, and peer specialist or community health worker. Such programs often have partnerships with FQHCs or other agencies who can provide nursing support as needed. Programs that directly provide light medical services tend to utilize care teams that include nurses, medical case managers, and behavioral health specialists. Higher acuity models (like the Edward Thomas House) tend to have larger care teams that often include physicians or other medical providers, psychiatrists, and behavioral health case managers, in addition to nurses. The Edward Thomas House also utilizes 24/7 milieu managers[4] trained in trauma-informed approaches to prevent and respond to behavioral health crises and has extensive staff capacity for ensuring the safety of patients with active substance use disorders.

One program in King County takes a novel approach to helping people experiencing homelessness with an acute need for psychiatric stabilization but *without* a co-occurring acute medical condition necessitating on-site intensive medical care. Downtown Emergency Service Center (DESC) operates residential facilities in Seattle that it calls "psychiatric respite care" for people in psychiatric crisis who do not require the level of medical support offered by

[4] A 'milieu manager' is responsible for managing the physical facility and ensuring the treatment spaces are safe, secure, and therapeutic.

the Edward Thomas House. As a result, a subset of homeless patients that in other communities might be referred to MRC is instead referred to DESC. DESC's capacity allows the Edward Thomas House to reserve space for patients who require its unique combination of intensive clinical and supportive services for people with acute medical *and* behavioral health needs. DESC's extra capacity has distinct advantages for caring for PEH, but it also highlights statewide systemic gaps in care for people who are homeless and have unmet serious mental health needs. As addressed later in this report, the availability of Medicaid reimbursement for post-acute behavioral health stabilization and other care, whether that care is provided by MRC programs or other entities, represents a significant community need.

Current Practice Using Medicaid for Medical Respite Care in Washington State: The two programs used as examples above—the Edward Thomas House in Seattle and Yakima Neighborhood Health Services—currently receive Medicaid reimbursements through individual, negotiated contracts with the MCO plans serving their areas using the G9006 HCPCS code (coordinated care, home monitoring). Reimbursements are currently either a per diem rate, or a fixed case rate (with an annual or bi-annual cap). The program in Seattle is currently reimbursed for a bundle of services that includes onsite health care services, support services (case management, care coordination, benefits, health education, and medication management), food, 24-hour access to rest/recuperation, and administrative costs. While the program in Yakima provides primary care services nearby at its FQHC sites, they are reimbursed for support services from the MCOs (including transportation when needed).

Washington State Health Care Authority recognizes the benefits of a statewide MRC service, and is proposing it as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

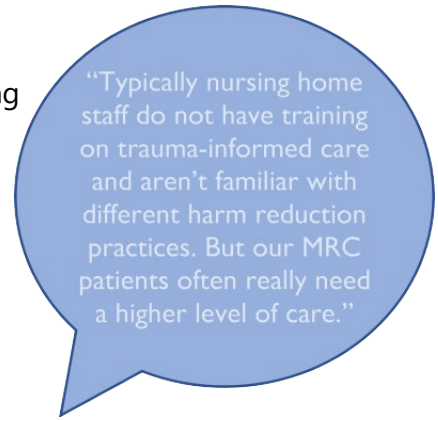
Feedback from Listening Sessions with Stakeholder Groups

From September through November 2021, 10 listening sessions were conducted with approximately 250 people from the following key stakeholder groups: MRC programs, community health centers/FQHCs, managed care organizations, hospital discharge planners, homeless services providers, Tribal members, and MRC consumers. This section synthesizes the feedback from all these stakeholder groups into three sections:

1. Barriers to higher levels of care,
2. Aspects of a statewide Medicaid benefit for MRC, and
3. Strategies for successful community partnerships with homeless services providers.

Barriers to Higher Levels of Care

Among all stakeholder groups, there was wide agreement there needed to be improvements in access to higher levels of medical and behavioral health care for PEH. Session participants consistently pointed to two significant issues that impact the ability to safely discharge PEH from the hospital: 1.) the difficulty of admitting higher-acuity patients and/or those with behavioral health conditions to appropriate venues of medical care, such as skilled nursing facilities and nursing homes; and 2.) the lack of medical treatment available in many behavioral health/crisis response venues. Both these barriers prolong hospital lengths of stay, leave PEH with no options for appropriate care, and create downward pressure on many MRC programs to admit more acutely ill patients than they are designed or staffed to serve [e.g., such as those who cannot manage their own ADLs, or those with dementia or unmanaged serious mental illness (SMI)].



Medical venues of care: Reasons for difficulty admitting to skilled nursing facilities (SNF) and nursing homes included not having a safe location for discharge, the presence of a behavioral health diagnosis (or anyone on medications for opioid-use disorder), low reimbursement rates, stigma against PEH, lack of training in harm reduction or trauma-informed care, and/or the need for a different type of care (e.g., help with ADLs, but not necessarily 'skilled' care). Patients with dementia (or other conditions) may need assisted living or an adult family home, but the connections to home- and community-based services often take a long time to obtain, are not covered by insurance, and are not reliably available to those without a home.

Behavioral health/crisis response venues of care: Reasons for difficulty admitting patients with serious behavioral health issues included an overwhelmed crisis response system that cannot conduct timely assessments, not being able to bill Medicaid for crisis services, and not being able/willing to treat medical conditions. The barriers to higher levels of behavioral health care create intense pressure on MRC programs (and other providers) to accommodate patients with significant, long-term mental health conditions.

To accommodate higher clinical needs, MRC programs are often willing to provide transportation for patients so they can receive health care services in other venues, and they are also willing to receive home health aides and/or hospice care in an MRC setting (when possible). However, they are often unable to bear the primary responsibility for stabilizing such acutely ill patients because patient needs exceed the level of available clinical care in the program.

Recommendation to consider: Ensure access to appropriate levels of care by improving the ability for all types of providers across the health care system to deliver integrated services.

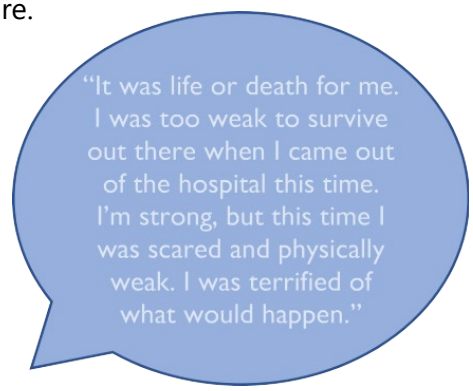
Aspects of a Statewide MRC Medicaid Benefit

Value of MRC programs: Unequivocally, all participants in the listening sessions strongly agreed there was a significant need for MRC programs for PEH, and that there was significant value in these programs across the health care system.

- For hospitals, MRC programs offer a safe and appropriate discharge option for non-acute patients who are in an acute care bed, especially for those needing intravenous (IV) antibiotics, wound care, and other ongoing care but who also need case management and connections to social services. MRC programs also prevent hospital admissions/readmissions.
- For Medicaid managed care plans, MRC programs connect beneficiaries to a wide range of services (primary care, behavioral health, specialty care, etc.), prevent hospital admissions/readmissions, conduct health assessments and screenings, and offer a safe space to stabilize. MCO participants said the demand for MRC regularly outpaces the current capacity of programs to admit patients and would like to see programs further expanded. They indicated the most common conditions referred to MRC include cellulitis, lower extremity wounds, and many different types of infections that require antibiotics/IV infusions or other IV care that sometimes requires six weeks of treatment.

- For FQHCs, MRC programs provide patients with more intensive services coupled with the stability of shelter to help them better manage acute and chronic conditions as well as navigate the health care system. One FQHC notes that patients connected to an MRC program have 3.5 more FQHC visits on average, which is evidence of the stronger connections to outpatient care.

- For patients, the value of MRC goes beyond simply a space to recuperate, receive services, and connect to a broader range of providers. Those who participated in the listening session were frank in expressing how MRC was integral to their very survival due to violence on the streets and how those who are vulnerable are often preyed upon. They valued the safety the program gave them, which was vital in helping focus on recovery rather than worry about survival.



- For homelessness services providers, MRC programs offer a much safer and more appropriate setting to address medical conditions compared to homeless shelters, which are generally not staffed or equipped to provide the level of medical care clients need. They described regularly trying to accommodate sick or injured clients but having no options for connecting them to appropriate care. This is very difficult on homeless services providers, who feel unable to fix this problem since they are not health care providers.

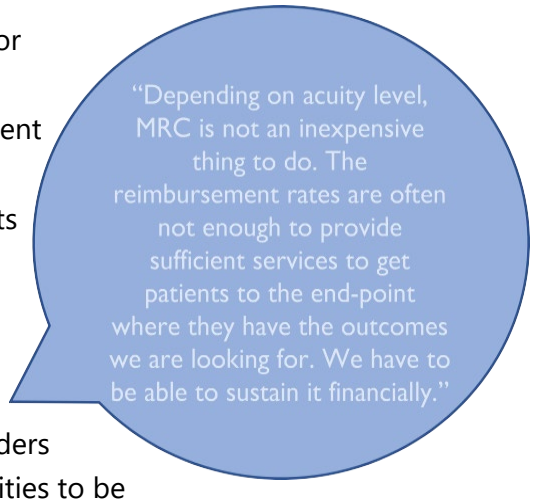
Advantages of a statewide benefit: MRC providers note that a statewide benefit would help standardize MRC as an offered benefit, better sustain programs through more consistent reimbursements, and clarify roles among partnering agencies. Other listening session participants noted that a statewide benefit would increase statewide MRC capacity by offering a more sustainable financing mechanism for starting/expanding programs. In addition, because not all Medicaid beneficiaries are enrolled in managed care, especially Tribal members, a benefit that includes fee-for-service (FFS) beneficiaries would also reach other vulnerable populations.

Services to include in a statewide benefit: Services available in MRC programs can vary widely, depending on the model of care being employed (as described in the introduction). At a minimum, however, the MRC benefit should support the utilization of multi-disciplinary teams that deliver the following services on a daily (or near-daily) basis:

- Nursing care
- Care transitions (to/from hospital and/or primary care)
- Case management
- Care plan development
- Behavioral health assessments and supportive services, such as case management
- Medication management
- Care coordination to specialty care and other services
- Connections to a housing specialist
- Peer supports
- Enrollment in benefits such as health insurance
- Transportation to medical appointments
- Three meals a day
- Laundry and housekeeping

The benefit should consider that many medical and behavioral health treatment services can be billed separately to Medicaid for reimbursement (e.g., through an FQHC, as is the current practice in Yakima), but that these Medicaid reimbursements may only cover a portion of the costs of providing the level of case management and care coordination required to help many patients complete their MRC medical treatment plans during their stay.

Recommendation to consider: A statewide benefit that adequately reimburses a bundled package of comprehensive supportive services and lower-level health care services in a medical respite setting.



Payment model: While several possibilities exist for payments (such as fee for service billing for each service provided, or a per patient "case rate"), the consensus in the listening sessions favored a bundled, per diem rate (consistent with the current practice for those already billing). Both MRC providers and MCO staff acknowledged this was the most straightforward way for payments to be structured, and that a case rate is hard to standardize and puts too much risk on the MRC provider. Importantly, however, the rate of reimbursement must cover the costs of the program to keep the program sustainable and achieve the intended outcomes. This includes the cost of staff and supplies, facility maintenance, and all services provided. MRC providers want to emphasize that eligibility for reimbursement should not require facilities to be licensed since they do not offer that level of care, however, ensuring a standard of care remains important to ensure quality. [Note: there is currently no national licensing standard established for MRC.] Finally, tribal providers emphasized their need to ensure they remain eligible for the encounter rate. A payment model would ideally address the episode of care in an equitable and comprehensive way that considers the diversity of funding streams that MRC providers have access to (for example, supplemental payments or encounter rates).

Recommendation to consider: A statewide benefit that uses a per diem rate based on costs of care.

Tiered payments: Participants in the listening sessions regularly acknowledged significant differences in the level of services being offered across programs and the corresponding level of staff needed to deliver that care. One approach may be to offer tiered payments to recognize different levels of patient acuity that require progressively intensive services (e.g., establishing "low, medium, high" categories). Consideration should be given to the definitions of each "tier", so they are appreciably distinct from each other, with corresponding reimbursement levels based on the increasingly intensive package of services provided. This could be modeled on the tiered structure of the Health Home program.

For example, higher "tiers" may support patients with higher needs that require a greater level/number of onsite licensed medical providers, more intensive onsite behavioral health care, 24-hour program staffing, onsite IV-based treatment capacity, or other services. One FQHC is using PRISM scores to assess health care needs, service utilization, and costs, which could help inform payment rates (although these scores can fluctuate day to day). Some noted that having multiple MRC programs in a community at different tiers offers the opportunity to develop "step-down

respite programs" as patients' needs stabilize over the course of their treatment. Others believe having tiered programs governed by clear admission criteria would help accommodate higher levels of acuity, though if program criteria are set too low, the needs of the larger population quickly exceed bed capacity.

The disadvantage to a tiered payment is that it could inadvertently discourage flexibility for a program to admit patients with significantly higher and/or lower acuity than established tiers. Reimbursement rates should take into consideration this flexibility and ensure a cost-based rate that includes both average and outlier patients.

Importantly, stakeholders maintain there should be a minimum standard of care established to qualify for a Medicaid reimbursement to ensure decent, quality care. National standards for medical respite care have been established (which were informed by MRC providers in Washington State) as well as a framework for tiered program models, which can serve as a baseline for quality assurance.

> *Recommendation to consider: Consider a tiered reimbursement structure based on program costs, patient acuity levels, level of services and staff, and/or other factors. Identify minimum standards for programs that must be met in order to qualify for reimbursement and ensure quality of care.*

"Psychiatric respite care": While the term "psychiatric respite care" was not a familiar one to those in most of the stakeholder groups, they did point to the significant gap in service availability for patients with serious psychiatric illnesses (also discussed above under "barriers to care"). Listening session participants noted that many patients have multiple comorbidities and readily acknowledged needing to accommodate some level of mental health and substance use disorders in addition to the acute medical conditions that drive their admission to MRC program. To that end, several MRC programs currently have behavioral health staff (e.g., social workers or therapist case managers).

At the same time, they also acknowledged it is quite difficult for most MRC programs to care for patients with significant behavioral health conditions (particularly unmanaged SMI), especially those who do not have a co-occurring acute medical condition. Not only are serious behavioral health conditions unlikely to stabilize or be resolved during a short- term stay, but these patients often cannot be safely managed in most MRC environments if they have acutely symptomatic behaviors that can be disruptive, unsafe, and/or compromise the completion of medical treatment plans (often resulting in suboptimal and/or premature discharges). This patient group changes the fundamental purpose of MRC, which exists to primarily address *acute medical* conditions, and connect to ongoing primary care and behavioral health services.

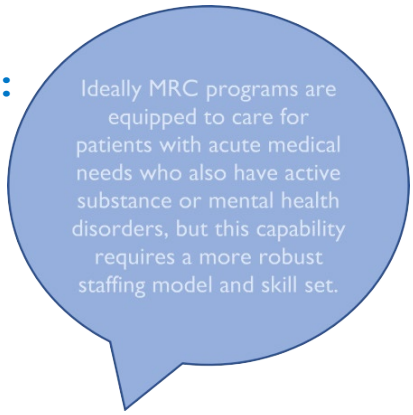
Separate programs for serious behavioral health conditions: The gap in meeting serious mental health needs raises a question of whether separate programs should be created for patients who require intensive behavioral health stabilization services (such as treatment and case management) but do not also need to recuperate from an acute medical condition. It also raises the question of how much extra reimbursement support is needed by MRC

programs, such as the Edward Thomas House, that provide the higher level of case management, milieu management, and other more intense behavioral health services.

The Downtown Emergency Service Center (DESC) in Seattle is an example of a separate program that focuses on more significant mental health conditions and provides 30 days of "crisis respite stabilization" for people recovering from a psychiatric emergency who are discharged from the hospital/ED or from jail. DESC currently does not receive Medicaid reimbursements and is requesting any statewide MRC benefit include psychiatric services when the mental health condition is the significant need. DESC envisions a model with two parts: 72-hours of intensive stabilization followed by two weeks of closer support/stabilization. They note this approach differs from evaluation and treatment (E&T) facilities in that their program is unlocked, provides lower intensity services, and might be viewed as a "step-down E&T program.

Stakeholders had mixed views on the merits of establishing separate programs to accommodate serious mental health conditions. Key factors expressed on both sides of this issue include the following:

Perspectives in favor of separate programs for patients with SMI:

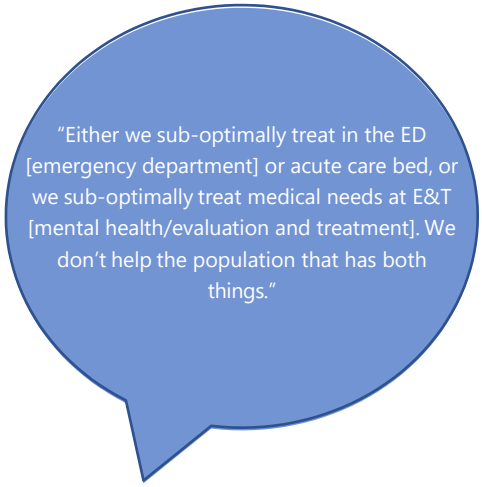


- Patients in serious psychiatric distress are generally unable to participate in a medical care plan (which negates the primary purpose of MRC programs) so would be better served separately.
- The longer lengths of stay needed to achieve psychiatric stabilization prevent MRC beds from turning over for other (medical) clients in need, which inhibits overall capacity and service delivery.
- It is extremely challenging for MRC programs to hire the high level of behavioral health staff needed to treat SMI, especially those who bring the needed training and skill set to work with PEH.
- Existing crisis stabilization programs and other behavioral health providers in the community could fill this need if they also provide some medical care.

Perspectives in favor of integrated programs:

- Many psychiatric programs will not take patients with any medical or mobility needs (insulin, wounds, a walker/wheelchair, etc.) so the MRC program is often the only venue willing and able to take a patient.
- The time and expense to bring up separate programs (especially where none exist now) is difficult to justify when resources can go toward adding more behavioral health staff, training, and skills to an existing MRC program to help with behavior and/or milieu management.

- Not all providers have a trauma-informed care approach or understand harm reduction, hence patients may not be well-served.
- Establishing single occupancy rooms could help better accommodate patients with SMI and mitigate against the disruption to others in the program.
- Smaller communities (especially suburban/rural) tend not to have many mental health providers, especially for PEH, so will likely not have the option for a separate program.



While the issue of separate programs yielded many views, participants acknowledged that this question was largely driven by the gaps in the broader crisis response system, rather than a failure of MRC programs. Some noted that improving the crisis response system is desperately needed, although "step-down" services after E&T discharge are also important to develop. Overall, most stakeholders agreed that the ability to establish separate "psychiatric respite care" programs would be highly dependent on local partners, MRC program capacity, available staff/workforce in the community, and the availability of culturally competent treatment approaches. They note that Seattle has a wealth of partners to help with SMI, and the MRC program there (the Edward Thomas House) is also equipped to take higher intensity patients; however, no other community could claim this level of resources or the number of options for service partners.

Recommendations to consider:

- *Improve the capacity and quality of the crisis response system to better respond to the needs of PEH.*
- *For MRC programs choosing to provide care to those with SMI, ensure MRC reimbursements are sufficient to cover the costs of the higher-level staffing and facility accommodations needed (which may inform a tiered reimbursement structure).*
- *Determine whether "psychiatric respite care" is part of an MRC statewide benefit or should be defined and/or reimbursed separately.*

Strategies for Successful Implementation/Partnerships with Homeless Services

It is vitally important that MRC programs work well in partnership with other homelessness services providers, to include Continuums of Care (CoC), which coordinate local homeless services and resources. Effective partnerships with homeless services will require separate policy and program decisions (apart from Medicaid) and are largely governed at the local level. Common pressure points between MRC programs and COCs are detailed in a recent national report, and involve issues related to admission criteria and program capacity, coordinated entry and program referrals, medical vulnerability and assessments, ongoing gaps in housing and health care, and the role of other responsible entities. The report also includes a spotlight on Yakima, Washington as an example of an effective partnership between the MRC program and it's local CoC.

Feedback from homeless service providers in Washington State indicate broad support for a statewide MRC Medicaid benefit. They also note that a statewide benefit would yield more equitable access to care because it would facilitate program development in new areas where programs are not yet available (especially in underserved, rural or Tribal areas).

Apart from Medicaid, homeless services providers outlined numerous successful policies and practices that local jurisdictions might consider, as well as those currently in place that should be continued and/or expanded. They cite the following actions that would improve service delivery for people experiencing homelessness:

1. Create numerous opportunities for MRC programs and CoCs to collaborate, communicate, and develop a common language so there is a greater understanding of mutual goals and shared actions.
2. Conduct coordinated entry housing assessments while clients are staying in the MRC program.
3. Consider how vulnerability assessments for housing can incorporate more medical information to determine priority for housing and/or use a health risk assessment tool, like PRISM scores.
4. Categorize MRC beds as "emergency shelter" in the housing inventory count to integrate MRC programs more seamlessly into the continuum, as well as to ensure clients are not inadvertently disqualified from permanent housing opportunities.
5. Discharge MRC clients directly into a permanent housing placement as often as possible (though the length of time needed for this process often exceeds the short-term stays in MRC).
6. Work together to ensure many community-based services are available (e.g., street medicine, FQHC services, laundry, meals, etc.).

> "Having a collaborative working relationship where we can bend and flex with each other is key. You can't do this without medical providers, but this needs to be a standard benefit."

7. Ensure shelter and MRC staff receive regular training on harm reduction, motivational interviewing, and trauma- informed care.
8. Consider a standardized referral process for MRC programs.
9. Consider holding weekly case conferences between MRC staff and CoC/homeless services providers so that especially vulnerable clients have more coordinated care plans.
10. Collectively advocate for greater affordable housing availability.

Cost-effectiveness Analysis

For the past several years, HCA has been engaged in an informal demonstration to test a strategy for providing MRC to Medicaid patients enrolled in a Managed Care Organization (MCO). HCPCS code G9006 (coordinated care, home monitoring) was opened in 2013 to provide an avenue for reimbursement for the Edward Thomas House in Seattle. As described on page 6, the Edward Thomas House is reimbursed a per diem rate if at least one clinical interaction occurs on the day of care (medical care, care coordination, chemical dependency, and mental health care, etc.). If no clinical interaction occurs, no per diem rate is paid. The MRC program at Yakima Neighborhood Health Services was established in 2010, though the program did not start receiving MCO reimbursements until 2015. The MCO contracts in Yakima have different financing arrangements, including paying a per diem rate with an annual cap, a set case rate with annual cap and a set case rate with a two-year cap per patient. Reimbursements are currently either a per diem rate, or a fixed case rate (with an annual or bi-annual cap).

There are several approaches to conducting a comprehensive cost-effectiveness analysis of MRC. One approach is to compare the cost of MRC to the administrative day rate in a hospital. The administrative day rate refers to the amount a hospital charges for each additional inpatient stay day for those who no longer require acute care but remain hospitalized for lack of discharge options. Currently, the highest amount Medicaid can reimburse for a hospital administration day is $283.16.

In this context, HCA examined internal Medicaid claims data to determine the day rate for patients already discharged to an MRC setting and where the G9006 code was charged. The analysis showed the average daily MRC rates paid by the MCOs ranged between $225 to $350; however, these rates represent an *average* daily rate and do not reflect specific reimbursement levels, which can be lower given different program models.

The encounter rate is not the sole factor in determining cost-effectiveness. There are additional factors that should be considered when making a cost-effectiveness assessment, to include the following:

- Reduced cost of averted hospital re/admissions
- Reduced cost of hospital lengths of stay
- Value of improved health outcomes and connections to care, especially as they pertain to behavioral health and substance use
- Value of providing care in a less restrictive setting

Further analysis is necessary in Washington State to estimate the impact of MRC on these additional factors. As one indicator, research conducted on the financial impact of MRC programs on hospitals and insurers in Connecticut and Florida found MRC programs reduced the hospital length of stay by 2 days, reduced subsequent emergency department visits by 45%, and subsequent inpatient admissions by 35%, offsetting $1.81 in hospital costs for each dollar invested in medical respite. One Medicaid expansion hospital in Connecticut found that even after funding 50% of the costs to provided MRC, the net savings would still amount to $1,575 per medical respite admission.

Moving Forward

The Centers for Medicare and Medicaid Services (CMS) have encouraged states to consider how to address social determinants of health in their Medicaid plans. Incorporating MRC into the state's Medicaid plan as a statewide benefit with federal funding contribution can be accomplished in different ways, to include through a new or existing 1115 demonstration waiver or 'in lieu of' services available through managed care. Benefits could be added as a 1915 (i) state plan amendment, but the requirement for institutional level of care is less likely to be a successful strategy for MRC. State-only funding would offer additional flexibility. Washington State policymakers will need to weigh the advantages and drawbacks of various Medicaid authorities, noting that some options would be limited to enrollees in managed care. Importantly, requirements for cost-neutrality should recognize and include the value of the broader connections to care, the impact on inpatient/emergency department utilization, and improvements in client health and well-being. State policymakers might also consider start-up funding, guidance to providers, and other factors that would better facilitate program development and expansion moving forward.

Recommendation: Explore with federal authorities and state policymakers how best to implement a statewide benefit that yields the most positive, equitable health outcomes for Apple Health enrollees who are homeless, while also optimizing the managed care flexibilities allowed by federal regulation. Continue forward with plans to include medical respite care as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

Other issues for policymakers to consider:

- **Start-up funding:** Assist new MRC programs with funds to help build capacity, support Medicaid billing systems, and negotiate with MCO plans.
- **Guidance to providers:** Provide guidance to MRC providers on standards of care/quality measures and how to effectively use the new Medicaid benefit (to include coding on claims). Require eligible providers to complete a certificate of attendance at relevant education and training courses aligned with current practice for Department of Commerce housing and emergency services providers (e.g., trauma-informed care, motivational interviewing, harm reduction, etc.). As national training opportunities continue to become available, require MRC providers to complete standards of care training, conducts an annual organizational self-assessment of their program's fidelity to the standards, and requests technical assistance as needed.
- **Telehealth provisions:** Include MRC programs in any policies that allow for the delivery and reimbursement of care through telehealth.
- **Housing availability:** Increase the supply of supportive housing so more patients can be discharged from MRC directly into a permanent, stable home.

- **Referrals**: Consider allowing referrals to MRC programs from a wider range of referral sources (beyond hospitals), to include FQHCs or other providers, shelters, and others as appropriate.

Appendix: List of MRC Resources

- Policy Brief: Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs
- Case Study: Spotlight on Yakima, Washington
- Medical Respite Care Programs: Models of Care
- Literature Review: Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care (Executive Summary)
- National Standards for Medical Respite Care Programs
- Medical Respite Care Organizational Self-Assessment: Online and PDF Guide
- Policy Brief: Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care
- Policy Brief: Medical Respite Care Programs & the IHI Triple Aim Framework
- Policy Brief: COVID-19 & the HCH Community: Medical Respite Care & Alternate Care Sites
- Research: The Business Case for Medical Respite Services (2016)

NATIONAL INSTITUTE for MEDICAL RESPITE CARE

A special initiative of the National Health Care for the Homeless Council

JANUARY 2024

ISSUE BRIEF

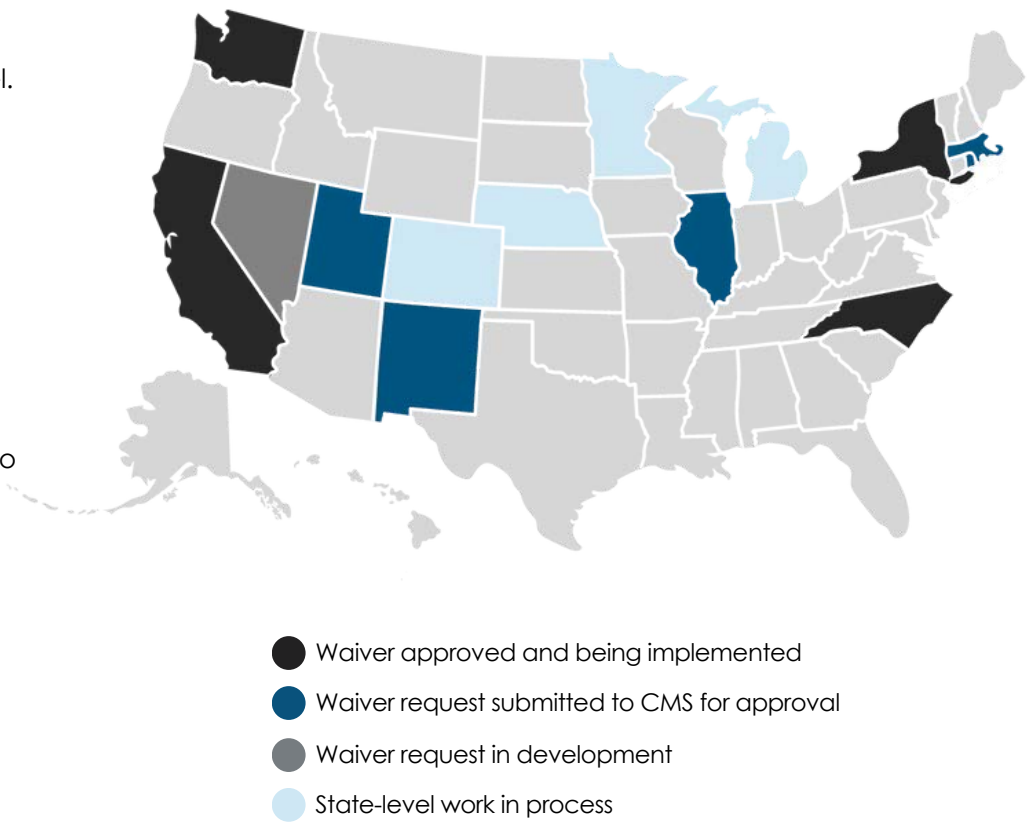
Status of State-Level Medicaid Benefits for Medical Respite Care

Medicaid respite care programs are rapidly growing in response to a rising need for people experiencing homelessness to have access to post-acute care in a safe, stable environment coupled with an increased awareness of the program model. While there are numerous financing strategies that work for medical respite programs, more state Medicaid plans and managed care organizations (MCOs) are paying for services through Medicaid as a way of creating more consistent and sustainable reimbursements. Further, some states are moving to add reimbursements for medical respite care as a statewide Medicaid benefit (see Figure 1).

The Centers for Medicare and Medicaid Services (CMS) is permitting substantial flexibility in programmatic design in state Medicaid waivers to allow transformative initiatives. At the same time, the federal agency is also establishing new guardrails and conditions — balancing that flexibility with new obligations. The programmatic flexibility and investments associated with these approvals will allow states to stabilize coverage, offer new benefits and services, and focus on whole-person care.

FIGURE 1

STATUS OF STATEWIDE MEDICAID ACTIVITY ON MEDICAL RESPITE CARE



This issue brief is intended to provide a current snapshot of the state-level Medicaid activity related to medical respite care. As often as possible, the exact language used in the Medicaid waiver requests has been included in this brief.

Please note: This brief focuses on state-level Medicaid activity, and does not include reimbursement arrangements between individual plans and programs, or fee-for-service payments to health centers as part of their usual reimbursement rate.

WAIVER APPROVED AND BEING IMPLEMENTED

CALIFORNIA

California received approval in December 2021 to add 14 community support services — to include recuperative care — to its 1115 Medicaid waiver as part of the state's California Advancing and Innovating Medi-Cal (CalAIM) Act (more details in our 2022 State of the States report). Since that time, California added enhanced case management as a service, and is in the process of applying to CMS for approval to add six months of rent to the Medi-Cal program. Both these services will complement recuperative care, and bolster the support needed for positive outcomes.

In the past two years, hospitals, managed care plans, and recuperative care providers have navigated significant challenges transitioning to third-party reimbursements. For more information about this transition, to include perspectives from these three stakeholder groups, further action steps to consider, and advice for other states, see our new issue brief "CalAIM Implementation of Recuperative Care Benefit: Lessons Learned."

Moving forward, the Department of Health Care Services issued policy guidance outlining changes that managed care plans must follow. These include following consistent service definitions and eligibility criteria without any further restrictions (see this "cheat sheet" for a summary of these changes).

NEW YORK

On Jan. 9, 2024, CMS approved New York's Medicaid 1115 waiver request, which includes recuperative care as an allowable health-related social need (HRSN) service. Individuals who meet the Department of Housing and Urban Development's definition of homeless and are transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level), are eligible to receive treatment on a short-term basis.

CMS stipulates that recuperative care may be offered for up to 90 days once every 12 months (assessed on a rolling basis). Further, the approval language requires eligible settings for recuperative care to have appropriate clinicians who can provide medical and/or behavioral health care. CMS specifies that the facility cannot be primarily used for room and board without the necessary additional recuperative support services. They include an example: A room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

CMS is requiring New York to develop an HRSN Services Protocol, which must include a description of the state's documented process to authorize Recuperative Care and document the medical need for the service. CMS is allowing the state to add other provider qualifications or other limits to the service as long as they are documented within the managed care plan contracts, HRSN Services Protocol, and state guidance.

NORTH CAROLINA

North Carolina received approval in September 2022 to add medical respite care to its 1115 waiver as part of the state's Healthy Opportunities Pilot Program (more details in our 2022 State of the States report). Since that time, the state has worked to establish reimbursement policies and procedures through managed care plans. One challenge has been that many people with Medicaid entering medical respite care are not yet enrolled in managed care, but in fee-for-service, which does not allow reimbursement for this service. The time required to do the transition to managed care often exceeds the time spent at the medical respite program.

Importantly, North Carolina recently expanded Medicaid eligibility to single adults starting Dec. 1, 2023. Moving forward, many more people experiencing homelessness will qualify for Medicaid and be enrolled in managed care, which should ease both access to care for individuals and reimbursement opportunities for providers.

WASHINGTON

The state submitted its 1115 waiver request to CMS in June 2022, and received approval in June 2023. The approval language includes recuperative care as a housing support under health-related social need (HRSN) services. Eligibility for housing supports includes individuals transitioning out of institutional care or congregate settings; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system. This service becomes eligible for statewide reimbursement effective July 1, 2024.

Like the New York waiver, CMS stipulates that recuperative care may be offered for up to 90 days. Further, the approval language requires eligible settings for recuperative care to have appropriate clinicians who can provide medical and/or behavioral health care. CMS specifies that the facility cannot be primarily used for room and board without the necessary additional recuperative support services. They include an example: a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

Also like the New York provisions, CMS is requiring Washington State to develop an HRSN Services Protocol, which must include a description of the state's documented process to authorize Recuperative Care and document the medical need for the service. CMS is allowing the state to add other provider qualifications or other limits to the service as long as they are documented within the managed care plan contracts, HRSN Services Protocol, and state guidance. Currently, this protocol is anticipated to be finalized in early 2024.

WAIVER SUBMITTED TO CMS FOR APPROVAL

ILLINOIS

In June 2023, Illinois submitted its Medicaid 1115 waiver request to CMS for approval, which includes medical respite care as a covered benefit. Aimed at individuals enrolled in Medicaid managed care, eligibility criteria will include those experiencing or are at risk for homelessness and are at risk of ED/hospitalization or institutional care, in the ED or hospitalized, or in institutional care.

The waiver proposes a length of stay up to six months, and seeks to cover specialized onsite case management, connections to other health related services, transition support, limited support for activities of daily living and/or instrumental activities of daily living, and monitoring of the individual's ongoing medical or behavioral health condition(s) (e.g., monitoring of vital signs, assessments, wound care, medication monitoring).

Meanwhile, the state is supporting a statewide capacity-building initiative that includes funding, technical assistance, and peer learning cohort for communities statewide that are developing, piloting, and/or expanding medical respite services.

MASSACHUSETTS

In October 2023, Massachusetts submitted to CMS a request to amend its 1115 demonstration waiver, which includes adding medical respite care as a reimbursable service starting Jan. 1, 2025 *[note that medical respite is called Short-Term Post Hospitalization Housing (STPHH) in MA's request]*.[1]

Like other states, Massachusetts' proposal includes up to six months of STPHH (i.e., medical respite care) and supportive services for eligible MassHealth members, including those enrolled in managed care and those in fee-for-service, who meet the following risk-based and clinical criteria:

- Currently experiencing homelessness; and
- Being discharged from a hospital after an inpatient stay or from an emergency department visit; and
- Has a primary acute medical issue that is not yet resolved, but no longer requires or does not require hospital level of care and does not meet skilled nursing facility level of care.

Services delivered to members in the STPHH program will include, but are not limited to, monitoring of vital signs, assessments, wound care, and medication monitoring and reminders as well as 24-hour on call medical support. Clinical services rendered will be tailored to the needs of each individual enrolled. Programs will provide transportation to and from medical appointments and support in coordinating needed clinical services.

In addition to medical services, these programs will have robust housing navigation services available to assist members with the goal of identifying permanent housing options once they have recuperated. Members who meet the criteria may receive STPHH, regardless of prior receipt of this service. Each stay in STPHH will last no more than 6 months.

Lastly, Massachusetts proposes allowing members experiencing homelessness who do not have consistent access to a private bathroom to utilize STPHH services for up to two days to prepare for colonoscopies. After the procedure, the member would not be eligible to continue to receive STPHH services unless they met the risk-based and clinical criteria outlined above.

1. States are sometimes using the same terminology to describe different services, which can get confusing. Example: Massachusetts is using 'short-term post-hospitalization housing' to describe medical respite care, while California is using the same term to describe a different service.

NEW MEXICO

On Dec. 16, 2022, the New Mexico Human Services Department (HSD) submitted its request for a five-year renewal of its 1115 Medicaid demonstration waiver, which would add 11 new benefits — to include medical respite care — to its state Medicaid program. [Note: HSD will publish its final application on its waiver webpage following CMS confirmation of completeness.] The State proposes to pilot a medical respite care program, operated by Albuquerque Health Care for the Homeless, by transforming part of a former hospital that is no longer in use into a medical respite unit with 24 beds (though the pilot will begin with 12 of those rooms before expanding to full capacity). Initially, all referrals will come from the University of New Mexico hospital, with plans to add other hospitals in Albuquerque over the five-year demonstration.

Payment for this pilot will come through managed care organizations, with an adjustment to their capitated rate. The State will require a two-month cap on reimbursement for the medical respite site after hospital discharge, per member per year (though there will not be a limit to the number of stays or a lifetime limit). Proposed services include care coordination, medical care on site, personal care services, and 24-hour staffing.

The request to CMS includes a requirement that the program adhere to NIMRC's 2021 Standards for Medical Respite Programs. Public comment on the draft proposal ended on Oct. 31, 2022, and the request was submitted to CMS in December 2022 for approval. While the request is still pending approval from CMS, the five-year pilot program is projected to start Jan. 1, 2025, and cost $16.4 million.

RHODE ISLAND

In December 2022, Rhode Island submitted their 1115 waiver extension request to CMS that included a request for authority to implement a Restorative and Recuperative Care (Medical Respite Care) Pilot program. As of November 2023, that request remains under review with CMS; a decision is anticipated in late 2024 or early 2025. The state envisions that the Pilot will support at least three sites. Recuperative Care Centers will provide services to individuals experiencing homelessness to prepare for, undergo, and recover from medical treatment, injuries, and illness. Individuals will be required to obtain a referral or be evaluated for medical necessity to receive services. Care Centers will ensure that referrals will be screened and managed using equitable admissions criteria and will strive to offer a low barrier to access services.

The state requested the length of stay be limited to active treatment and/or recovery not to exceed 36 months. Individuals are eligible to receive services through the Pilot by meeting each of the following two criteria: 1. Unsheltered, unhoused or at high-risk of homelessness OR staying in a setting that is inappropriate for pre or post hospitalization or recovery; and 2. Have a health need that requires a safe and supportive environment.
Rhode Island plans to test how medical respite can improve health care utilization, decrease Medicaid spending, and improve housing status and access to social services. The state anticipates that the Pilot will operate through the FFS delivery system with the goal of transitioning to managed care following the pilot period. While awaiting approval from CMS, Rhode Island is piloting temporary respite programs utilizing a shared funding model supported by State and local resources. One current site opened in January and has served 75 clients, and a second site is planned to open by January 2024 that will expand state-supported respite capacity to 38 beds.

UTAH

On Dec. 30, 2021, Utah submitted to CMS a request to amend its 1115 Primary Care Network (PCN) Demonstration Waiver allowing the State to provide temporary medical respite care for individuals covered under the Adult Expansion Medicaid program who are also chronically homeless and/or living in a supportive housing program. If approved, the state will contract with a single entity to operate the pilot program where individuals will be eligible for a maximum of 40 days of medical respite care services per year. Initially services will be paid through fee-for-service, though this may transition to managed care at a later date. The demonstration aims to begin as soon as possible after approval, and estimates that 400-500 individuals will be served per year, costing $12.5 million over the course of a 5-year period (ending June 30, 2027). *Current status: Approval pending negotiations with CMS, which are still ongoing. These negotiations may result in changes to the original proposal.*

WAIVER REQUEST IN DEVELOPMENT

NEVADA

On Nov. 29, 2022, the NV Department of Health and Human Services released a proposal outlining provisions for four housing supports to be added into managed care as "In Lieu of Services" (ILOS), which included recuperative care.

Under the proposal, short-term recuperative care/medical respite is an allowable service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions; 2) not more than 90 days in continuous duration; and 3) does not include funding for building modification or building rehabilitation.

At a minimum, this service must include interim housing with a bed and meals and monitoring of the member's ongoing medical or behavioral health condition. This service may also include: (1) limited or short-term assistance with activities of daily living; (2) coordination of transportation to post-discharge appointments; (3) connection to any other on-going services an individual may require including mental health and substance use disorder services; and (4) support in accessing benefits and housing.

Providers of recuperative care may include:

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities

The proposal stipulates that "services must not include the provision of room and board or payment of rental costs without necessary medical and recuperative care as defined by the state" and also includes specific billing codes that managed care plans must use in reporting housing support services to the state.

STATE-LEVEL WORK IN PROCESS

COLORADO

The Colorado Department of Health Care Policy & Financing (HCPF) is partnering with the University of Colorado School of Medicine (an academic medical center) to evaluate data from Ascending to Health medical respite program after providing one year of grant funding. HCPF is currently assessing the data to better understand the impact of medical respite care on hospitals and the Medicaid program. The evaluation is expected to be complete in the summer of 2024.

MICHIGAN

The state is currently evaluating and developing policy to support the FY 24 budget allocation to support recuperative care efforts, and is not currently pursuing a Medicaid waiver. Instead, they anticipate leveraging state general fund dollars to support room and board services (which are not eligible for match) and leveraging match dollars to support care coordination services (which are eligible for federal match). The proposed braided funded approach will assist in meeting recuperative care goals.

MINNESOTA

In December 2022, the MN Department of Human Services released a report outlining a set of recommendations for the state legislature to consider in order to advance support for Medicaid-reimbursable recuperative care. These recommendations included support for technical assistance, establishment of care coordination benefits and a daily bundled rate for recuperative care programs, and short- and long-term support for state-only funding for room and board. In the 2023 state legislative session, legislation passed establishing a definition, services, and rates for recuperative care. At this time, DHS is finalizing the details of operating and financial policies to add to the provider manual; however, the state does not anticipate seeking an 1115 waiver for the recuperative care service (though they will likely amend the state's Medicaid plan to reflect the state-only changes).

NEBRASKA

The 2024 state legislative session includes a bill that would require the state's Department of Health and Human Services to submit a Medicaid waiver or state plan amendment for medical respite care.

DISCUSSION

As of this publication, four states (CA, NY, NC, WA) have approved Medicaid 1115 waivers and are under way with implementation. Five states (IL, MA, NM, RI, UT) have already submitted 1115 waiver requests to CMS and are in various stages of negotiation. One state (NV) is considering a unique approach using In Lieu of Services rather than an 1115 waiver. Finally, four states (CO, MI, MN, NE) are advancing state-level work related to Medicaid and medical respite care.

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DISCUSSION CONTINUED

The CMS guidance on health-related social needs specifically references medical respite care (other terms include post-hospitalization recuperative care, short-term pre-procedure and/or post-hospitalization housing) as an intervention appropriate for Section 1115 demonstrations. The purpose of these demonstrations is to test and evaluate state-specific policy approaches to better serving Medicaid populations. Importantly, if room and board are to be included in the reimbursement, CMS is not allowing medical respite to be approved under home- and community-based service authorities (such as Section 1915) or In Lieu of Services. This guidance provides important direction to states still considering whether and how to add medical respite care to its Medicaid program.

The nine states with published 1115 waivers (either proposals or approvals) outlined their requests in different ways, with various lengths of stay, details of benefits provided, terminology used, service venues, and integration with other benefits/services. The differing language may highlight opportunities to test different approaches, which is the purpose of 1115 demonstration waivers. The last two waivers approved by CMS (NY and WA) contain similar language, perhaps indicating that a more consistent approach is developing. As CMS approves additional waivers, template waiver language is likely to emerge, making it a useful model for other states to replicate.