FY 2025 Houston EMA/HSDA Ryan White Part A Service Definition **Housing – Temporary Assisted Living** Approval Date: October 2024	
HRSA Service Category Title: **RWGA Only**	**Housing**
Local Service Category Title:	**Housing – Temporary Assisted Living**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Housing activities cannot be in the form of direct cash payments to clients. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.
Local Service Category Definition:	Housing - Temporary Assisted Living should provide room, board, and medical support for up to a maximum of 30 days with a physician's request, for individuals who have been discharged from a medical facility but are not medically able to return to a dwelling in which they do not have a current caregiver or support structure. The program should include physician-ordered nursing and supportive health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals such as occupational and physical therapists.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Persons with HIV living within the Houston Eligible Metropolitan Area (EMA). Eligible person should enter temporary assisted living upon release from a medical facility following disruption in ongoing Ryan White care.
Services to be Provided:	Services to be provided should be designed to support ongoing HIV care, increased functioning, and the return to self-sufficiency for PLWH through the provision of treatment and activities of daily living.

	Services must include: • Room and daily nutritious meals and snacks, • Skilled Nursing to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, ongoing monitoring of client's physical condition and communication with attending physician(s) and personal care team • Other Therapeutic Services including physical and occupational therapies Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA), Nurse (RN, LVN), licensed Social Worker, or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = One (1) day
Financial Eligibility:	Refer to the RWPC's approved *FY 2025 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	• Persons with HIV living within the Houston Eligible Metropolitan Area (EMA). • Client must receive referral for service from an MD, NP, or PA. • Client must have a qualifying inpatient hospital stay of at least three (3) days in a row defined as the day of admission, but not counting the day of discharge. • Client must enter the facility within 30 days of discharge from a hospital.
Agency Requirements:	Facility must have all required federal, state and local licenses, certifications and permits and must comply with local, state, and federal regulations.
Staff Requirements:	Staff must have all required federal, state and local licensure, certifications, permits and must comply with local, state, and federal regulations. The contractor is responsible for ensuring that services are provided by State licensed MDs, NPs, PAs, RNs, LVNs, social workers, and pharmacists. In addition, Contractor must ensure the following staff requirements are met: **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the

	preceding five (5) years in HIV care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling.
Special Requirements: **RWGA Only**	Must comply with Houston EMA/HSDA Part A/B Standards of Care. No direct payments to clients are allowed.

FY 2026 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/12/2025**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/05/2025**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/13/2025**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #3**	Date: **04/16/2025**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

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.

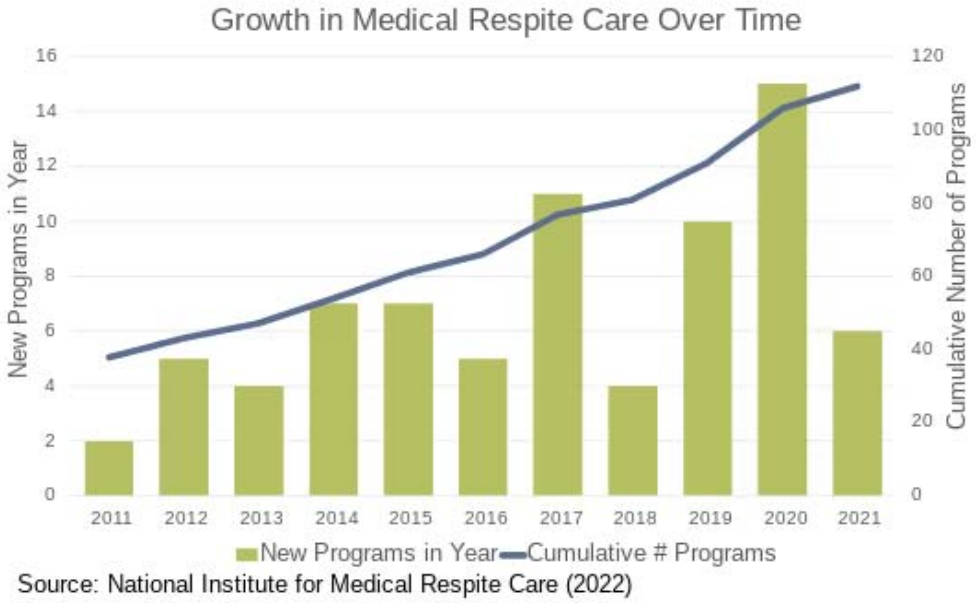
What Is Medical Respite?

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

BY CINDY HADENFELDT, EdD, RN; MARTHA J. TODD, PhD, APRN-NP; AND CHELSEA HAMZHIE, DNP, APRN-NP

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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At the Creighton University College of Nursing, Cindy Hadenfeldt is an associate professor, Martha Todd is a professor, and Chelsea Hamzhie is an assistant professor. **The authors acknowledge the collaborative support of Creighton University's Kingfisher Arts program and the Health and Housing Coalition and Medical Respite Steering Committee.**

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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

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NATIONAL INSTITUTE for MEDICAL RESPITE CARE

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ISSUE BRIEF

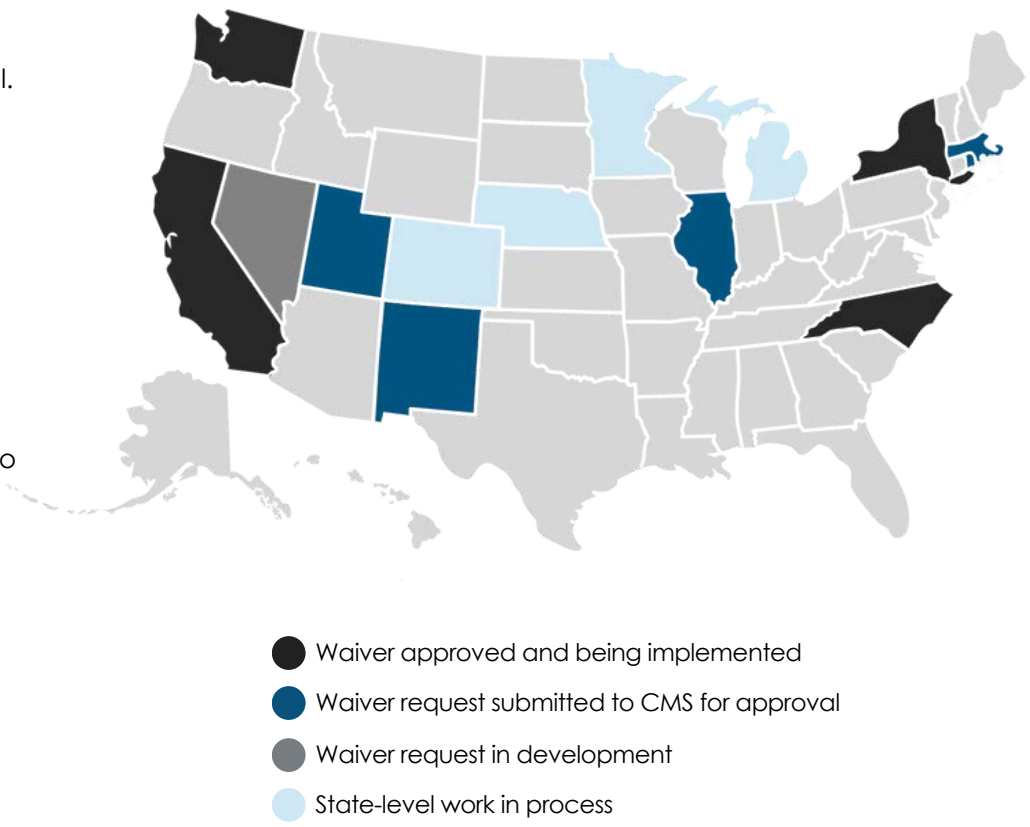
Status of State-Level Medicaid Benefits for Medical Respite Care

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.