

## Medicaid Reimbursement Principles for Medical Respite Care

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As communities across the country continue to adopt effective approaches to homelessness, state Medicaid agencies and managed care plans are increasingly turning to [medical respite care programs](#) to provide post-acute care to a vulnerable, high-need population. There are multiple [financing options](#) for medical respite care, and some states and managed care plans have [already established reimbursements](#) for these services. Based on the experiences from these partnerships, and as more states and plans consider reimbursing for services, there are a number of issues to consider when setting parameters for funding. **This issue brief describes a set of principles for Medicaid reimbursement that states and health care plans can use in their collaborations with medical respite care programs.**

- **Limit Program Eligibility to Individuals Experiencing Homelessness**

Medical respite care programs are designed specifically to accommodate the post-acute care needs of those without housing. Hence, **eligibility for the program should be limited to people experiencing homelessness.** Expanding medical respite care eligibility to other vulnerable groups (e.g., frail elders living alone, those in supportive housing, etc.) will likely quickly overwhelm bed availability for the target population, once again leaving those without stable housing no options for recuperation. Further, it becomes more difficult to evaluate outcome measures for medical respite care if those in the program come from diverse settings. Finally, other populations should have to access home- and community-based services (HCBS) for additional support in their home, and may be more appropriate services to use. Programs (especially those operated through health centers) should be aware that federal programs use [differing definitions](#) of homelessness.

Exceptions should always be possible—at program discretion—for admitting others on a case-by-case basis, such as those fleeing domestic violence or those imminently at risk of homelessness.

- **Do Not Exclude Patients with Behavioral Health Conditions**

Many individuals who would benefit from a medical respite stay have multiple chronic health conditions. Barring entry to those who may have current/past mental health and/or substance use conditions will severely limit the number of people eligible to receive medical respite services. At minimum, staffing models should expect to screen for behavioral health conditions, and connect patients to appropriate treatment. Importantly, admission and exclusion criteria for all medical respite programs should be based on the program staff capacity and ability to safely meet the needs of each patient. Programs with robust behavioral health staffing will be able to accommodate more acute behavioral health needs.

### Medical Respite Care

Provides people experiencing homelessness a safe space to recuperate from acute illness/injury:

- Individualized case management and care coordination
- Access to medical care and connection to community health care
- 24-hour/7-day access to room and board
- Assistance obtaining documentation & benefits
- Medication support & health management skills
- Housing assessments & connection to coordinated entry system

- **Reimburse on a Daily Basis or with Pre-paid Beds**

**The easiest and most effective reimbursement is a daily (“per diem”) rate that covers a bundled set of services delivered on a daily basis.** Daily payments better accommodate the varying lengths of stay at medical respite programs and offer more flexibility than flat case rates, per member/per month (PMPM) payments, or pre-purchased beds. A daily payment also better accommodates transitions between care environments (e.g., moving from a medical respite care program to a recovery or substance use program). Because many program costs remain steady throughout the year (e.g., facilities, staff, equipment, etc.), a per diem rate that adequately covers the cost of expenses will help ensure sustained operations throughout the year.

In communities where per diem payments may not be received in a timely manner or where pre-arranged beds are preferable, **it may be advantageous for partners to lease (or “pre-pay”) for a specific number of beds at a program,** which would guarantee quicker access for patients and lower the administrative burden of pursuing reimbursements on the back-end. Leasing beds would also better accommodate very short patient stays of only a few days where the administrative effort of processing per diem payments may be inefficient. Note, however, this arrangement may risk access to available beds at a time when community demand for care is high. In this case, an effort should be made to ensure medical respite program capacity is maximized (e.g., some programs have empty beds while others have to turn patients away).

- **Set Sufficient Payments that Include Short-term Room and Board**

Access to a stable place to rest is [central](#) to the goal of medical respite, and is the basis for effective case management and clinical services. Hence, **the cost of the bed (and other short-term room and board services such as meals, laundry, etc.) should be included in the bundled set of services being reimbursed.** Excluding essential services risks undermining the effectiveness of the program, and leaves gaps in financing that may make the entire program vulnerable to closing. Medicaid reimbursements should cover the full cost of care to ensure consistent access to high-quality care in a stably funded program. Medicaid plans covering “medical respite care” or “recuperative care” services should cover both support services and the cost of the short-term bed, though this may mean drawing on multiple sources of Medicaid funding (e.g., federal match, state-only funding, special initiative dollars, intergovernmental transfers, quality initiatives, etc.). Note CMS has approved using federal Medicaid funding for [six months of rent for other populations](#) (e.g., those coming out of institutions), and includes the cost of the room and board for other groups as well (e.g., nursing homes, skilled nursing, etc.).

- **Allow for Tiered Payments**

There are [a range of program models](#) that medical respite care programs might provide, with some programs providing a broader range of services or a more intensive level of care. Each of these models will require a different staffing structure, resulting in programs with significantly variant costs. Reimbursement rates should be tailored to the costs of each program’s unique set of services, and **states or plans may want to establish separate levels (or “tiers”) of reimbursement rates to recognize different levels of care.** While some states or plans may want to establish a program-by-program reimbursement rate, others may want to standardize reimbursement rates. Either way, reimbursement rates should always be sufficient to cover the costs of the services provided.

- **Place No Limits on Length of Stay**

People experiencing homelessness have disproportionately high rates of acute and chronic health care conditions, which is why medical respite care programs are needed. At the same time, many people without homes have also experienced trauma, racism, classism, and poor quality care when accessing health care in their community. As a result, people who are homeless often (understandably) struggle to trust service providers and meaningfully engage in developing a care plan, even though they may be very ill and/or have serious ongoing health care issues. This may mean that clients leave a program prematurely and/or need multiple admissions before a trusting relationship can form. In addition, the health screenings and more intensive supportive services offered in respite settings often uncover additional health care conditions that were previously unknown, which may add complexities to the care plan. Multiple admissions (or longer admissions) should be determined by medical necessity, and may also be required in order to address ongoing health issues that need a longer period of time to stabilize. To recognize this reality, **there should be no limits placed on the length of stay, nor on the number of medical respite care admissions allowed per person.**

- **Connect to Standards of Care**

Offering high-quality services is paramount to making medical respite care programs effective for those they serve. States or plans who are reimbursing for services are also interested in ensuring quality care. **Connect reimbursements to [the Standards of Care for Medical Respite Care Programs](#) in order to avoid poor quality programs.** These standards are a guiding framework to help medical respite care programs operate safely, effectively, and seamlessly with local health care systems. Medical respite programs are able to evaluate their alignment to the Standards using the [Organizational Self-Assessment](#), demonstrating adherence to the Standards and supporting quality improvement efforts.

- **Focus on Values and Outcomes, Not Cost-Savings**

States and managed care plans have many reasons for contracting with medical respite care programs. These reasons may include a commitment to racial equity, interventions addressing social determinants of health, supporting innovative care approaches, improving overall health care system throughput (especially for hospitals needing greater bed availability), and providing their beneficiaries with needed wrap-around services to ensure positive health outcomes. To that end, medical respite care programs promote [the Triple Aim framework](#) to help lower costs, improve care, and increase quality, and [a growing body of research](#) has shown positive outcomes. However, while overall cost-savings are likely to occur given the averted hospital expenses and other factors, **the desire for “return on investment” should not be the driving interest when contracting with a program.** Rather, providing high-quality care in a safe, appropriate space that offers dignity and trust is the right thing to do for very vulnerable people, and fulfills many of the stated values being promoted by health care systems.