NATIONAL INSTITUTE for MEDICAL RESPITE CARE

Medical Respite Playbook: A Practical Guide for Managed Care Plans

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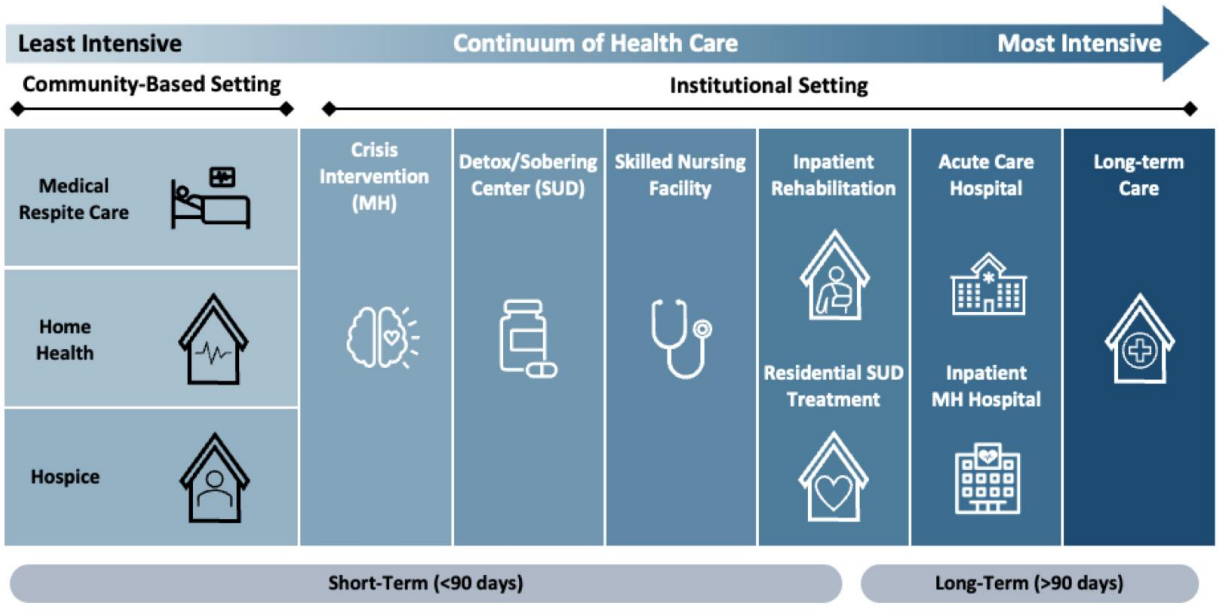
Introduction

The goal of this Playbook is to provide Managed Care Plans (MCPs) with information about the philosophy and practice of medical respite care, and offer suggestions on how MCPs can most effectively partner with medical respite care programs. The Playbook will first present Medical Respite 101, with information about scope of care, range of services, and standards of care applicable to medical respite services. The Playbook will then look at program design, including Models of Care, types of facilities, and typical funding sources utilized by medical respite programs. The following section will present ways in which medical respite care can share benefits with MCPs—including tips on data sharing and payment approaches—and offer a few examples of established relationships between medical respite programs and MCPs. Finally, the Playbook will offer some recommendations, including lessons learned from California, the state that has the most medical respite care programs in the country.

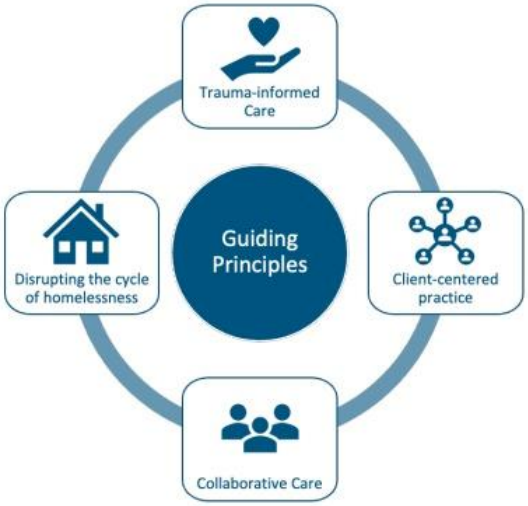
Medical Respite 101

Medical respite care is defined as "acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in shelter or on the streets, but who are not sick enough to be in a hospital."[i] The terms "medical respite" and "recuperative care" can be used interchangeably. Medical Respite Care's role within the Health Care Continuum can be seen in the visual below.

Medical Respite Care's Role within the Health Care Continuum



The four Guiding Principles of medical respite care are trauma-informed care, client-centered care, collaborative care, and disrupting the cycles of homelessness. The Guiding Principles are woven throughout medical respite programs and their service delivery, and collectively ensure that care is grounded and centered in the needs of the people it is intending to serve. The Guiding Principles are what differentiate medical respite care from other types of care that exist.[ii]



People experiencing homelessness have higher hospitalization rates than the general population, including emergency department (ED) visits and inpatient admissions.[iii]Researchers have hypothesized that increased acute care use can be attributed to several factors including:

- High prevalence of predisposing conditions;
- Communicable and non-communicable diseases;
- Unintentional injuries;
- Comorbid mental health and substance misuse; and
- Experiencing internal and external barriers to care that limits management of conditions as an outpatient. [iv]

Emergency shelters typically offer only overnight accommodations: Guests typically arrive late in the afternoon, receive a hot meal and shower, and are required to leave early the following morning. Many emergency shelters do not allow guests to stay during the day, for various reasons. For example, some expect their clients to spend the day searching for employment, while others lack the resources to provide daytime staffing, or they utilize that time for facility maintenance. Even for those who are not ill, navigating through a day without easy access to

bathrooms, food, or a place to rest can be exhausting. Shelter staff may not have the necessary training or feel equipped to handle or monitor people with significant health needs. Additionally, there are individuals who choose not to use the shelter system, feel unsafe in shelters, or have been disqualified from using the system, and instead sleep outdoors. However, when a person experiencing homelessness is sick or in need of recovery, relying on an overnight emergency shelter bed or sleeping on the streets is insufficient for proper recuperation.

Several studies have shown that discharge to medical respite programs can lead to a 24% reduction in hospital admissions in the 12 months following a respite stay.[iv] Given that medical respite represents a mere 5 to 10% of the cost of an average hospital day, these programs can save money while delivering more appropriate, effective, and compassionate care compared to releasing a client to the street or a shelter.

Because affordable housing shortages are prevalent in nearly all communities across the United States,[v] expanding access to supportive services at all points on the spectrum of care is a critical task facing the health care system. After a hospital stay, it is highly unlikely for a person experiencing homelessness to be discharged to stable housing. Medical respite care offers a solution to address those disparities by providing a stable and secure environment for individuals to stay, rest, and recover. By temporarily addressing shelter needs, medical respite care can improve outcomes by connecting individuals to primary care and benefits, and decreasing rates of expensive ED utilization. It may also serve as a pathway towards achieving stable housing, which is the ultimate support for improved long-term health outcomes. The visuals below provide a macro level view of communities without and with Medical Respite as well as a study to provide a more tangible real life example.

Case Example	
George is managing diabetes and severe depression. George had an accident resulting in a leg fracture, but due to previous hospital experiences where his needs were ignored and he was treated poorly, he avoids seeking care until he is in excruciating pain and unable to walk. George seeks out care at the ED at his local hospital and is admitted for a short inpatient stay. He is treated and ready for discharge after two days of care.	
Without medical respite care:	**With medical respite care:**
George returns to the emergency shelter where he is only able to rest his leg after 5 p.m., and is required to leave daily by 6:30 a.m. Two weeks after his discharge, George returns to the ER due to swelling and pain in his fractured leg. His diabetes has contributed to poor healing in his leg, in addition to being unable to rest, and he is hospitalized again, this time for longer, to prevent his leg from worsening. George reports increasing depression due to ongoing pain from his leg and feeling unable to prevent his health conditions from worsening.	George is discharged from the hospital to the local medical respite program where he is able to rest his leg throughout the day. The RN provides daily checks to ensure his leg and fracture are healing, and provides support for his diabetes management. Due to the positive relationships he develops with staff at the respite program, George is agreeable to establishing a PCP at the local health center for long-term follow-up for his leg and diabetes. George feels healthy and strong enough to leave the medical respite after three weeks, and in that time he attended his first PCP appointment, received a referral for and scheduled his first physical therapy appointment, and identified a case manager to navigate the housing process in his community.

Scope of Care

As previously noted, Medical respite care fills a service gap between hospital and shelter, providing a safe place to recover by ensuring that basic needs are met. This also allows the person experiencing homelessness to focus on their health by attending appointments, managing medications, and connecting with specialty care. Programs also support recovery by offering case management and connection to benefits and mental health care. Enabling services—or non-clinical services that enable individuals to access health care and improve health outcomes—are also typically part of the programs. These enabling services may include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, and outreach, among other services.

Medical respite care has been found to have multiple positive outcomes, including decreased hospitalization and readmissions, increased use of community-based health services, overall

decreased healthcare costs, reduced gaps in services, and improved quality of life and health outcomes for clients.[vi]

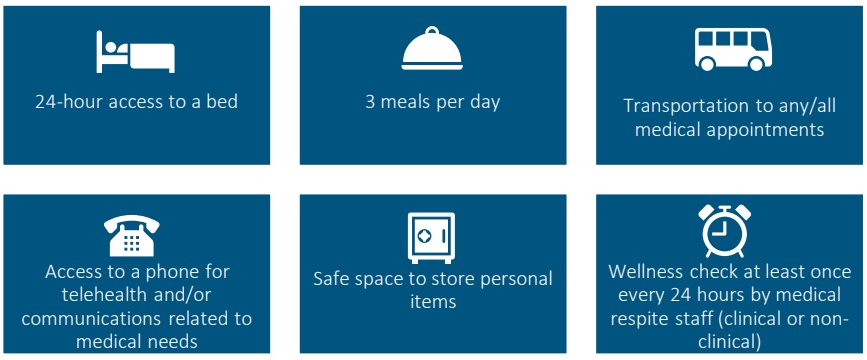
Because of these documented outcomes, many communities have established medical respite care programs. At the publication of this document, there are 145 documented MRC programs across the US.[vii] (You can learn more about *these* programs—including their locations, capacities, and other efforts—using the National Institute for Medical Respite Care (NIMRC)'s online tool, The State of Medical Respite Care.) Due to the growing need and visible positive impacts of these extant medical respite care programs, many other communities are currently seeking to establish their new programs.

Common characteristics of medical respite care programs include the following:

- Closes the gap between hospitals/emergency rooms and homeless shelters that do not have the capacity to provide medical and support services.
- Provides a low-cost, high-quality, and innovative discharge option to aid emergency room diversion and hospital discharge options.
- Serves as an integral component of the Continuum of Care (CoC) for homeless services in any community.
- Provides participants the opportunity to access medical and supportive services needed to assist their recuperation.
- Allows a length of stay determined by medical need and progress on an individual treatment level.
- Provides continuity of care when clients are transitioning between hospital and home.
- Engages participants in the process of their recuperation and discharge planning.
- Allows a flexible service delivery model that reflects unique community needs, priorities, and resources.
- Shows respect for human dignity by preventing unsafe and illegal discharges to the streets or shelters. viii

Range of Services Provided

To achieve the essential goal of medical respite care of providing a safe place to heal, recover, and connect to health care services, every program should, at minimum, contain these key components:



To prevent exacerbation of acute medical issues and promote health and recovery, programs also often offer enabling services. These services help prepare clients for transition from the respite program and support continuity of care by connecting them to needed community services. Enabling services within medical respite focus on addressing the various barriers that impact health and quality of life. Care coordination focuses directly on engagement in health services and addressing the social needs that impact a person's ability to care for their health. Case management in medical respite programs differs from other settings in that there is an intentional emphasis on connection to primary care, attending medical appointments, and accessing health resources, such as prescriptions or medical supplies.

Clinical Services	Enabling Services
• Vital sign monitoring. • Management of acute conditions. • Management of chronic conditions. • Medication management (education, instruction). • Care coordination with specialists. • Mental health screening and intervention. • Substance use screening and treatment. • Escorts and support to attend appointments. • Advocacy and support for clients' health needs. • Health education.	• Connection to benefits programs such as food stamps. • Initiation of or connection to income, such as Social Security or supported employment programs. • Care coordination to connect to primary care, attend medical appointments, and follow-up. • Navigation or connection to Coordinated Entry and housing programs in the community. • Peer supports. • Reconnecting to family and other support systems. • Leisure and recreational activities.

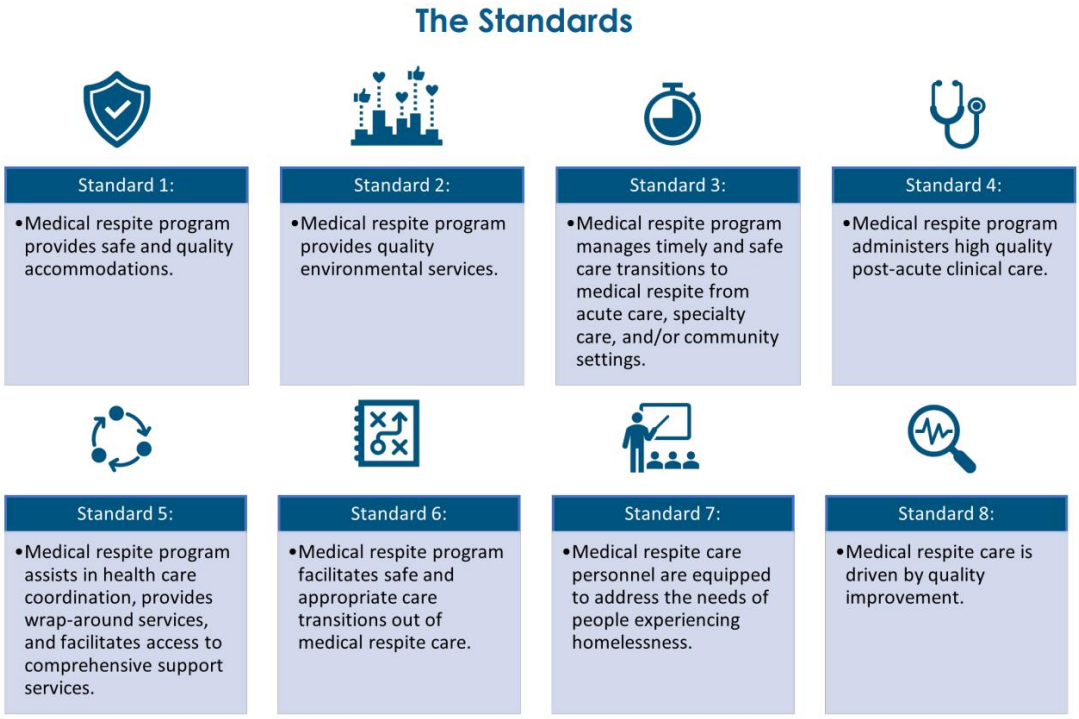
It is important to note that community partnerships play a critical role in ensuring a comprehensive array of enabling services, and it is crucial for medical respite programs to collaborate with established entities that already offer specific programs or services, such as the homelessness response system for housing and SSI/SSDI Outreach, Access, and Recovery (SOAR). Most medical respite programs have a dedicated case manager responsible for addressing care coordination and enabling service requirements. The case manager's or care coordinator's responsibilities differ depending on the internal resources and objectives of the medical respite program, as well as the availability of existing services within the community. Making connections with other community organizations is a key piece of caring for clients in a holistic way.

Standards for Medical Respite Care

In July 2020, the National Health Care for the Homeless Council (NHCHC) launched the National Institute for Medical Respite Care (NIMRC) to identify best practices, offer expert services, and advance state-of-the-field knowledge in medical respite care. One key contribution has been the

updating of standards of care—first developed in 2016 by the Respite Care Providers' Network (RCPN)—to unite medical respite care programs.

The *Standards for Medical Respite Care Programs* (also known as the Standards; published in 2021) provide a framework for implementing quality medical respite care. Since medical respite programs are diverse and reflect the needs of their specific community, the Standards ensure consistency on key components of programs, and quality of care for people experiencing homelessness, while reflecting the diversity across programs. Although a new medical respite program may not initially meet the Standards, they provide a framework for developing a high-quality program. Each Standard has specific criteria detailing how it can be met, which is a useful tool that can be used throughout the program design and quality improvement process:



Program Design

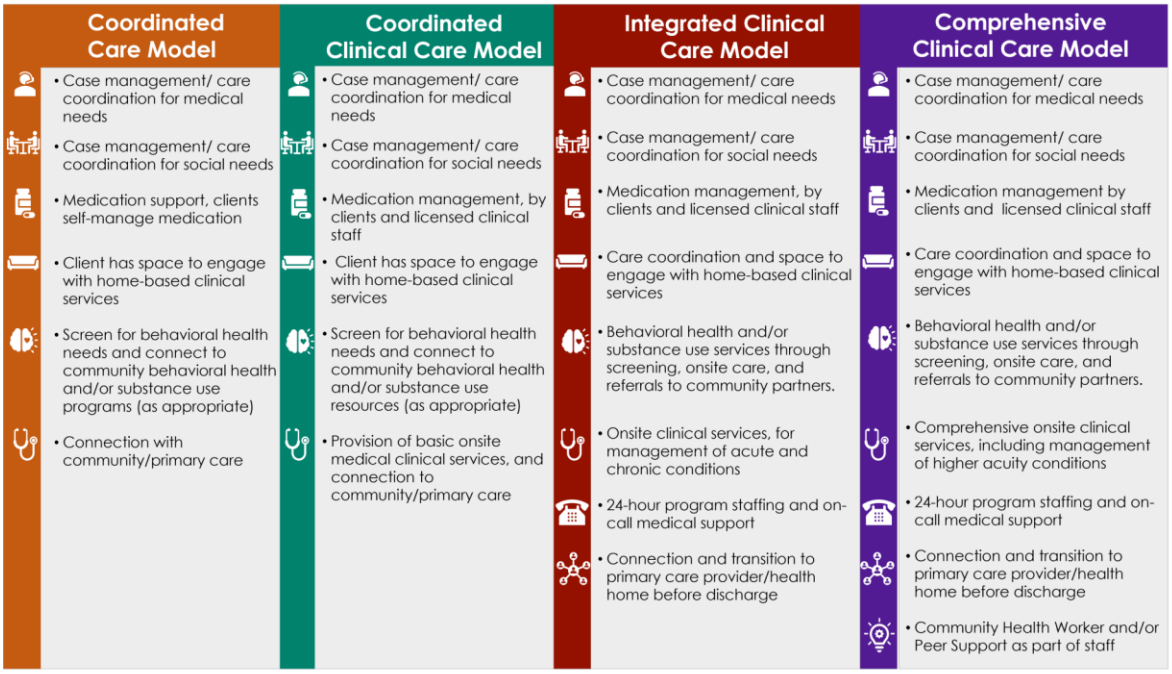
Because individual medical respite care programs aim to be responsive to the local context and needs of their communities, there are differences in how programs are designed and structured. The Standards for Medical Respite Care can be applied equally across different Models of Care, types of service delivery facilities, and funding sources.

Models of Medical Respite Care

Within medical respite care, there are several overarching program structures and approaches for service delivery. The Models of Medical Respite Care (Models of Care [MoCs]) fall on a

spectrum where the intensity of on-site clinical services increases. It is important to note that there is not one "best" model of care. Instead, the ideal model is the one that is responsive to the community's need and will be sustainable. Programs may opt to start with a lower intensity of onsite clinical services as part of their pilot program and then increase the number and types of services offered as they establish consistent partnerships and expand funding sources. There are four MoCs: The Coordinated Care Model, the Coordinated Clinical Care Model, the Integrated Clinical Care Model, and the Comprehensive Clinical Care Model, each described here:

Models of Medical Respite Care



Facility Types

There are a variety of ways that medical respite facilities can be structured. They vary depending upon the communities' and populations' needs, available space, and funding. Programs may begin in one type of facility, but evolve to change or expand their facility in order to better meet clients' needs, expand bed availability, or respond to the specific needs of the population being served.

Free Standing

Benefits	Drawbacks & Considerations
• Requires higher operating costs to run and maintain an independent building. • Able to design space to implement clinical services. • On-site staff. • Can have private clinical spaces for care. • Controls quality of physical environment.	• Requires higher operating costs to run and maintain an independent building. • May need to rehabilitate an older or existing building. • Program planners must be aware and comply with local and state zoning laws and regulations. • Requires higher operating costs to run and maintain an independent building.

Shelter or Shelter-based

Benefits	Drawbacks & Considerations
• Minimizes costs of building, rehabbing, and maintaining a building. • May be co-located with other services (such as an onsite health center, case management, etc.). • May already have existing structure to provide regular needs (meals, laundry). • Eases transition from respite into shelter setting at discharge. • Expertise in providing shelter services to people experiencing homelessness. • Likely already serving individuals who need medical respite care.	• Respite program staff and administrators may need to comply with shelter rules that may conflict with preferred service delivery (e.g. harm reduction). • May not be able to provide private space to respite residents. • May not be able to accommodate all clinical services desired to be offered. • Less autonomy over decisions regarding the building • May have to follow shelter policies, procedures, and admissions criteria (versus developing its own).

Apartments or Motel Rooms

Benefits	Drawbacks & Considerations
• Does not require an independent building or structure and could exist within structures already existing in the community. • Ensures a private space or only sharing space with 1-2 others for clients. • Cost of program can be specific to number of people referred. • Effective for families or people with contagious illness requiring a separate space.	• May have difficulty negotiating access to rooms due to stigma regarding people experiencing homelessness. • Limited-no control over quality and upkeep of facility. • Scattered sites and locations may make it more difficult to engage with clients regularly. • A strategy to provide services such as meals and transportation will have to be developed.

Assisted Living Facility, Nursing home, or Skilled Nursing Facility

Benefits	Drawbacks & Considerations
• Facilities can accommodate a range of medical and clinical services • Facilities will be accessible for varying ranges of mobility • Minimizes costs of operating a stand-alone building and/or clinical staff. • Accommodations will be semi-private or private and include meals, laundry services, etc.	• May have a limited number of beds that can be reserved for medical respite. • May have limitations on diagnoses that will be accepted, or may choose not to accept people with mental health diagnoses or symptoms, who have active substance use, or are on medication assisted treatment. • Staff may not be trained in trauma-informed care or best practices for people experiencing homelessness. • May have restrictions on clients ability to leave the building, limiting ability to engage in outside services.

Transitional Housing or Substance Use Programs

Benefits	Drawbacks & Considerations
• Limited costs to operating building/facility. • Can provide a direct transfer from medical respite into the housing or program for longer-term housing or care. • May provide additional services as part of the facility (such as case management or mental health services).	• Limited-no control over the accessibility, quality, or cleanliness of the building/facility. • May have to comply with program's regulations (e.g. requiring sobriety) that can limit some clients from being accepted. • Will require coordination between medical respite and facility staff, and onsite visits by the medical respite staff.

Housing and the Discharge Planning Process

While MRC programs vary in size and structure, they are all guided by the Standards for Medical Respite Care Programs (the Standards) and share the same fundamental element: short-term residential care that allows people experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services.

Within the Standards, Standard 5 states, "Medical respite program assists in health care coordination, provides wraparound services, and facilitates access to comprehensive support services." Additionally, Standard 6 states, "Medical respite program facilitates safe and appropriate care transitions out of medical respite care." Unfortunately, there are challenges in meeting and exceeding these two standards due to a significant lack of affordable housing that meets the needs of various community members, and the complexity of the homelessness response system and housing process to access available housing.

In response to this challenge, NIMRC has developed several resources to support MRC programs to include (but limited too):

- The Medical Respite Care online course: Discharge Planning and Processes
- Housing and the Medical Respite Care Program: A Practical Guide to Navigating the Homelessness Response System
- Standards for Medical Respite Care Programs Companion: The Standards Companions

Click this Resource to Find:

- Homelessness Response System Definitions
- Housing Discharge Planning Checklist

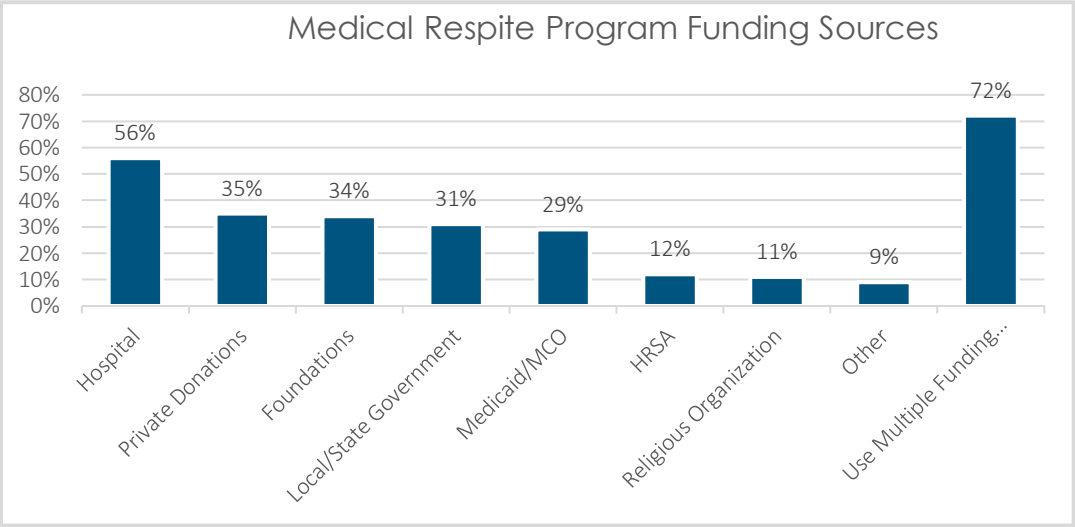
It is important to note, it is not the sole responsibility of the MRC program to end homelessness in their community. However, it is the MRC program's role and responsibility to support clients in making meaningful progress toward their housing goals and resolving homelessness with clients when possible.

In MRC, housing and the discharge planning process begins at admission in order to most effectively utilize time, community resources, and ultimately support the client while in the program recuperating. Examples of housing discharge planning questions and workflows of MRC programs are actively working to answer and accomplish with clients include (but are not limited to):

- Have you attempted diversion or prevention with the client?
- Have you discussed and shared resources on discharge placement options (e.g., local emergency night shelter, day centers, transportation)?
- Has the client been connected to the Homelessness Response System (HRS) and received a Coordinated Assessment (CA)?
- Is the client on all eligible community and public housing waitlists?
- Has the client been connected with their vital documents?
- Does the client have a housing case manager with access to HMIS?
- Have you supported the client in documenting their homelessness status prior to admission?
- If applicable, has the client started the SOAR process?
- If the client is being discharged back to unsheltered homelessness has their location and contact information been documented internally and in HMIS?

Key Funding Sources

Most medical respite programs use more than one funding source in order to meet all program expenses, as the following graph depicts:



Hospitals, insurers, and health care systems are increasingly focusing on interventions that improve care, reduce costs, and promote positive outcomes—a strategy known as the "Triple Aim" approach to health care that is promoted by the Institute for Healthcare Improvement. Medical respite programs are well-positioned to align their services with these larger goals to demonstrate their value and to negotiate appropriate financing. Programs often obtain funding for innovation and capacity-building in the early stages of program development, but long-term investment that provides ongoing funding for operations, plus opportunities for renewal funding, is also critical for longevity.

This section outlines the common funding sources used by medical respite programs: hospitals, MCPs, government sources, private grants, and HRSA.

Hospitals

Hospitals are often the primary referral source for medical respite programs, and they benefit directly from these placements due to shorter lengths of stay, reduced readmission rates, and safe discharge venues. Importantly, the Hospital Readmission Reduction Program established by the Centers for Medicare and Medicaid Services (CMS) aims to reduce avoidable readmissions by linking payment to quality of care.[viii]

There are five ways in which a medical respite program might receive funding from a hospital.

Per diem rate:

A contract may be "payment per referral daily rate," in which the hospital pays a daily rate for each person referred while they are at the respite facility.

Flat case rate:

A "payment per referral flat rate," in which the hospital pays a one-time payment for each person referred. In each of these cases, the medical respite program is guaranteed financial coverage for each individual referred.

One-time payments:

Annual grants or payments from hospitals, in which programs receive a one-time, annual payment. This funding approach guarantees a predictable amount of funding each year.

Reserved beds:

Reserving a specific number of beds for a hospital partner.

Community benefits funds:

Non-profit hospitals are required to conduct community health needs assessments and dedicate a portion of funds to meeting those needs, which could include medical respite care for hospital clients experiencing homelessness.

Local and State Government

Funding from local and state governments for medical respite care can vary widely by program, and is often dependent on individual community circumstances, availability of resources, and/or the type of facility. Engaging with Continuums of Care (CoCs) and/or the broader homelessness response system may also help identify partnership/funding opportunities that can be utilized to help pay for beds, facility costs, or other expenses that other funding streams may not allow.

Key partners and/or stakeholders in this process may include (but are not limited to):

HRSA

(U.S. Department of Health and Human Services/ Health Resources and Services Administration)

Medical respite programs operated by community health centers may use health center funds to support medical respite care services. In 2002, "recuperative care services" was added to Section 330 of the Public Health Service Act (42 USCS § 254b, the authorizing statute for the HRSA Health Center Program) as an "additional health service" that health centers are permitted to offer using their health center grants. If the medical respite program is added into the health center's scope of service, then HRSA grant funds can be used to cover health services (such as medical visits) that occur with the medical respite program.

Note: Although HRSA health center funds can cover the cost of health services and some supportive services, these funds do not cover costs associated with providing and maintaining the residential component of a medical respite program. Therefore, health centers that wish to operate a medical respite program often work collaboratively with a shelter or other housing-based program to balance program costs.

Private Donations & Foundations

Funding from private sources (individual or corporate donations or in-kind contributions, and national or local foundation grants) is extremely valuable and may offer greater flexibility than is possible with public grants. Private and foundation funding may only be for a specific period of time, often to cover start-up costs, and then have requirements for identifying other sources for ongoing funding thereafter.

Medical Respite Care & Medicaid MCP Partnerships

As this Playbook has shown, medical respite programs offer a host of potential clinical and economic benefits from the services they provide. These may include, but are not limited to:

Reduction 	in inpatient admissions
	in inpatient length of stay
	in ED visits
	in 30-day readmission rate
Increased 	use of community-based services
	medication adherence
	vaccination rate (including flu and COVID-19)
Connection 	to primary care
	to long-term housing options
	to elligble benefits (including SNAP and Medicaid) xii

Sometimes, individual programs may have insufficient data to prove all of these benefits within their program. Medical respite service providers often face difficulties in collecting, tracking, andaccurately reporting data, which hampers their ability to advocate for broader changes in referral and reimbursement processes. The complex landscape of referrals, and the challenges associated with data tracking, make it challenging for medical respite programs to justify expanding their services to reach more individuals. As a result, opportunities for risk-averse payors to provide sustainable funding are limited. However, this challenge can be addressed by fostering more collaborative partnerships across various healthcare service lines that emphasize data measurement to demonstrate outcomes. As the focus on social determinants of health grows among multiple stakeholders, these partnerships can help alleviate the barriers and provide evidence of the impact of medical respite programs on health interventions.

Data Sharing Recommendations

Medical respite programs with existing relationships or partnerships with MCPs can benefit from aggregate data that MCPs can provide. MCPs are ideal partners in demonstrating the value of medical respite services because they have access to claims data tools that can collect the information needed to measure the overall health benefits and cost savings of these interventions—beyond the short-term period of an individual's respite stay. For example,

measuring health plan data from medical respite programs annually shows promising outcomes, including:

- 24% **reduction** in Medicaid cost per enrollee
- 30% **decrease** in hospital admissions
- 38% **reduction** in emergency department visits
- 92% **attendance** rate at follow-up appointments within 30 days of hospital discharge xi

Program evaluation is an opportunity for programs to assess the operations and outcomes of the program. Data collection and sharing should be a collaborative process between stakeholders. The program evaluation process informs quality improvement activities, identifies areas of strengths, and gives an opportunity to adjust areas of the program that may not be functioning as intended. The evaluation process will likely include the collection of data that reflects program and consumer outcomes.

There are several outcomes that could potentially be collected. The outcomes for each program are determined by information required from funders, capacity of the program, information requested by priority stakeholders and regulatory bodies, and what the program has determined will demonstrate effectiveness of their services. NIMRC recommends collecting at minimum the following metrics within three major categories:

Data Categories	Metrics
Health Outcomes focus on the health needs of clients and the clinical care provided by the medical respite program. This can include type and frequency of clinical services offered, health needs addressed, and outcomes of clinical care.	• Primary diagnoses of clients admitted to the program • Improvements in medical and mental health • Outcomes of specific health interventions implemented in medical respite program • Length of stay • Types of services provided • ED and hospital readmissions • Number of clients who remain engaged in care with PCP • Number of clients who remain engaged in mental health care and/or substance use treatment

Social Outcomes focus on care coordination and connection to social supports. These can include a number of types of services offered within the program, number of clients referred for social services, and types of social service needs met and addressed while at the program.	• Number of clients admitted to the program with social service needs • Number and type of social service needs met • Care plan creation and completion • Number of clients approved for SSI/SSDI • Number of clients transition to housing or other stable placement
Program Outcomes help to evaluate the delivery of medical respite services and promote quality assurance, program development, and growth. This includes operations, broad service delivery, and partnerships established within the community	• Number of clients served and demographics • Admission & discharge • Fidelity to the Standards for Medical Respite Care • Client surveys collected and information gained/implemented from that feedback • Number and type of community partners who refer to the program • Cost of care for clients served

Payment Approaches

State Medicaid programs, MCPs, and state and federal agencies like the Centers for Medicare and Medicaid Services (CMS) have increasingly made available various financing options that can apply to medical respite care programs. These financing options are particularly relevant in states that have expanded Medicaid, as a larger number of individuals who are homeless now qualify for Medicaid. In these expansion states, medical respite programs can benefit from a streamlined funding approach, as clients are already receiving services through MCPs, which can then create a more integrated funding stream. In non-expansion states, Medicaid coverage is much more limited for a large proportion of clients experiencing homelessness. These states will likely experience a larger financing gap that service providers must fill, necessitating multiple funders to support the medical respite programs.

Some MCPs express concerns about the financial impact of covering medical respite services beyond those clinical services that are traditionally reimbursable. Two primary questions and concerns are 1) how contracting for these services will affect their medical loss ratio and 2) the calculation of their capitated rates. While strategies to address these concerns will vary from state to state, there is often an opportunity to develop a contracting approach focused on quality improvement that aligns as closely as possible with the allowances in a state's health plan (e.g., HEDIS measures).

Service providers can establish business relationships with MCPs, hospitals, health systems, and state governments to form contractual partnerships that generate more sustainable revenue for their programs. By taking a more active role in funding medical respite services, MCPs and state Medicaid agencies can directly contribute to data collection for tracking and evaluating health outcomes, client priorities, and client satisfaction. This collaborative approach to continuous learning and improvement is crucial in further validating medical respite as an important and effective care model. Community-based organization agreements can also provide funding for additional programs, such as housing assistance, workforce development, outpatient counseling, and education, which help members regain stability and progress towards self-sufficiency.

Medicaid and Medicaid Managed Care Plans (MCPs)

Engaging with state Medicaid agencies and/or MCPs (as the health plan) is another source of sustainable funding. Medicaid systems have a direct interest in decreasing hospital stays, reducing overall costs of care, and focusing on quality of care measures.[ix] "Value-based payments," where payments are tied to defined health outcomes, are increasingly common to incentivize specific results.

While there are numerous financing strategies that work for medical respite programs, more state Medicaid plans and MCPs are paying for services through Medicaid as a way of creating more consistent and sustainable reimbursements. Further, some states are actively moving to add reimbursements for medical respite care as a statewide benefit. 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 substantial investments associated with these approvals will allow states to stabilize coverage, offer new benefits and services, and focus on whole-person care.[x]

Other pathways for working with MCP reimbursements are somewhat similar to hospital funding:

Per diem rate:

A contract may be "payment per referral daily rate" in which the MCP pays a daily rate for each person referred while they are at the respite facility.

Capitated per-member per-month (PMPM) rate:

A standardized monthly payment from the MCP to the program

Monthly payments:

The MCP provides a monthly payment to the medical respite program to reserve a designated number of beds for their members.

Flat case rate:

The MCP pays a one-time payment for each person admitted to the program, regardless of the length of stay.

For additional information regarding medicaid reimbursement principles for medical respite care please review this resource.

Examples in Practice

Here are three examples of existing Medical Respite programs, each with a unique operational and funding structure, which utilize Medicaid and MCP resources to support their services.

1) *Program A – Medicaid & FQHC Payments*

Program A is a medical respite program and Federally Qualified Health Center (FQHC) in a Medicaid expansion state that opened its doors in 2012. It operates a standalone medical respite care facility of 100 beds. Program A is partially funded by HRSA through the Health Care for the Homeless Health Center Program (330h). As an FQHC leveraging clinical staff to provide services in medical respite care, Program A benefits from the Medicaid Prospective Payment System (PPS) which allows FQHCs to receive a bundled payment to cover the cost of providing comprehensive care to clients. This arrangement results in one payment for every day that a Medicaid-enrolled client receives qualifying clinical or comprehensive support services. Examples of these qualifying services include:

- Health assessments

- Primary care
- Screenings, treatment, and preventative services for chronic diseases
- Clinical health education

Because Program A receives reimbursement for their direct services, they have a certain amount of financial flexibility to cover room and board as well as other non-reimbursable services (e.g., housing navigation, employment counseling, and transportation). For additional information, please see this Medicaid Managed Care Financing Approaches for MRC resource.

2) ***Program B – Capitated Rate***

Program B is a shelter-based medical respite program in a Medicaid expansion state. The program is run by a hospital-based health system with more than 600 physicians across three different counties. Program B operates 10 respite beds and provides nursing care, case management, housing navigation, referrals, and care coordination for clients.

Program B partners with their regional MCP which recognizes the value of medical respite care. The regional MCP has set aside a dedicated budget for medical respite care in their service area, which includes three unique programs. This budget is allocated depending on the bed capacity of each individual medical respite program. To establish their budget, the MCP determined a capitated rate, which is paid to each medical respite program based on bed utilization. Through this process, Program B receives a per-member-per-month payment based on its 10-bed service capacity. For additional information, please see this Medicaid Managed Care Financing Approaches for MRC resource.

3) ***Program C – MCP Bed Reservation or Bed Lease***

Program C is a 100-bed apartment-based medical respite program in a Medicaid expansion state. Program C provides nursing, social services, services through an onsite medical clinic, mental health services, substance use services, and more. Program C partners with multiple MCPs within their state by offering monthly bed reservations. Each month, MCP partners have an opportunity to claim a set number of medical respite beds by paying a "pre-purchase" rate. In this model, each MCP assumes the risk for cost, regardless of whether the bed is utilized. Since payments are set up in advance, monthly invoices can be auto-generated and payments made to the medical respite program on the first of every month, claims for utilization of individuals are not necessary. An example of this model is included in an Issue Brief published by The Commonwealth Fund in 2021 about National Health Foundation's Pico Union Recuperative Care facility in Los Angeles, CA.

Case Study: The State of California

The state of California has the largest homeless population out of any state in the country, with more than 151,000 people experiencing homelessness.[xi] California also has pioneered many innovations in service delivery for people experiencing homelessness, and has more medical respite care programs in operation (42) than any other state. As such, California has many lessons to share with care providers and MCPs in other states and localities that are introducing and expanding medical respite care programs.

National Landscape of Medical Respite Care

The United States has 145 documented medical respite programs in operation across 40 states and territories. The states with the most medical respite programs are:

1. California (42)
2. Washington (10)
3. Michigan (5)
4. Minnesota (5)
5. Virginia (5)
6. Florida (4)
7. Illinois (4)
8. New York (4)
9. North Carolina (4)
10. Ohio (4)

(Statistics retrieved June 28, 2023 from The State of Medical Respite Care)

In 2018, National Health Foundation (NHF), a nonprofit created by the Hospital Association of Southern California (HASC) to address the needs of unhoused individuals discharging from hospitals, successfully leased beds at a new Recuperative Care facility in the Pico-Union District of Los Angeles to MCPs. While MCPs were not able to use Medicaid funds or include the cost of these services in their Medical Loss Ratio (MLR), it did give local MCPs an opportunity to conduct a Recuperative Care Pilot and measure the cost-effectiveness of referring its unhoused members from hospitals and skilled nursing facilities (SNFs) into a medical respite facility. This bed leasing payment model is showcased in a Commonweath Fund Issue Brief published in August 2021, How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness.[xii]

In 2021, NIMRC and CommonSpirit published four case studies of medical respite programs in California, with special attention to the risk mitigation measures these programs took during the

early days of the COVID-19 pandemic: Capacity-Building for Medical Respite/Recuperative Care Programs in California in Response to COVID-19.

Also in 2021, the California Department of Health Care Services (DHCS) announced plans to launch the California Advancing and Innovating in Medi-Cal (CalAIM) transformation initiative on January 1, 2022. The three primary goals of CalAIM are to:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value- based initiatives, modernization of systems and payment reform.

CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. The CalAIM initiative recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal (California's Medicaid program) that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and put the focus on improving outcomes for all Californians. It is hoped that attaining these goals will have significant impact on individuals' health and quality of life, and ultimately reduce the per-capita cost over time.[xiii]

Under CalAIM, MCPs also have the option to provide non-clinical services from a menu of 14 approved in lieu of services (ILOS) called Community Supports, which includes Recuperative Care/Medical Respite. Bottom line, for the first time, MCPs had CMS and State authority to use Medi-Cal (Medicaid) funds to pay for medical respite effective January 1, 2022, and include the cost in MCPs' medical loss ratio (MLR). Also included is a new statewide enhanced care management (ECM) benefit that addresses clinical and non-clinical needs of high-need Meci-Cal beneficiaries[xiv].

The cost of Community Supports, which are provided at the MCPs' option is included in the development of the managed care rate (unlike other Health Related Social Needs strategies which might require that the plan use administrative funds, profit, or other mechanisms). Total cost of all offered ILOS (including behavioral health ILOS but excluding short-term stays in institutions for mental disease) cannot exceed five (5%) percent of the managed care program. ILOS must be cost effective, when evaluated in the aggregate. ILOS can be more preventive in nature (i.e., reduce the need for certain covered services like inpatient admission). Since payment for Recuperative Care and other Community Supports is added to MCPs capitation, it does not appear as a separate reimbursement and has been somewhat confusing for the MCPs as to how they are being paid for the 14 non-clinical ILOS.

The State of California's Department of Health Care Services has also developed and released robust guidelines on non-binding ILOS pricing[xv], enhanced care management, and community supports that are supportive of medical respite care provision. Thus far, CA MCPs are paying Recuperative Care providers a per diem rate – "payment per referral daily rate" in which they are paid for each authorized day while the member is at the respite facility.

Concurrent with the launch of CalAIM, the Biden Administration passed the American Rescue Plan Act of 2021 (ARPA), to mitigate the impacts of the COVID-19 Pandemic, which resulted in California receiving $43 billion in combined recovery funds. Approximately $4.22 billion of ARPA funds were divided into three funding opportunities for CalAIM proiders two of which need to be earned by MCPs, that provide funding to community-based organizations (CBOs) to assist with capacity-building to hire staff, purchase technology, etc., to be able to serve more MCP members under CalAIM. The three funding opportunities has provided much-needed funding to Recuperative Care providers that opted to contract with MCPs.

In preparation for CalAIM, the National Health Foundation (NHF), in collaboration with Pamela Mokler & Associates, released a publication and accompanying webinar Planning for a Learning Network among Los Angeles Medical Respite Payers and Providers , that outline lessons learned from navigating payment systems in Los Angeles County. This publication includes findings from interviews with stakeholders across the medical respite payment and provision system, finding that stakeholders shared an interest in developing a learning network to broaden and deepen connections between payers and providers. The California Health Care Foundation provided funding to establish the LA Recuperative Care Learning Network, which launched in January 2022, concurrent with the launch of CalAIM. LA County Medi-Cal (California's Medicaid program) MCPs, recuperative care providers, hospital discharge planners and case managers, as well as the Los Angeles County Department of Health Services – Housing for Health Program, and several foundations that provide grant funding in the local homelessness industry, enthusiastically voluntarily participate in working together to resolve challenges in integrating Recuperative Care into the local MCPs' models of care. CHCF showcased the collaborative work of the Learning Network in its June 2023 Issue Brief publication, Lessons from the Field: How an Ad Hoc Stateholder Network is Helping Redefine Medical Respite Care in Los Angeles .

Examples in Practice

COTS Recuperative Care in Petaluma, California
Number of beds: 8
Length of Stay: 4-6 weeks/90-day maximum
Referral Source: Providence Health and Kaiser Permanente
Funding Source: 2 referring hospitals provide annual flat rate, Health Plans (CalAIM)

Committee on the Shelterless (COTS) Recuperative Care center is located within a shelter in Petaluma, California. The main respite dorm offers six beds, with two of the beds located in a private room. Clients come to medical respite from Kaiser Permanente and Providence Medical Group, both of whom also fund the program annually. Respite is also funded through CalAIM reimbursement. Referring providers initially estimate a discharge date of two weeks, but the average length of stay is four to six weeks with a 90-day maximum. Roughly half of the medical respite clients discharge to the shelter after healing from their illness or injury.

Julia Gaines, Senior Supportive Programs Manager, works collaboratively with three recuperative care specialists that provide case management and health coordination, and a nurse practitioner that sees patients on site. Medical respite specific staffing is limited to daytime, evenings, and weekends, but the shelter provides overnight staffing for monitoring and emergencies. Clients are supported in managing their own medications by being provided with pill containers and locked storage. Respite clients receive three meals per day, prepared by an on-site chef, and food is received through donations and from local grocery stores. Lunch and dinner services are accessible to the entire community.

COTS operates as a low-barrier and harm-reduction focused program, and clients can leave the facility as long as they return in time for the 10 pm to 6 am curfew. Access to MAT and other substance use treatments, behavioral health care and primary health care is available through partnerships with community providers. Hospital discharge planners are responsible for scheduling follow up medical appointments, and medical respite staff assist with scheduling transportation through Medicaid, or they provide it with a company vehicle. Respite care specialists also refer clients to specialty services, such as Home Health, and organizations for seniors, veterans, and domestic violence programs. The program offers in-house recovery and life skills groups, art therapy four times a week, and has a library with recovery resources and games. Upon arriving at medical respite, clients are given a set of headphones so that they may watch television on their individual devices and are connected with a peer mentor to orient them to the respite program.

"What makes us COTS is that we go the extra mile and are focused on the solutions." Julia went on to say that she is proud of the quality of care that staff provides for clients and their willingness to let them be themselves and work on their personal goals. The program is proud to be expanding into a new space later this year that will house 20 beds and offer 24/7 care. "The city and county are seeing the importance of our work, especially with the aging population." Although there is a large number of older adults in the shelter, they are seeing progress being made towards permanent housing and a reduction in returns to the emergency room after leaving medical respite.

Watch a virtual site tour of COTS Recuperative Care here and for more program examples see the Models of Medical Respite Care Program Examples document.

Local Level Action Steps to Improve Partnerships

Issues to Address	Steps for Hospitals & Medicaid/MCPs
Understand each other and build relationships across systems	Get to know MRCs, CoC staff, and homelessness services programs and discuss shared roles and responsibilities for clients who are homeless. Consider engaging state hospital associations as key partners also.
	Add CoC and MRC representation to community health needs assessments and other initiatives
	Train discharge staff on appropriate criteria for MRC admission and access to other community resources.
Allocate funding strategically to achieve broader goals	Fund MRC programs, housing units, housing- related services, and other needed interventions for people experiencing homelessness.
Clarify process for program referrals & coordinated entry participation	Allow for direct referral from shelters and unsheltered locations into MRC (especially to avoid ED/hospital readmissions).
Consider the information most needed for decision-making	Collect and share data relevant to homeless status and medical needs.
Center racial equity measurement and evaluation	Establish, track, and regularly evaluate performance metrics related to equity, which may mean recording/tracking homelessness status more consistently.
Advocate to address gaps in housing and health care	Regularly evaluate the impact of homelessness on hospital readmissions.
	Advocate for greater public funding for housing and to eliminate barriers accessing appropriate levels of care for people experiencing homelessness.

Conclusion

The expansion of medical respite programs nationwide reflects the ongoing demand for more extensive and holistic healthcare services for individuals experiencing homelessness. It also demonstrates the increasing recognition within communities and healthcare systems of the importance of establishing high-quality and alternative discharge options to foster health and recovery. The individuals who have collaborated to establish medical respite programs are actively pursuing an evidence-based and compassionate solution to address the current health and housing crisis in the country. By joining the network of medical respite program planners, they contribute to a collective effort dedicated to delivering safe and exceptional care for those experiencing homelessness who require a secure environment to recuperate. This commitment is beneficial to individuals and to the broader community.

As the landscape of recuperative care grows and changes, medical respite care providers and MCPs alike stay engaged with changes to health care policies and the climate in their area. Significant changes may have large implications for medical respite programs in terms of funding and service delivery. National, local, and state policies all impact how health care is delivered in a community, whether it is through increased funding for certain types of services or regulations on care. Keeping up to date with policies and changes, and understanding their implications, can be complicated. This is another instance in which engaging with stakeholders and community partners is beneficial in determining what is changing and what the intended or potential effects are. Stakeholders can stay informed and up to date by participating in learning opportunities with the National Institute for Medical Respite Care and the Respite Care Providers Network, and by working with other community organizations to develop increasingly-robust networks of care for medically-vulnerable people experiencing homelessness.

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