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Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care

Investing in Solutions for Homeless Populations

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Medical Respite Care

People experiencing homelessness have significant health care needs and use hospitals at higher rates and for longer periods of time than their housed counterparts.[1,2] Because they lack housing, hospital discharge planners often have difficulty finding safe and appropriate venues for these patients to rest, recuperate, and receive follow-up services after they no longer need acute care.[3,4]

Medical respite care programs can help solve this problem and offer a better setting for ongoing clinical care, more comprehensive case management, and care transition planning. While identifying permanent housing is the ultimate goal, medical respite care programs can help provide a more effective care transition between hospital and home.

This policy brief describes medical respite care programs, outlines the gaps in the continuum of care and funding sources for these care venues, and offers the rationale for investing in this care model. This brief also includes examples where Medicaid is currently paying for these services, and offers lessons learned and recommendations for stakeholders to consider. While prior publications outlined financing approaches in general, this report builds on these resources and responds to frequent technical assistance requests to establish consistent medical respite services in Medicaid.[5,6]

The goal of this brief is to give medical respite care providers, state and federal Medicaid leadership, and managed care organizations (MCOs) specific reimbursement options to incorporate into the care systems they are designing for medically complex homeless patients.

Medical Respite Care Programs

Medical respite care is acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover on the street or in a shelter, but are not ill enough to need hospital-level care. While the term "respite" traditionally refers to caregiver support, "medical respite care" instead refers to short-term residential care that allows patients who are homeless to recuperate in a safe environment while accessing medical care and other support services (e.g., case management, care coordination, connections to behavioral health care, medication management, etc.). Importantly, medical respite care is distinct from skilled nursing facilities, nursing homes, assisted living facilities, hospice care, and supportive housing programs.[7]

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[1] Feigal, J., et al. (November 2014.) Homelessness and Discharge Delays from an Urban Safety Net Hospital. Public Health 128: 1033-1035. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4258462/.
[2] Kertesz SG, et al. (January 2009.) Post-hospital Medical Respite Care and Hospital Readmission of Homeless Persons. Journal of Prevention and Intervention in the Community, 37(2): 129-142. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2702998/.
Zur, J., Linton, S., & Mead, H. (April 2016). Medical Respite and Linkages to Outpatient Health Care Providers among Individuals Experiencing Homelessness, [3]Journal of Community Health Nursing, 33 (2). http://dx.doi.org/10.1080/07370016.2016.1159439.
[4] Buchanan, D., et al. (July 2006.) The Effects of Respite Care for Homeless Patients: A Cohort Study. American Journal of Public Health, 96(7): 1278–1281. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1483848/.
[5] National Health Care for the Homeless Council (June 2017). Medical Respite Care: Financing Approaches.
[6] National Health Care for the Homeless Council (May 2016). Hospital Community Benefit Funds: Resources for the HCH Community.
[7] A note about terminology. The terms "medical respite care" and "recuperative care" are used interchangeably to describe the same service. "Recuperative Care" is defined by the Health Resources and Services Administration (HRSA) 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 Health Care for the Homeless Council's Respite Care Providers' Network adopted the term "medical respite care" on the grounds that it is more encompassing than the literal meaning of the term "recuperative."

There are widely varying approaches to medical respite care programs currently, with approximately 65 programs known to exist nationally.[8] These programs are located in a number of different settings, including homeless shelters, transitional housing programs, apartments, motels, or stand-alone facilities. Typically, these programs have between five and 35 beds (though some are larger) and are staffed with both clinical and non-clinical staff. While lengths of stay vary widely, most stays are several weeks to two months long. Admission criteria also has significant variation, though most programs require patients to be able to perform activities of daily living and have a condition that can reasonably be resolved in a short period of time. This ensures patients are receiving care in the most appropriate setting based on their needs.

Medical Respite Care

- Provides acute & post-acute medical care for people who are homeless and too ill to be on the street/in shelter, but not ill enough for hospital level care
- Shortens hospital lengths of stay, reduces readmissions, improves outcomes, lowers cost
- Differs from skilled nursing facilities, nursing homes, assisted living facilities, hospice care, and supportive housing programs

Gaps in the Continuum of Care

Most communities have few (if any) appropriate venues where people who are homeless can stay off their feet and recuperate from an illness or injury or connect to primary care, specialty care, and/or follow-up referrals when they are discharged from the hospital. The process for obtaining supportive housing takes at least several months, but often much longer. In the meantime, hospitals have nowhere to safely discharge homeless patients who still require post-acute care. Shelters, transitional housing, and recovery programs tend not to have medical staffing, are not conducive to healing, and frequently will return patients to the very hospital that discharged them. These types of programs also commonly require residents to depart in the early morning and not return until evening, leaving those with medical needs struggling to identify where they can rest during the day. Park benches and tent encampments typically are not safe or clean environments and do not offer needed services. Libraries and other public venues are not equipped to handle medical care needs or offer case management.

The majority of medical respite care programs provide a less intensive level of care than is required for entities with traditional licensures. Because of this, these programs tend to not align with existing regulatory or reimbursement structures, there is no dedicated federal funding source, and most policymakers are unfamiliar with them. However, while funding for these programs is currently a fragmented combination of public and private sources, established programs are becoming more sophisticated and demonstrating their value to insurers.

To help provide some credibility and structure, the National Health Care for the Homeless Council produced a set of national standards for medical respite care programs to promote a safe, hygienic care environment.[9] These standards were developed with the hope that it would lead to better recognition of the value of this model of care and sustainable reimbursement models. Because Medicaid is the primary insurer for people who are homeless,[10] state and federal Medicaid agencies and MCOs have a vested interest in having medical respite care programs available to them and their beneficiaries.

Rationale for Medical Respite Care in Medicaid

Gaps in the continuum of care and funding sources present opportunities for state and federal Medicaid policymakers and managed care plans to be more innovative in how they respond to the needs of their homeless beneficiaries. As vested stakeholders in the cost and quality of the health care services they finance and manage, Medicaid agencies and

[8] National Health Care for the Homeless Council, Medical Respite Directory.
[9] National Health Care for the Homeless Council (October 2016). Standards for Medical Respite care programs.
[10] National Health Care for the Homeless Council (January 2020). Health Insurance at HCH Programs, 2018.

MCOs can partner with medical respite care programs to offer a safe hospital discharge option, deliver needed services in a medically appropriate environment, reduce hospital lengths of stay, and lower overall costs of care. Additionally, there is tremendous incentive in the current environment to collaborate with community programs that can better address the underlying problems that drive poor health, frequent emergency department visits, longer inpatient stays, and higher readmission rates. Medicaid agencies and managed care plans thus have a tremendous incentive to fund medical respite care programs so they can better meet goals related to access, quality, and cost of care.

In addition, there has been significant growth in the number of states and territories implementing value-based payment (VBP) programs in just the last five years.[11] Such initiatives seek to improve quality and reduce cost by linking provider payments to defined outcomes. Medical respite care programs could help with achieving a number of identified goals, such as completing cancer screenings, linking to primary care, and receiving health education to manage chronic diseases (among others). Promoting medical respite as a care venue that can help with VBP goals could further add value for both payers and providers.

Current Funding Examples of Medical Respite Care in Medicaid

There are numerous ways to pay for medical respite care. Hospitals, private funders, and state/local governments are the most common payment sources.[5] However, state Medicaid programs and MCOs are increasingly recognizing the value of investing in these programs as well. While the details of each medical respite care program currently funded by Medicaid dollars vary, the payment arrangements are fairly straightforward:

- **Type of payment:** Medical respite care programs in Phoenix, AZ and Boston, MA are part of federally qualified health centers (FQHCs), which receive reimbursements as part of their negotiated rate with the state Medicaid program and/or MCOs [or Accountable Care Organizations (ACOs)]. In both of these programs, a medical provider delivers an eligible service each day a Medicaid-enrolled patient is in care and bills accordingly, as they would with any other health center patient visit.

  Medical respite care programs in Yakima and Seattle, WA; Los Angeles and Santa Barbara, CA; and Chicago, IL have negotiated individual payment rates with one or more of their contracting MCOs in four different ways. In these programs, MCOs are paying either a per diem rate, a capitated per-member-per-month (PMPM) amount, a one-time case rate (e.g., paying a lump sum for each admission per time period regardless of length of stay), or a monthly payment to reserve a designated number of beds (see table 1 below).

Table 1. Types of Payments to Medical Respite Care Programs

	Boston	Chicago	Los Angeles	Phoenix	Santa Barbara	Seattle	Yakima
Medicaid/FQHC payments	X			X			
MCO/per diem rate	X	X				X	X
MCO/capitated PMPM					X		
MCO/one-time case rate		X					X
MCO/pre-purchased beds		X	X				

- **Services included in payments:** While each payment arrangement varies, all but one includes the rich set of supportive services typically offered in medical respite care programs (case management, care coordination, health education, assistance with benefits, etc.).[12] Likewise, nearly all of these agreements include the cost of transportation, food, beds/housing, and administration. Note that some programs provide health care services onsite, while others

[11]Change Healthcare (2019). Value-Based Care in America: State-by-State/A 50-State Review of Value-Based Care and Payment Innovation.
[12] The exception is one MCO in Chicago where the rate only covers the cost of housing. This rate is currently being renegotiated to include a greater array of services.

have close relationships with offsite medical care. Table 2 below shows the types of services covered under the Medicaid/MCO payment.

Table 2. Services Included in Medical Respite Payments, by Site

	Boston	Chicago	Los Angeles	Phoenix	Santa Barbara	Seattle	Yakima
Onsite health care services	X			X		X	
Support services (case management, care coordination, benefits, health education, medication management)	X	X	X	X	X	X	X
Food	X	X	X		X	X	X
Beds/housing	X*	X	X		X	X	X
Transportation	X	X	X				X
Administration/indirect costs	X		X	X	X	X	X

*Notes: Services not included in the medical respite payment rate are covered through other funding sources (e.g., onsite health services billed directly, use of private/philanthropic funds, etc.). Boston is only able to capture room and board expenses from the MCO/ACO payments (not state Medicaid) because they have negotiated greater flexibility with these entities.

- **Additional collaboration between program and payer:** Programs have varying agreements with their payers for how they collaborate. One of the medical respite care programs issues a census report to their MCO three times a week, holds a weekly case conferencing meeting, and provides a monthly discharge summary. Another program issues weekly census reports and will soon issue quarterly outcome reports. Another program provides an annual report to each MCO. Yet another program invites MCO staff to quarterly steering committee meetings to discuss program updates and improvements as well as patient success stories. The remaining three programs do not have additional data or collaboration requirements specific to the medical respite care program. These approaches offer MCO partners different ways of becoming more closely involved in client care and provide a greater understanding of the value of medical respite care program.

Medical Respite Care Program Descriptions in More Detail

Medical respite care providers are dedicated to meeting the unique needs of vulnerable and medically complex people experiencing homelessness, often working with very limited resources. When they are able to collaborate with their Medicaid/MCO partners and achieve more sustainable funding for services, they are able to improve the quality of care they provide, demonstrate the value of medical respite as a needed health care intervention, and serve more people. There is also great pride and satisfaction when patients are able to get the care they need and go on to a more stable living situation, thus ending their experience with homelessness.

- **Circle the City in Phoenix, AZ:** This 100-bed program started in 2012 and became a federally qualified health center (FQHC) in 2015. As a health center, this program has beds at two locations and receives a standardized rate in return for billable services. Circle the City receives one payment for each day that a Medicaid-enrolled patient sees an eligible provider. For example, if a respite patient receives a professional service from a physician five times in a week, the program will be reimbursed for five FQHC visits that week.
- **The Stacy Kirkpatrick House at Boston Health Care for the Homeless Program, MA:** This freestanding, 20-bed program is part of the Boston Health Care for the Homeless Program (BHCHP), an FQHC, and offers 24-hour case management support, daily nursing services, 12 hours per week of nurse practitioner/physician care, and recovery

groups. The program admits medically frail patients from a nearby, higher-intensity medical respite care program (The Barbara McInnis House) who continue to need ongoing care, but not 24-hour clinical services. Nurses in the program are performing dressing changes, medication management, and health education, among other services. Patients in this program usually stay four to eight weeks to finish a treatment regimen (e.g., IV antibiotics, wound care, post-surgical healing, etc.) or they are staying for longer periods because they have significant chronic medical conditions, have not been approved for housing, and are not yet ready to return to the street or a shelter. As a health center, BHCHP rates have been negotiated with the state Medicaid program as well as with the local ACOs and MCOs. Because managed care can offer greater flexibility in how payment models can be designed, BHCHP has been able to work with its ACO and MCO partners to also include room and board costs in those negotiated rates.

- **Cottage Health Recuperative Care Program in Santa Barbara, CA:** Started only recently in October 2018, this 10-bed medical respite care program is located at the local shelter. It is unique in that it is served by one county-organized MCO while the medical respite care program is operated by Cottage Health, a hospital-based health care system. The MCO established a maximum budget for supporting three medical respite care programs in the area, divided its total budget across the number of respite beds located in each of the three programs, and established a capitated PMPM for Cottage Health based on utilization of its 10 beds. Since this arrangement is relatively new, the MCO will be evaluating utilization and making adjustments based on actual, rather than projected, bed use.
- **National Health Foundation in Los Angeles, CA:** This 61-bed, stand-alone facility focuses on medical case management, care coordination, medication education, and connection to primary care providers. However, it does not provide onsite clinical care. Four MCOs contract with NHF to pre-purchase (or lease) a specified number of beds. Rates for the beds are set in a three-tiered format, with the highest per-bed price point set for those purchasing 1-5 beds, a lower rate set for 6-10 beds, and the lowest rate set for purchasing 11 or more beds. This cost structure incentivizes plans to purchase more beds. MCOs pay for their reserved portion of beds at the first of each month, with payment due whether the beds were full or empty on any given night.
- **Edward Thomas House, Harborview Medical Center in Seattle, WA:** This 34-bed, stand-alone facility is operated by Harborview Medical Center (a county public hospital across the street). In 2013, the Washington State Health Care Authority (state Medicaid agency) sent an email to MCO plans giving approval for MCOs to recognize a home health care service billing code (HCPCS code G9006) to reimburse medical respite care programs for their services in lieu of hospitalization. This code was not in use at the time given the myriad of other home health care codes, and is approved to be designated for this specific purpose. No additional coding is needed to realize reimbursement. Subsequently, Edward Thomas House established a per-diem rate that is inclusive of all services provided at the program. In order to obtain reimbursement, the program must provide at least one clinical interaction a day, whether that be care coordination, a nurse visit, or a psycho-social assessment. If the client does not receive any service on a given day, the program does not bill for a per diem rate that day. Currently, there are five MCO plans serving the community, and four have contracted with Edward Thomas House for medical respite reimbursements. Efforts to contract with the remaining MCO are ongoing.
- **Yakima Neighborhood Health Medical Respite Program in Yakima, WA:** This 10-bed program includes a registered nurse, behavioral health specialist, outreach worker, care coordinator/case manager, and housing specialist who are all supported at the nearby FQHC by medical and dental providers. The program has received MCO reimbursements since 2015. Primary care providers or the hospital provider will refer patients to the program, but a nurse at the respite program determines appropriateness of admission and then notifies the MCO with the diagnosis, reasons for referral to respite, and an anticipated length of stay. The program submits claims to three participating MCOs using the HCPCS G9006 code in addition to the standard admitting/discharge medical coding. Each of the three managed care plans has a different financing arrangement. Plan 1 pays a per-diem rate, with an annual cap per patient. Plan 2 pays a case rate based on a set fee, with an annual cap per patient, regardless of length of stay or number of admissions throughout the year. Plan 3 pays a case rate based on a set fee, with a two-year cap per patient,

regardless of length of stay or number of admissions in a two-year period.

- **The Boulevard in Chicago, IL:** This 64-bed medical respite care program is located in a large transitional housing facility and serves approximately 300 individuals per year. The program provides onsite health and behavioral health care, assessments, support services (meals, case management, transportation, life skills, group education, etc.) and housing services (assess needs, identify options, and secure placement). The Boulevard contracts with three managed care plans to receive payment for their medical respite services. Since 2012, Plan 1 contracts for capitated, one-time payments per patient per year that are divided into two tiers regardless of actual length of stay. One payment level is for routine care up to 30 days, and a higher payment level is for more complex clients who need more than 30 days of care. Since 2014, Plan 2 pays a daily rate and is invoiced monthly for the eight reserved beds. Since 2018, Plan 3 contracts to pay a monthly per diem rate for each day one of their members is admitted to the program.

Lessons Learned

Program administrators from both MCOs and medical respite care programs described four common themes as they recounted their lessons learned from working together to pay for services:

- Ensure that negotiated payments cover the cost of the services being provided
- Establish value by developing outcome measures and evaluating cost savings
- Develop strong positive relationships between medical respite and Medicaid and MCO staff and leadership
- Consider a statewide Medicaid benefit to achieve more program stability and alleviate the administrative burden of negotiating payments on a plan-by-plan basis

California Statewide Proposed Medical Respite Funding Policy

California has proposed a Medicaid 1115 waiver application that includes a provision to make medical respite care a statewide Medicaid benefit (though California uses the term “recuperative care”). As part of its proposed menu of “in lieu of” services, the medical respite care service would need to be:

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. not inclusive of funding for building modification or building rehabilitation.

It is important to note that this waiver has not yet been approved by U.S. Department of Health and Human Services, but it provides a good example of how states are thinking more broadly about implementing a statewide benefit for medical respite care.

Recommendations

Medical respite care providers, state and federal Medicaid policymakers, and MCO leadership across the United States are able to replicate the payment arrangements described below (see table 3). Use this policy brief to begin (or further) discussions about the best financing options given the program model, the level of Medicaid enrollment among patients, and the clinical and supportive services needs of vulnerable clients. The ultimate goal is to provide high-quality, cost-effective, sustainable care for those needing short-term, post-acute hospital care.

Table 3. Actions to Consider

Medical Respite Care Providers	State & Federal Medicaid Policymakers	Managed Care Organizations
Establish a payment rate that covers the cost of services being provided	Encourage FQHCs and other health care providers to include medical respite among their services	Conduct data analyses to determine prevalence of beneficiaries who are homeless, evaluate service utilization, and determine need for medical respite care programs
Develop strong relationships with Medicaid directors and MCO staff at all levels	Consider statewide Medicaid benefit for medical respite care	Convene stakeholders to discuss data, patient experiences, and feasibility of creating medical respite care programs
Work with MCO staff to establish the need for a medical respite care program	Authorize MCO plans to reimburse for medical respite services based on a designated billing code	Be proactive to champion the need for a wide range of specialized services for people who are homeless and have complex health care needs
Develop outcome measures and identify benchmark goals to demonstrate value	Consider how medical respite care will benefit value-based payment initiatives	Tour existing medical respite facilities with care coordination staff and others who are involved with patient care
Periodically evaluate outcome measures and payment rates to ensure they reflect current needs	Issue federal guidance that describes medical respite care programs, encourages states to adopt these models of care, and outlines reimbursement options to consider	Contract with medical respite care providers to pay for needed services

Conclusion

As states continue to seek cost-effective alternatives to address emergency department and inpatient hospital readmission rates for Medicaid beneficiaries, medical respite care programs provide appropriate discharge venues so people who are homeless can receive needed post-acute care. These venues not only help improve health outcomes, but they also provide a care setting based on dignity and respect.

Partnerships between medical respite care programs and payers like state Medicaid agencies or managed care entities are increasingly negotiating reimbursement arrangements to help close the existing gap in needed services for this complex population. As states and local communities continue to integrate new service approaches for special populations, current methods of paying for medical respite care can be replicated more widely. Looking ahead, medical respite program staff, state and federal Medicaid policymakers, and MCO leaders can all take steps to further promote this model of care.

Further Resources

- Standards for Medical Respite Care Programs
- Medical Respite Care Program Directory
- Tool Kit (research, template contracts, planning materials, etc.)
- Respite Care Providers Network
- Policy brief: Medical Respite Care: Financing Approaches
- Policy brief: Medical Respite Care Programs & the IHI Triple Aim Framework
- Policy brief: Managed Care and Homeless Populations: Linking the HCH Community and HCH Partners
- Technical Assistance requests

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