

Approaches to Financing Medical Respite/Recuperative Care Programs

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1.0 Executive Summary

Individuals experiencing homelessness are at higher risk for complex health conditions and often have nowhere to heal safely when they are discharged from a hospital inpatient admission. Care providers and hospital discharge planners struggle to find safe and appropriate (i.e., non-shelter) referrals for these patients to rest and recuperate. This represents a serious, persistent, and expensive challenge for ill patients at risk of homelessness who need access to care and supportive follow-up services. Without a safe place to recover following hospital discharge, patients experiencing homelessness have a high likelihood of using hospitals at higher rates and for longer periods of time.

Many public and private health organizations are looking to address this problem through strategies that reduce inpatient hospital stays and readmissions, while also decreasing homelessness. Medical respite programs offer a solution by providing temporary care and support strategies for individuals who are too sick to be in a shelter or on the street, but not sick enough to remain hospitalized. This can deliver significant health and wellbeing improvements for those served and reduce the overall costs of care.

This white paper describes trends and opportunities for funding medical respite programs and services and offers methods to expand and scale programs through innovative financing mechanisms and increased flexibility in payment policy. The paper outlines various approaches to finance medical respite programs, offering providers, state and federal Medicaid leadership, policymakers, and managed care organizations (MCOs) specific partnership options to ensure continuity and quality of care for patients with long-term health and housing needs.

1.1 The Crisis of Homelessness

While the supply of transitional housing and permanent supportive housing (PSH) has increased in nearly every state during the past decade, soaring eviction and unemployment rates have thrown many Americans into crisis. The 2020 national Point-in-Time count of homeless individuals revealed more than 580,400 individuals experienced homelessness on any given night in the U.S., with nearly 226,100 living on the streets or in abandoned buildings.¹ The pandemic has further illuminated health disparities and vulnerabilities for individuals experiencing homelessness, and deficiencies in the systems that support them. An Aspen Institute analysis of US Census data in 2020 showed an estimated 30-40 million people in America could be at risk of eviction due to the confluence of the

¹ HUD 2020 Continuum of Care Homeless Populations and Subpopulations

COVID-19, economic uncertainty, and a lack of affordable housing.² Homeless service providers are bracing for the additional demand for services as a direct result of the end of eviction moratoriums. These providers have limited resources to expand services to meet anticipated capacity. And additional demand will likely divert resources from efforts to develop more resilient programs that can respond to future crises.

Individuals experiencing homelessness are at increased risk for serious illness, which is often caused or exacerbated by their living conditions. A combination of factors, including poor nutrition, inadequate hygiene, exposure to violence, climate-related illness and injury, exposure to communicable diseases, and the constant stress of housing instability all have profound negative effects on the health of homeless individuals and families.

1.2 Why Medical Respite

Medical respite is an intervention that provides post-acute medical care for individuals experiencing homelessness who are not sick enough to warrant hospitalization, but who are too frail or ill to recover safely in a shelter or on the streets. By providing a safe bed, clean restrooms, nursing assistance, and appropriate meals, medical respite services can improve health outcomes and begin a process of addressing other critical health-related social needs, such as stable housing.

Once individuals experiencing homelessness are discharged from a hospital, they often land back in a shelter, transitional housing, or recovery programs that are often not equipped with medical staff to provide ongoing treatment. While roughly two-thirds of homeless patients spend their first night after hospital discharge at a shelter, about 11% spend their first night on the streets.³ Respite care bridges the gap between hospital and home, providing hospitals a reliable discharge option and individuals experiencing homelessness with a space to rest, recuperate, and work toward achieving improved health, overall well-being, and stable housing.

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.⁴ Given that medical respite represents a mere 5-10% of the cost of an average hospital day, these programs can both save money and deliver more appropriate and effective care.

The National Health Care for the Homeless Council established a set of [Medical Respite Standards](#) to encourage providers to learn about and prioritize best practices to optimize high levels of care and improve health outcomes. These standards not only provide a roadmap for practitioners to build successful programs, but also suggest necessary services that should be provided and adequately financed for program success. These standards are as follows:

² Aspen Institute: The COVID19 Eviction Crisis

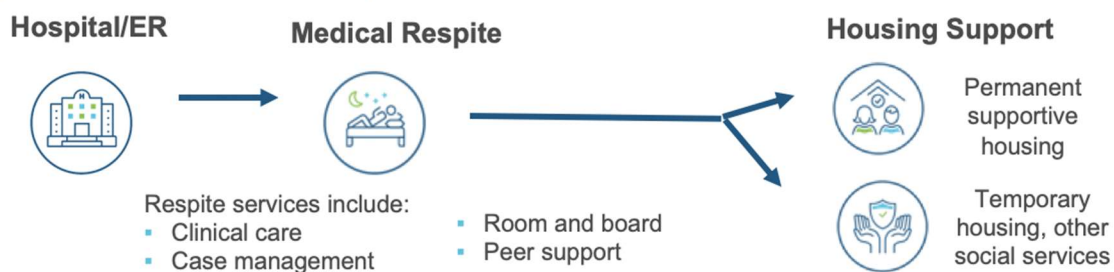
³ Understanding Transitions in Care from Hospital to Homeless Shelter: a Mixed-Methods, Community-Based Participatory Approach

⁴ Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons

- Safe and quality accommodations
- Environmental services
- Safe care transitions into medical respite from other settings
- Access to high quality post-acute clinical care
- Care coordination and wrap-around services
- Safe care transitions out of medical respite to the community
- Quality improvement

The diagram below depicts a sample medical respite program model:

Program Model: Medical Respite



While programs can vary, baseline services typically include clinical care, case management, and a housing component that focuses on peer support and behavioral health needs. These services differ across sites based on geography, demonstrated need, physical space / building constraints, funding sources, and access to capital.

2.0 Challenges and Demonstrated Need

2.1 Reimbursement Challenges

Medical respite programs do not receive sufficient Medicaid reimbursement to fully cover operating expenses. As a result, these programs differ substantially in terms of scale, funding levels, and available services. It also means that there are always funding gaps to be filled which requires service providers to focus on fundraising as opposed to service delivery. This prevents providers from funding expansion services that intervene in arenas of behavioral, physical, and mental health care – all of which could make their programs more effective. Because non-reimbursable services may make up a large portion of the total model of care, medical respite programs can struggle to find sustainable financing, which often results in limited capacity and/or a discontinuation of care for patients who need it.

Medical respite service providers often lack the internal capacity to collect, track, and report data accurately, which limits visibility into the need for broader changes to referral and reimbursement processes. The complicated referral landscape and tracking challenges makes it difficult for medical respite programs to make the case for expanding respite services to more people, barring

opportunities for risk averse payors to provide sustainable capital. This challenge can be mediated through more health partnerships across service lines that measure data to show outcomes, which are starting to emerge as social determinants of health becomes a focus of intervention for multiple parties.

While many medical respite programs experience funding gaps, the magnitude of the gap varies based on the provider and facility type. Medical respite programs operated by, or in partnership with, a Federally Qualified Health Center (FQHC) benefit from the Medicaid Prospective Payment System (PPS) which allows FQHCs to receive a bundled payment to cover the cost of providing comprehensive care to patients, leaving them with a gap to cover room and board. While the PPS intends to create a uniform payment system for FQHCs, current regulations allow states to develop unique Advanced Payment Methodologies and value-based payment arrangements for FQHCs, provided they offer a total reimbursement equal or greater to PPS. Alternatively, medical respite programs located within shelters may already receive funding for room and board and instead, may have difficulty obtaining reimbursement for services such as nursing care.

A sample reimbursement model for a non-shelter, FQHC-led or with a FQHC-partnered, medical respite program is depicted in the table below:

Landscape of Reimbursable Medical Respite Services

Reimbursable Services	Non-Reimbursable Services
<ul style="list-style-type: none"> Individualized treatment plans/care management Psychiatric and health assessments Residential primary care Screenings, treatment, and prevention for HIV/AIDS Clinical health education Inpatient psychotherapy Medication Assisted Treatment Outpatient treatment 	<ul style="list-style-type: none"> Employment assistance Transportation to external services Room and board Housing navigation Transitional housing Permanent supportive housing Long term counseling and care

**Note: This table only includes state reimbursement guidelines. Non-FQHC designated medical respite facilities may not receive reimbursement for as many services and may have a greater funding gap.*

Medicaid, Managed Care Organizations (MCOs), and state and federal agencies such as the Center for Medicare and Medicaid Services (CMS) have made encouraging progress in creating sustainable financing solutions for medical respite programs, since many individuals experiencing homelessness in need of medical care qualify for Medicaid. This progress is even more salient in expansion states, where more individuals with critical health needs become eligible for Medicaid, needs that could be improved and mitigated through medical respite. With more patients covered by Medicaid, medical respite programs in expansion states can achieve singular funding streams from MCOs since these patients are already beneficiaries of their services. In non-expansion states, Medicaid covers a much

smaller portion of patients struggling with homelessness who need additional services post-discharge, which leaves a larger financing gap for service providers to fill that requires multiple funders.

Managed care plans 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. For example, measuring health plan data from medical respite programs annually shows promising outcomes, including:

- 24% reduction in Medicaid cost per enrollee⁵
- 30% decrease in hospital admissions⁶
- 38% reduction in emergency department visits⁷
- 92% attendance rate at follow-up appointments within 30 days of hospital discharge⁸

The following sections lay out how healthcare providers, local governments, and community stakeholders have funded services in the past, and how they can finance additional respite services to achieve desired outcomes through various funding models and policies.

3.0 Traditional Models for Medical Respite Payments

3.1 Grant Funding

Historically, many medical respite program structures have relied on short-term grants with limited reimbursement from Medicaid, which constrained their ability to administer a wider range of needed services. Reapplying for grants to fill funding gaps requires significant time and resources that impede scale and sustainable, long-term planning efforts, even if the community needs are greater than their current service offerings. Only seeking grant funding to finance a program can inhibit the development of partnerships with healthcare stakeholders and providers like health systems and plans.

Mixed Grant Funding Example: Christ House Inc.

Christ House is a Washington D.C., based residential medical respite facility that provides 24-hour comprehensive health care to sick individuals struggling with homelessness. Operating at a 33-bed capacity, Christ House provides shelter, substance use counseling, case management, appointment transportation, patient activities, and meal services. Christ House also runs a permanent supportive housing program for patients with chronic health conditions that prevent them from finding full time work. This program funds 47 formerly homeless patients to go through a 12-step program to recovery. Funding for the medical respite program's \$3.5 million operating budget comes from grants and contributions from multiple philanthropic foundations.

⁵ ROI Calculator for Partnerships to Address the Social Determinants of Health

⁶ Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons

⁷ When Crises Converge: Hospital Visits Before and After Shelter Use Among Homeless New Yorkers

⁸ HCIA II Final Performance Progress Report

3.2 Local Health System and Government Funding

Another common payment source for public health, social services, and behavioral health services is local government. In select states, some local governments have taken part in improving the health of chronically ill people who experience homelessness through providing grant funding toward medical respite programs. Usually these grants are local, need based, and distributed on an annual basis.

Local Government Funding Example: Baltimore Healthcare for the Homeless

Baltimore Healthcare for the Homeless (HCH) operates a 25-bed medical respite program at the largest public shelter in Baltimore, MD. The program is collaboratively run through a partnership between HCH, which manages the medical respite program, Catholic Charities, which oversee the shelter, and the Baltimore City government, which owns the facility and dictates the local continuum of care. Half of the cost is funded by the State of Maryland via a statewide hospital pooling system, 25% is funded by the City through the continuum of care, 13% is funded through a private grant, and 12% is funded through Medicaid billing for eligible medical encounters and nursing visits.

4.0 Emerging Trends of Medical Respite Payment Models

4.1 Partnership Opportunities with Managed Care Plans

Many MCOs are unfamiliar with contracting and paying for services that are not reimbursable services in their state Medicaid plan. Many managed care plans worry about the impact of paying for respite services beyond those that are currently reimbursable through capitation rates and calculations. Two of their main questions and concerns are how contracting for these services will affect their medical loss ratio and calculation of their capitated rates. While strategies to mitigate these concerns will differ state to state, there is often the potential to develop a quality improvement focused contracting mechanism that aligns as closely as possible to the allowances in a state's health plan.

Service providers can establish business relationships with MCOs, hospitals, health systems, and state governments to create contractual partnerships that provide sustainable revenue for their programs. Increasingly, medical respite programs are receiving predictable revenue from MCOs seeking to improve member outcomes and reduce costs. Many MCOs have provided medical respite as a benefit to their members through a per diem payment, a per-member-per-month, a one-time case rate, or a monthly payment to reserve a designated number of beds in a medical respite program, which can cover all services needed and therefore, leave the provider without a financing gap for MCO members in need of medical respite.

By taking a more prominent role in funding medical respite services, managed care providers and Medicaid agencies can be directly involved in gathering data to track and assess health outcomes, patient priorities, and patient satisfaction. This is exactly the type of continuous learning and improvement collaboration needed to further validate medical respite as an important and viable model of care. MCO-CBO agreements can also fund additional programming such as housing

assistance, workforce development, outpatient counseling, and education, which helps members get back on their feet.

MCO Funding Example: Central City Concern, Portland

Central City Concern (CCC) is a 40-year-old Portland, Oregon-based nonprofit that serves individuals impacted by homelessness, poverty, and addiction. CCC operates a 35-bed Recuperative Care Program, which is synonymous with medical respite. CCC works closely with local hospital systems and CareOregon - a health plan that administers Oregon Health Plan (Medicaid) - to identify patients in need of medical respite and case management. CareOregon serves as an enhanced partner with CCC, directly staffing its primary care teams with Health Resilience Specialists. CareOregon employees work in primary health homes and specialty practices to provide high utilizers of the healthcare system with additional support. To provide a full range of services to patients, CCC partners with a wide variety of organizations such as food banks, primary care clinics, mental health providers, housing nonprofits, Meals on Wheels, and the Portland Housing Bureau.

4.2 Expanding Government Funding Through Policy

State agencies can also develop policies that help advance new versions of medical respite by making all necessary medical respite services a completely covered benefit for Medicaid beneficiaries. This benefit would continue to make medical respite programs easier to launch and maintain, by requiring or incentivizing plans to offer respite as a benefit to all eligible members. Doing so also would allow policy makers and healthcare providers to better measure outcomes and evaluate the success of medical respite facilities in each geography through more robust access to claims data from covered services. By making medical respite programs core Medicaid covered benefits, policymakers can improve the medical respite landscape through expanded services, resources, and access points for Medicaid beneficiaries.

MCO Funding Example: Policy Change

In December 2020, CMS approved a 12-month extension of California's 1115 demonstration, "Medi-Cal 2020" to expand Whole Person Care (WPC) pilots that coordinate physical and behavioral health and social services for designated high utilizers. The WPC program encourages counties, cities, hospital authorities, health plans, providers, and community-based organizations (CBOs) to harness their collective resources to identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

After 12 months, Enhanced Care Management and In Lieu of Services (ILOS) will replace WPC pilots, scaling up interventions to form a statewide care management approach.

ILOS, which include medical respite, are medically appropriate and cost-effective alternatives to services covered under Medicaid to address complex costly health challenges that are impacted by social determinants of health. Through contracts with community-based organizations including homeless service providers, housing authorities, medically tailored meal providers, and Counties, MCOs will be permitted to offer ILOS wrap around services and funding that yield positive outcomes and cost savings and fill gaps in state plan benefits and health needs.

4.3 Improving Services Through Sustainable Financing

Medical respite programs that identify stable funding sources have the capacity to provide a wider array of services through a community-aligned operating model that measures outcomes crucial to program success. With stable upfront funding and service costs, medical respite program service providers can offer enhanced services to people in need, including expanded physical, mental health, and social services that extend from residential care to well beyond discharge. These services include:

- Expanded nursing care, behavioral health services, and capacity for licensed social workers
- Longer-term respite care and outpatient services (i.e., longer lengths of stay)
- No specific admission criteria beyond homelessness and health needs
- Workforce development, family counseling, and connection to housing

In this virtuous cycle, enhanced services become more readily available with greater flexibility in financing, and improved outcomes can be achieved that contribute to lower costs and long-term wellness of people who are supported by medical respite facilities. Key metrics relating to employment or housing stability include reductions in avoidable emergency department visits and hospital admissions (and readmissions) and improved adherence to medication. Other key program features include access to case management, referrals to transitional or permanent housing, improved chronic disease management, and access to behavioral health and substance use services.

5.0 Funding Opportunities

To optimize the cost and quality of services offered by Medicaid, MCOs can partner with medical respite care programs managed by CBOs 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.

An array of financing strategies through MCO-CBO partnerships are shown in the figure below:

Funding Opportunities to Scale Programs Through MCO-CBO Partnerships

	Direct value-based contracting	Single outcomes-based investment deal	Outcomes-based fund
	Value-based contract established between CBO and health plan based on CBO costs and estimated program benefits to the health plan	Outcomes-based investment deal that provides one-time financing for CBO upfront costs for a single program and geography	Outcomes-based investment fund that finances CBO upfront costs for priority programs in multiple geographies
Value-based contract between CBO and health plan	✓	✓	✓
3 rd party investors finance upfront CBO funding gap		✓	✓
Fund structure with seed capital used to attract greater investment dollars			✓

5.1 Direct Value-Based Contracting

Through outcomes-based financing, CBOs can tap into external capital that allows them to build capacity, transfer program performance risk, and reduce upfront and overall costs for health plans. As part of this approach, a direct value-based purchasing agreement can be established between a CBO and one or more health plans, basing CBO costs on size and scale and estimated program benefits to the health plan(s). With MCOs providing upfront capital with the intent of being repaid through outcomes, CBOs can test a service model that promises to improve member outcomes while reducing costs, where the achievement of outcomes drive enhanced measurement, transparency, and accountability.

5.2 Single outcomes-based investment

If the upfront funding is not met due to a larger volume need or an expansion to multiple sites, third party investors such as MCOs, health plans, or impact investors can fill that funding gap and be repaid upon achievement of outcomes and cost savings. These partnerships are essential to increasing the capacity and successful outcomes of medical respite programs by reducing the risk and cost burden that each entity would have to shoulder alone.

5.3 An Outcomes-Based Fund to Engage Multiple Stakeholders at Scale

By engaging a braided system of multiple stakeholders along multiple service lines, larger and longer-term medical respite programs can be funded through shared contributions to a health outcomes fund that can support programs at a larger scale. This fund – managed by a third party with additional funding provided by impact investors - provides upfront capital for program development, reducing the risk of involvement for CBOs and MCOs so they can focus on delivering services and improving outcomes. As outcomes are measured and improved over a larger scale, savings can be rendered across all parties that prove the viability of services.

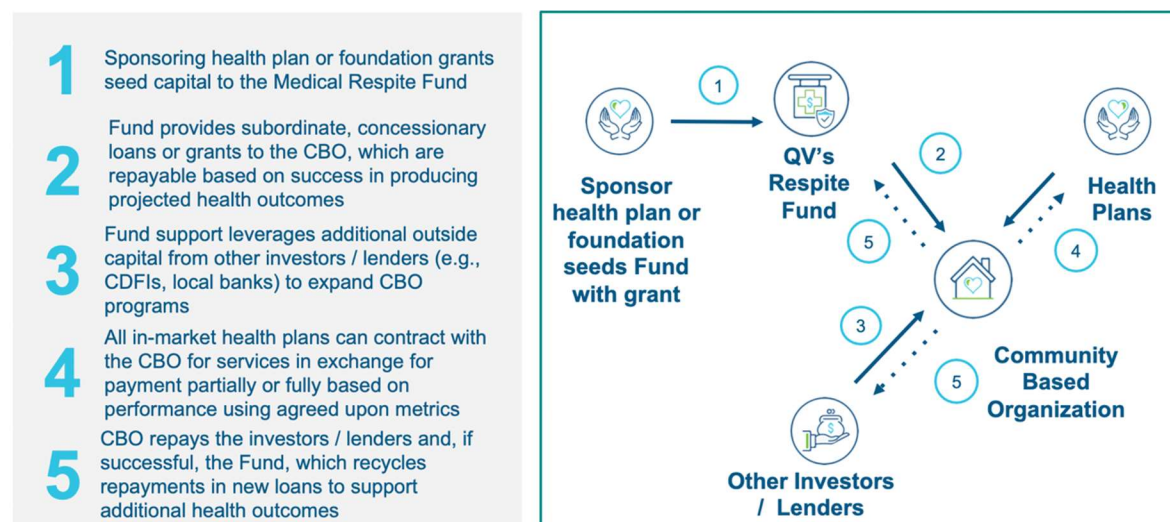
Multiple Payor Program Example: Harborview Medical Center

Harborview Medical Center is a public hospital located in Seattle and run by the University of Washington. In 2011, Harborview opened the Edward Thomas House at Jefferson Terrace, a 34-bed medical respite program. The program is built on a harm reduction philosophy, as case managers and medical providers work closely with patients to treat medical issues, mental illness, and substance use, and to provide more stable access to primary care, public benefits, and permanent housing. The medical respite program is funded through local hospitals, contracts with four Medicaid managed care organizations, County grants, and the Public Health Department.

Accountability among all involved parties ensures alignment of goals and supports achievement of positive health outcomes. This can reduce reliance on public and private grants – helping to streamline and enhance program revenue while freeing up time and human resources to focus on providing optimal care. While this model provides more sustainable funding to expand medical respite programs and services, referrals and reimbursement are still a challenge for practitioners, since reimbursement structures do not include medical respite services in billing codes in all states.

The figure below depicts a Medical Respite Fund strategy that could combine various sources of capital to make medical respite services sustainable over time and provide an opportunity to expand based on need:

Fund Strategy to Leverage Capital More Effectively



6.0 Future State

6.1 Strategies for Preparing Effective Funding Agreements

To determine which of the financing models outlined in section 5 is most appropriate for a given program vision and geography, it is important to:

- Understand the landscape of funding and reimbursement and any gaps that need to be filled by additional payors
- Identify stakeholders, policy makers, and service providers with similar priorities who might be interested in partnering
- Establish an evaluation plan for data collection and outcomes that can be measured over a set time period
- Determine the level and nature of medical respite need in the community, and identify ways to meet population need through service offerings
- Accurately estimate up front as well as ongoing operations and maintenance costs at scale that would play into the contract
- If a funding gap exists, determine who provides upfront funding to the service provider and negotiate first-loss capital agreements where needed

The table below provides an overview of actions that various healthcare stakeholders can take to establish ongoing partnerships that progress medical respite financing, reduce the overall healthcare cost burden, and ensure sustainability and quality of care:

Future State Timeline

	Short Term	Medium Term	Long Term
Provider	<ul style="list-style-type: none"> ▪ Identify needed medical respite services from landscape assessments 	<ul style="list-style-type: none"> ▪ Administer a plan of action for health intervention, including on the ground information to increase user access 	<ul style="list-style-type: none"> ▪ Establish sustainable service model that meets population health need
Health System	<ul style="list-style-type: none"> ▪ Establish data collection and evaluation systems to evaluate medical respite outcomes 	<ul style="list-style-type: none"> ▪ Provide claims data to service providers and health plans to measure outcomes 	<ul style="list-style-type: none"> ▪ Track positive outcomes through claims data and cost savings to support research base of health outcomes
Managed Care Organization	<ul style="list-style-type: none"> ▪ Understand the landscape of data collection and outcomes achieved ▪ Understand need in plan and community, to estimate scale and expansion costs that would play into a contract 	<ul style="list-style-type: none"> ▪ Identify funding gaps and reimbursement limitations ▪ If a funding gap exists, determine who provides upfront funding to CBO (health plan or third-party investor or a mix of the two) 	<ul style="list-style-type: none"> ▪ Finalize certainty of program outcomes and establish long term capital through an outcomes-based financing agreement
Government Policy	<ul style="list-style-type: none"> ▪ Understand the need and opportunity for expanded reimbursement codes for medical respite ▪ Consider how medical respite will benefit internal initiatives and priorities 	<ul style="list-style-type: none"> ▪ Encourage FQHCs and other health care providers to include medical respite among their services ▪ Authorize medical respite programs to reimburse for expanded services 	<ul style="list-style-type: none"> ▪ Implement statewide Medicaid reimbursement benefits for medical respite

Medical respite will continue to be a needed service across the United States as rates of homelessness, substance use disorders, and mental health issues persist. Novel approaches to finance and scale medical respite programs are increasingly common, as the benefits of (and imperative to move toward) value-based care become more realized. Service providers, health care companies, and state governments are in strong positions to improve services and meet the increasing demand through new partnerships and financing agreements.