

# Statewide Medicaid Benefit for Medical Respite Care

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## Issues Informing Benefit Design and Implementation

Engrossed Substitute Senate Bill 5092, Sections 211(69) and 1210(75), Chapter 334, Laws of 2021

January 15, 2022



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## Executive Summary

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**Background:** ESSB 5092 (2021), Sections 211(69) and 1210(75) directed the Health Care Authority (HCA) to develop an implementation plan to incorporate medical and psychiatric respite care as statewide Medicaid benefits. This plan includes a description of medical respite care nationally and in Washington State; feedback from interested stakeholders (to include hospitals, Medicaid managed care organizations, federally qualified health centers (FQHC), organizations providing medical respite care, consumers, and Tribal members; an analysis of the cost-effectiveness of providing medical and psychiatric respite care benefits for Medicaid enrollees; strategies for successful community partnerships with homeless services providers; and additional issues to consider moving forward.

**Medical Respite Care: A National Model:** People experiencing homelessness (PEH) have high rates of chronic and acute medical conditions, behavioral health issues, and needs for supportive services. As a result, this population also experiences high rates of emergency department (ED) and inpatient hospitalizations. Lack of discharge options and other factors lead to high re-admission rates and poor health outcomes for this vulnerable population. To help address these issues, [medical respite care](#) (MRC) programs offer acute and post-acute medical care for PEH who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. These programs provide short-term residential services (often in a shelter or transitional program) coupled with support services and access to medical care. There is a nationwide need for MRC programs because of the lack of affordable housing and the significant health care needs of PEH. As of January 2022, there were nearly [120 MRC programs nationwide](#). While these programs vary significantly in their scope and intensity of services, they share the same [defining characteristics](#) and ensure quality of care through [national standards](#) that can be applied to any program model.

**Medical Respite Care in Washington State:** There are [eight known MRC programs](#) in Washington State that use different models of care, and additional programs are in various stages of development. Most programs are based in homeless shelters (or other congregate settings) and offer a package of supportive services daily such as care transitions and coordination/medical case management, outreach, medication management, care plan development, education, connections to health care providers, enrollment in benefits, assessment of behavioral health care needs, crisis stabilization, and housing assessments/referrals. In many of these programs, most medical and behavioral health treatment services are provided by FQHCs or other community health care providers. Two of these eight MRC programs in Washington State currently receive Medicaid reimbursements through either a per diem rate, or a fixed case rate (with an annual or bi-annual cap per person). An additional program in King County takes a novel approach to helping people experiencing homelessness with an acute need for psychiatric stabilization but without a co-occurring acute medical condition necessitating on-site intensive medical care.

**Feedback from Listening Sessions with Stakeholder Groups:** Listening sessions were conducted with MRC program staff, FQHC staff, hospital discharge planners, managed care organizations, homelessness services providers, consumers, and Tribal council members. They offered perspectives related to the following areas:

- Barriers to Higher Levels of Care
- Aspects of a Statewide MRC Medicaid Benefit:
  - Value of MRC programs
  - Advantages of a statewide benefit
  - Services to include in a statewide benefit
  - Payment model
  - “Psychiatric respite care”
  - Separate programs for serious behavioral health conditions
- Strategies for Successful Implementation/Partnerships with Homeless Services

**Cost Effectiveness Analysis:** For the past several years, HCA has been engaged in an informal demonstration to test a strategy for providing MRC to Medicaid patients enrolled in a Managed Care Organization (MCO). There are several approaches to conducting a comprehensive cost-effectiveness analysis and understanding the full cost of MRC. One approach is to compare the cost of MRC to the administrative day rate in a hospital. However, the encounter rate is not the sole factor in determining cost-effectiveness as there are additional factors that should be considered when making a cost-effectiveness assessment including:

- Reduced cost of averted hospital re/admissions
- Reduced cost of hospital lengths of stay
- Value of improved health outcomes and connections to care, especially as they pertain to behavioral health and substance use
- Value of providing care in a less restrictive setting

Further analysis is necessary to estimate the impact of MRC on these additional factors in Washington State. Research conducted on the financial impact of MRC programs on hospitals and insurers in Connecticut and Florida found MRC programs reduced the hospital length of stay by 2 days, reduced subsequent emergency department visits by 45%, and subsequent inpatient admissions by 35%, offsetting \$1.81 in hospital costs for each dollar invested in MRC.

**Moving Forward:** The Centers for Medicare and Medicaid Services (CMS) have encouraged states to consider [how to address social determinants of health](#) in their Medicaid plans. Incorporating MRC into the state’s

Medicaid plan as a statewide benefit with federal funding contribution can be accomplished in different ways, to include through a new or existing 1115 demonstration waiver or 'in lieu of' services available through managed care. Benefits could be added as a 1915 (i) state plan amendment, but the requirement for institutional level of care is less likely to be a successful strategy for MRC. State-only funding would offer additional flexibility. Washington State policymakers will need to weigh the advantages and drawbacks of various Medicaid authorities, noting that some options would be limited to enrollees in managed care. Importantly, requirements for cost-neutrality should recognize and include the value of the broader connections to care, the impact on inpatient/emergency department utilization, and improvements in client health and well-being. State policymakers might also consider start-up funding, guidance to providers, and other factors that would better facilitate program development and expansion moving forward.

Washington State Health Care Authority recognizes the benefits of a statewide MRC service, and is proposing it as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

# Medical Respite Care: A National Model

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People experiencing homelessness (PEH) have high rates of chronic and acute medical conditions, behavioral health issues, and needs for supportive services. As a result, this population also experiences high rates of emergency department (ED) and inpatient hospitalizations. In addition, because they often do not have a safe place to recover once they are ready for discharge, patients who are homeless often incur longer stays in the hospital at greater expense to hospitals and insurers. Those discharged to a homeless shelter (or to the street) who require ongoing care after an acute hospitalization often are not able to manage post-acute conditions, hence having poorer health outcomes and higher rates of ED/hospital re-admissions. Further, homeless services providers (such as shelters) are not trained or staffed to provide medical care and cannot accommodate illnesses, injuries, or post-operative wound care.<sup>1</sup>

To help address these issues, [medical respite care](#) (MRC) programs offer acute and post-acute medical care for PEH who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.<sup>2</sup> These programs provide short-term residential services (often in a shelter or transitional program) coupled with support services and access to medical care. The range of services can vary widely depending on the program, but at the most basic level, programs provide care coordination/care plan development, case management, nursing care, medication and disease management, care transitions and connections to medical and behavioral health care as well as primary care and/or specialty care, connections to benefits (such as insurance, food assistance, identification, etc.), and connections to housing assessments. Importantly, MRC programs are generally intended for clients able to manage their own activities of daily living (ADL) such as bathing, dressing, eating, etc.) and are not a substitute for higher levels of care such as skilled nursing facilities or nursing homes.

## Medical Respite Care

Provides people experiencing homelessness a safe space to recuperate from illness/injury post-hospitalization:

- Medical care & case management
- Help with documentation & benefits
- Medication & disease management skills
- Housing assessments & search preparations
- Ongoing care plan development & care coordination

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<sup>1</sup> Research demonstrating MRC outcomes can be found at [Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care](#) (March 2021).

<sup>2</sup> Note: MRC is also called recuperative care, and is different than “caregiver respite,” a term used in the long-term care community to refer to short-term relief for caregivers.

Health care systems benefit from MRC programs because they offer a safe hospital discharge option for individuals without housing, lower hospital lengths of stay, reduce readmission rates, improve health outcomes for a vulnerable population, stabilize patients with unmet chronic disease care management and care coordination needs, and lower overall costs. Patients benefit from MRC programs because these venues offer a safe space to recuperate and stabilize from illness; connections to medical care, case management, and support services; and help with developing an ongoing care plan.<sup>3</sup> MRC programs that can take referrals from non-hospital partners [e.g., shelters or health care providers, such as federally qualified health centers (FQHC)], may be able to avoid a hospital admission altogether.

There is a nationwide need for MRC programs because of the lack of affordable housing and the significant health care needs of PEH. As of January 2022, there were nearly [120 MRC programs nationwide](#). While these programs vary significantly in their scope and intensity of services, they share the same [defining characteristics](#) and ensure quality of care through [national standards](#) that can be applied to any program model. [COVID-19 responses](#), which emphasized [alternate care sites](#), only heightened the need for MRC and further illustrated the importance of connecting vulnerable people to the post-acute care services normally provided in one's home.

Several states have been using [Medicaid and/or managed care to finance medical respite care](#). Currently, California is in the process of implementing a statewide optional benefit through its [CAL-Aim](#) plan, while other states are currently in the process of considering and/or seeking approval to do so (Michigan, Minnesota, New York, North Carolina, and [Utah](#)).

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<sup>3</sup> Research demonstrating MRC outcomes can be found at [Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care](#) (March 2021).



## Medical Respite Care in Washington State

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There are [eight known MRC programs](#) in Washington State that use different models of care, and additional programs are in various stages of development. Most programs are based in homeless shelters (or other congregate settings) and offer a package of supportive services daily such as care transitions and coordination/medical case management, outreach, medication management, care plan development, education, connections to health care providers, enrollment in benefits, assessment of behavioral health care needs, crisis stabilization, and housing assessments/referrals. In many of these programs, most medical and behavioral health treatment services are provided by FQHCs or other community health care providers.

Two current programs illustrate the wide range of MRC approaches and services in Washington. Yakima Neighborhood Health Services, an FQHC, operates an MRC program that offers all these supportive services plus onsite nursing and behavioral health care, with traditionally billable services provided at its nearby FQHC sites. By contrast, the Edward Thomas House in Seattle (operated by Harborview Medical Center) provides an array of more intensive clinical and case management services through a stand-alone facility. It's onsite medical and behavioral health teams provide care 24 hour/7-days a week, including intensive medical and behavioral health case management, which enables it to serve patients who are more acutely ill, those requiring IV antibiotic treatments, and/or have more complex care needs, including acute behavioral health needs.

Across the spectrum, Washington MRC programs employ teams of service providers that vary depending on the program model. For more basic programs focused primarily on supportive services, teams typically include a case manager, outreach worker, and peer specialist or community health worker. Such programs often have partnerships with FQHCs or other agencies who can provide nursing support as needed. Programs that directly provide light medical services tend to utilize care teams that include nurses, medical case managers, and behavioral health specialists. Higher acuity models (like the Edward Thomas House) tend to have larger care teams that often include physicians or other medical providers, psychiatrists, and behavioral health case managers, in addition to nurses. The Edward Thomas House also utilizes 24/7 milieu managers<sup>4</sup> trained in trauma-informed approaches to prevent and respond to behavioral health crises and has extensive staff capacity for ensuring the safety of patients with active substance use disorders.

One program in King County takes a novel approach to helping people experiencing homelessness with an acute need for psychiatric stabilization but *without* a co-occurring acute medical condition necessitating on-site intensive medical care. Downtown Emergency Service Center (DESC) operates residential facilities in Seattle that it calls "psychiatric respite care" for people in psychiatric crisis who do not require the level of medical support offered by

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<sup>4</sup> A 'milieu manager' is responsible for managing the physical facility and ensuring the treatment spaces are safe, secure, and therapeutic.

the Edward Thomas House. As a result, a subset of homeless patients that in other communities might be referred to MRC is instead referred to DESC. DESC's capacity allows the Edward Thomas House to reserve space for patients who require its unique combination of intensive clinical and supportive services for people with acute medical *and* behavioral health needs. DESC's extra capacity has distinct advantages for caring for PEH, but it also highlights statewide systemic gaps in care for people who are homeless and have unmet serious mental health needs. As addressed later in this report, the availability of Medicaid reimbursement for post-acute behavioral health stabilization and other care, whether that care is provided by MRC programs or other entities, represents a significant community need.

**Current Practice Using Medicaid for Medical Respite Care in Washington State:** The two programs used as examples above—the Edward Thomas House in Seattle and Yakima Neighborhood Health Services—currently receive Medicaid reimbursements through individual, negotiated contracts with the MCO plans serving their areas using the G9006 HCPCS code (coordinated care, home monitoring). Reimbursements are currently either a per diem rate, or a fixed case rate (with an annual or bi-annual cap). The program in Seattle is currently reimbursed for a bundle of services that includes onsite health care services, support services (case management, care coordination, benefits, health education, and medication management), food, 24-hour access to rest/recuperation, and administrative costs. While the program in Yakima provides primary care services nearby at its FQHC sites, they are reimbursed for support services from the MCOs (including transportation when needed).

Washington State Health Care Authority recognizes the benefits of a statewide MRC service, and is proposing it as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

## Feedback from Listening Sessions with Stakeholder Groups

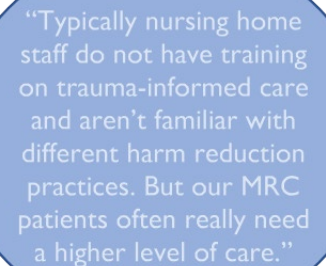
From September through November 2021, 10 listening sessions were conducted with approximately 250 people from the following key stakeholder groups: MRC programs, community health centers/FQHCs, managed care organizations, hospital discharge planners, homeless services providers, Tribal members, and MRC consumers. This section synthesizes the feedback from all these stakeholder groups into three sections:

1. Barriers to higher levels of care,
2. Aspects of a statewide Medicaid benefit for MRC, and
3. Strategies for successful community partnerships with homeless services providers.

## Barriers to Higher Levels of Care

Among all stakeholder groups, there was wide agreement there needed to be improvements in access to higher levels of medical and behavioral health care for PEH. Session participants consistently pointed to two significant issues that impact the ability to safely discharge PEH from the hospital: 1.) the difficulty of admitting higher-acuity patients and/or those with behavioral health conditions to appropriate venues of medical care, such as skilled nursing facilities and nursing homes; and 2.) the lack of medical treatment available in many behavioral health/crisis response venues. Both these barriers prolong hospital lengths of stay, leave PEH with no options for appropriate care, and create downward pressure on many MRC programs to admit more acutely ill patients than they are designed or staffed to serve [e.g., such as those who cannot manage their own ADLs, or those with dementia or unmanaged serious mental illness (SMI)].

**Medical venues of care:** Reasons for difficulty admitting to skilled nursing facilities (SNF) and nursing homes included not having a safe location for discharge, the presence of a behavioral health diagnosis (or anyone on medications for opioid-use disorder), low reimbursement rates, stigma against PEH, lack of training in harm reduction or trauma-informed care, and/or the need for a different type of care (e.g., help with ADLs, but not necessarily 'skilled' care). Patients with dementia (or other conditions) may need assisted living or an adult family home, but the connections to home- and community-based services often take a long time to obtain, are not covered by insurance, and are not reliably available to those without a home.



"Typically nursing home staff do not have training on trauma-informed care and aren't familiar with different harm reduction practices. But our MRC patients often really need a higher level of care."

**Behavioral health/crisis response venues of care:** Reasons for difficulty admitting patients with serious behavioral health issues included an overwhelmed crisis response system that cannot conduct timely assessments, not being able to bill Medicaid for crisis services, and not being able/willing to treat medical conditions. The barriers to higher levels of behavioral health care create intense pressure on MRC programs (and other providers) to accommodate patients with significant, long-term mental health conditions.


To accommodate higher clinical needs, MRC programs are often willing to provide transportation for patients so they can receive health care services in other venues, and they are also willing to receive home health aides and/or hospice care in an MRC setting (when possible). However, they are often unable to bear the primary responsibility for stabilizing such acutely ill patients because patient needs exceed the level of available clinical care in the program.

*Recommendation to consider: Ensure access to appropriate levels of care by improving the ability for all types of providers across the health care system to deliver integrated services.*

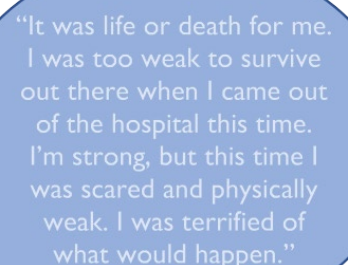
## Aspects of a Statewide MRC Medicaid Benefit

**Value of MRC programs:** Unequivocally, all participants in the listening sessions strongly agreed there was a significant need for MRC programs for PEH, and that there was significant value in these programs across the health care system.

- For hospitals, MRC programs offer a safe and appropriate discharge option for non-acute patients who are in an acute care bed, especially for those needing intravenous (IV) antibiotics, wound care, and other ongoing care but who also need case management and connections to social services. MRC programs also prevent hospital admissions/readmissions.
- For Medicaid managed care plans, MRC programs connect beneficiaries to a wide range of services (primary care, behavioral health, specialty care, etc.), prevent hospital admissions/readmissions, conduct health assessments and screenings, and offer a safe space to stabilize. MCO participants said the demand for MRC regularly outpaces the current capacity of programs to admit patients and would like to see programs further expanded. They indicated the most common conditions referred to MRC include cellulitis, lower extremity wounds, and many different types of infections that require antibiotics/IV infusions or other IV care that sometimes requires six weeks of treatment.
- For FQHCs, MRC programs provide patients with more intensive services coupled with the stability of shelter to help them better manage acute and chronic conditions as well as navigate the health care system. One FQHC notes that patients connected to an MRC program have 3.5 more FQHC visits on average, which is evidence of the stronger connections to outpatient care.
- For patients, the value of MRC goes beyond simply a space to recuperate, receive services, and connect to a broader range of providers. Those who participated in the listening session were frank in expressing how MRC was integral to their very survival due to violence on the streets and how those who are vulnerable are often preyed upon. They valued the safety the program gave them, which was vital in helping focus on recovery rather than worry about survival.



“There’s a lot of things that can *only* be done in a hospital. This problem ends up prioritizing non-acute patients over acute ones—and that’s not how it should work. MRC would help the whole system work better. The importance of the system overall warrants the investments in MRC.”



“It was life or death for me. I was too weak to survive out there when I came out of the hospital this time. I’m strong, but this time I was scared and physically weak. I was terrified of what would happen.”

- For homelessness services providers, MRC programs offer a much safer and more appropriate setting to address medical conditions compared to homeless shelters, which are generally not staffed or equipped to provide the level of medical care clients need. They described regularly trying to accommodate sick or injured clients but having no options for connecting them to appropriate care. This is very difficult on homeless services providers, who feel unable to fix this problem since they are not health care providers.

**Advantages of a statewide benefit:** MRC providers note that a statewide benefit would help standardize MRC as an offered benefit, better sustain programs through more consistent reimbursements, and clarify roles among partnering agencies. Other listening session participants noted that a statewide benefit would increase statewide MRC capacity by offering a more sustainable financing mechanism for starting/expanding programs. In addition, because not all Medicaid beneficiaries are enrolled in managed care, especially Tribal members, a benefit that includes fee-for-service (FFS) beneficiaries would also reach other vulnerable populations.

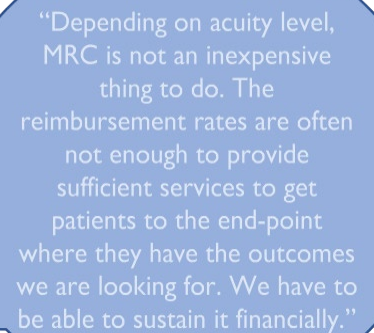
**Services to include in a statewide benefit:** Services available in MRC programs can vary widely, depending on the model of care being employed (as described in the introduction). At a minimum, however, the MRC benefit should support the utilization of multi-disciplinary teams that deliver the following services on a daily (or near-daily) basis:

- Nursing care
- Care transitions (to/from hospital and/or primary care)
- Case management
- Care plan development
- Behavioral health assessments and supportive services, such as case management
- Medication management
- Care coordination to specialty care and other services
- Connections to a housing specialist
- Peer supports
- Enrollment in benefits such as health insurance
- Transportation to medical appointments
- Three meals a day
- Laundry and housekeeping

The benefit should consider that many medical and behavioral health treatment services can be billed separately to Medicaid for reimbursement (e.g., through an FQHC, as is the current practice in Yakima), but that these Medicaid reimbursements may only cover a portion of the costs of providing the level of case management and care coordination required to help many patients complete their MRC medical treatment plans during their stay.

*Recommendation to consider: A statewide benefit that adequately reimburses a bundled package of comprehensive supportive services and lower-level health care services in a medical respite setting.*

**Payment model:** While several possibilities exist for payments (such as fee for service billing for each service provided, or a per patient “case rate”), the consensus in the listening sessions favored a bundled, per diem rate (consistent with the current practice for those already billing). Both MRC providers and MCO staff acknowledged this was the most straightforward way for payments to be structured, and that a case rate is hard to standardize and puts too much risk on the MRC provider. Importantly, however, the rate of reimbursement must cover the costs of the program to keep the program sustainable and achieve the intended outcomes. This includes the cost of staff and supplies, facility maintenance, and all services provided. MRC providers want to emphasize that eligibility for reimbursement should not require facilities to be licensed since they do not offer that level of care, however, ensuring a standard of care remains important to ensure quality. [Note: there is currently no national licensing standard established for MRC.] Finally, tribal providers emphasized their need to ensure they remain eligible for the encounter rate. A payment model would ideally address the episode of care in an equitable and comprehensive way that considers the diversity of funding streams that MRC providers have access to (for example, supplemental payments or encounter rates).



“Depending on acuity level, MRC is not an inexpensive thing to do. The reimbursement rates are often not enough to provide sufficient services to get patients to the end-point where they have the outcomes we are looking for. We have to be able to sustain it financially.”

*Recommendation to consider: A statewide benefit that uses a per diem rate based on costs of care.*

**Tiered payments:** Participants in the listening sessions regularly acknowledged significant differences in the level of services being offered across programs and the corresponding level of staff needed to deliver that care. One approach may be to offer tiered payments to recognize different levels of patient acuity that require progressively intensive services (e.g., establishing “low, medium, high” categories). Consideration should be given to the definitions of each “tier”, so they are appreciably distinct from each other, with corresponding reimbursement levels based on the increasingly intensive package of services provided. This could be modeled on the tiered structure of the [Health Home program](#).

For example, higher “tiers” may support patients with higher needs that require a greater level/number of onsite licensed medical providers, more intensive onsite behavioral health care, 24-hour program staffing, onsite IV-based treatment capacity, or other services. One FQHC is using [PRISM scores](#) to assess health care needs, service utilization, and costs, which could help inform payment rates (although these scores can fluctuate day to day). Some noted that having multiple MRC programs in a community at different tiers offers the opportunity to develop “step-down



respite programs” as patients’ needs stabilize over the course of their treatment. Others believe having tiered programs governed by clear admission criteria would help accommodate higher levels of acuity, though if program criteria are set too low, the needs of the larger population quickly exceed bed capacity.

The disadvantage to a tiered payment is that it could inadvertently discourage flexibility for a program to admit patients with significantly higher and/or lower acuity than established tiers. Reimbursement rates should take into consideration this flexibility and ensure a cost-based rate that includes both average and outlier patients.

Importantly, stakeholders maintain there should be a minimum standard of care established to qualify for a Medicaid reimbursement to ensure decent, quality care. [National standards for medical respite care](#) have been established (which were informed by MRC providers in Washington State) as well as a [framework for tiered program models](#), which can serve as a baseline for quality assurance.

*Recommendation to consider: Consider a tiered reimbursement structure based on program costs, patient acuity levels, level of services and staff, and/or other factors. Identify minimum standards for programs that must be met in order to qualify for reimbursement and ensure quality of care.*

**“Psychiatric respite care”:** While the term “psychiatric respite care” was not a familiar one to those in most of the stakeholder groups, they did point to the significant gap in service availability for patients with serious psychiatric illnesses (also discussed above under “barriers to care”). Listening session participants noted that many patients have multiple comorbidities and readily acknowledged needing to accommodate some level of mental health and substance use disorders in addition to the acute medical conditions that drive their admission to MRC program. To that end, several MRC programs currently have behavioral health staff (e.g., social workers or therapist case managers).

At the same time, they also acknowledged it is quite difficult for most MRC programs to care for patients with significant behavioral health conditions (particularly unmanaged SMI), especially those who do not have a co-occurring acute medical condition. Not only are serious behavioral health conditions unlikely to stabilize or be resolved during a short- term stay, but these patients often cannot be safely managed in most MRC environments if they have acutely symptomatic behaviors that can be disruptive, unsafe, and/or compromise the completion of medical treatment plans (often resulting in suboptimal and/or premature discharges). This patient group changes the fundamental purpose of MRC, which exists to primarily address *acute medical* conditions, and connect to ongoing primary care and behavioral health services.

**Separate programs for serious behavioral health conditions:** The gap in meeting serious mental health needs raises a question of whether separate programs should be created for patients who require intensive behavioral health stabilization services (such as treatment and case management) but do not also need to recuperate from an acute medical condition. It also raises the question of how much extra reimbursement support is needed by MRC

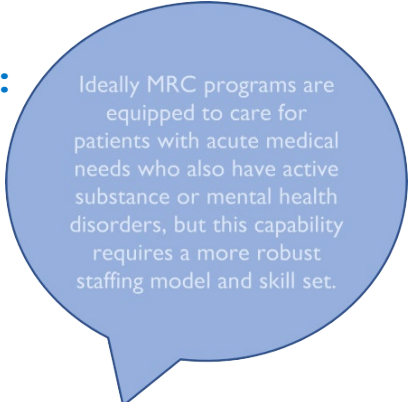
programs, such as the Edward Thomas House, that provide the higher level of case management, milieu management, and other more intense behavioral health services.

The Downtown Emergency Service Center (DESC) in Seattle is an example of a separate program that focuses on more significant mental health conditions and provides 30 days of “crisis respite stabilization” for people recovering from a psychiatric emergency who are discharged from the hospital/ED or from jail. DESC currently does not receive Medicaid reimbursements and is requesting any statewide MRC benefit include psychiatric services when the mental health condition is the significant need. DESC envisions a model with two parts: 72-hours of intensive stabilization followed by two weeks of closer support/stabilization. They note this approach differs from evaluation and treatment (E&T) facilities in that their program is unlocked, provides lower intensity services, and might be viewed as a “step-down E&T program.”

Stakeholders had mixed views on the merits of establishing separate programs to accommodate serious mental health conditions. Key factors expressed on both sides of this issue include the following:

### Perspectives in favor of separate programs for patients with SMI:

- Patients in serious psychiatric distress are generally unable to participate in a medical care plan (which negates the primary purpose of MRC programs) so would be better served separately.
- The longer lengths of stay needed to achieve psychiatric stabilization prevent MRC beds from turning over for other (medical) clients in need, which inhibits overall capacity and service delivery.
- It is extremely challenging for MRC programs to hire the high level of behavioral health staff needed to treat SMI, especially those who bring the needed training and skill set to work with PEH.
- Existing crisis stabilization programs and other behavioral health providers in the community could fill this need if they also provide some medical care.



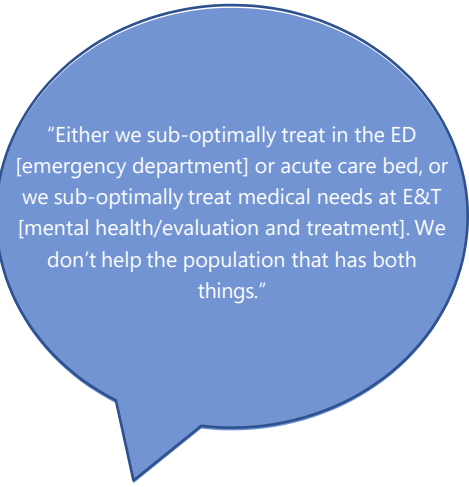
Ideally MRC programs are equipped to care for patients with acute medical needs who also have active substance or mental health disorders, but this capability requires a more robust staffing model and skill set.

### Perspectives in favor of integrated programs:

- Many psychiatric programs will not take patients with any medical or mobility needs (insulin, wounds, a walker/wheelchair, etc.) so the MRC program is often the only venue willing and able to take a patient.
- The time and expense to bring up separate programs (especially where none exist now) is difficult to justify when resources can go toward adding more behavioral health staff, training, and skills to an existing MRC program to help with behavior and/or milieu management.



- Not all providers have a trauma-informed care approach or understand harm reduction, hence patients may not be well-served.
- Establishing single occupancy rooms could help better accommodate patients with SMI and mitigate against the disruption to others in the program.
- Smaller communities (especially suburban/rural) tend not to have many mental health providers, especially for PEH, so will likely not have the option for a separate program.



"Either we sub-optimally treat in the ED [emergency department] or acute care bed, or we sub-optimally treat medical needs at E&T [mental health/evaluation and treatment]. We don't help the population that has both things."

While the issue of separate programs yielded many views, participants acknowledged that this question was largely driven by the gaps in the broader crisis response system, rather than a failure of MRC programs. Some noted that improving the crisis response system is desperately needed, although "step-down" services after E&T discharge are also important to develop. Overall, most stakeholders agreed that the ability to establish separate "psychiatric respite care" programs would be highly dependent on local partners, MRC program capacity, available staff/workforce in the community, and the availability of culturally competent treatment approaches. They note that Seattle has a wealth of partners to help with SMI, and the MRC program there (the Edward Thomas House) is also equipped to take higher intensity patients; however, no other community could claim this level of resources or the number of options for service partners.

*Recommendations to consider:*

- *Improve the capacity and quality of the crisis response system to better respond to the needs of PEH.*
- *For MRC programs choosing to provide care to those with SMI, ensure MRC reimbursements are sufficient to cover the costs of the higher-level staffing and facility accommodations needed (which may inform a tiered reimbursement structure).*
- *Determine whether "psychiatric respite care" is part of an MRC statewide benefit or should be defined and/or reimbursed separately.*

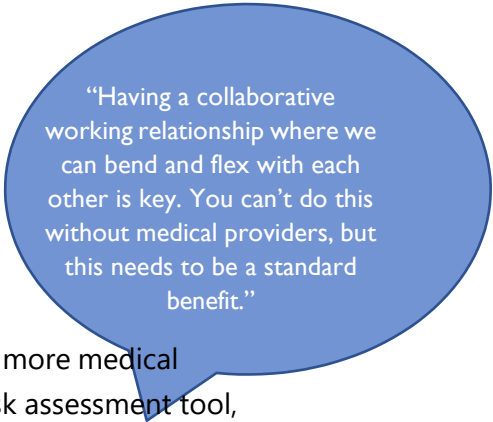
## Strategies for Successful Implementation/Partnerships with Homeless Services

It is vitally important that MRC programs work well in partnership with other homelessness services providers, to include [Continuums of Care](#) (CoC), which coordinate local homeless services and resources. Effective partnerships with homeless services will require separate policy and program decisions (apart from Medicaid) and are largely governed at the local level. Common pressure points between MRC programs and COCs are detailed in [a recent national report](#), and involve issues related to admission criteria and program capacity, coordinated entry and program referrals, medical vulnerability and assessments, ongoing gaps in housing and health care, and the role of other responsible entities. The report also includes a [spotlight on Yakima, Washington](#) as an example of an effective partnership between the MRC program and its local CoC.

Feedback from homeless service providers in Washington State indicate broad support for a statewide MRC Medicaid benefit. They also note that a statewide benefit would yield more equitable access to care because it would facilitate program development in new areas where programs are not yet available (especially in underserved, rural or Tribal areas).

Apart from Medicaid, homeless services providers outlined numerous successful policies and practices that local jurisdictions might consider, as well as those currently in place that should be continued and/or expanded. They cite the following actions that would improve service delivery for people experiencing homelessness:

1. Create numerous opportunities for MRC programs and CoCs to collaborate, communicate, and develop a common language so there is a greater understanding of mutual goals and shared actions.
2. Conduct coordinated entry housing assessments while clients are staying in the MRC program.
3. Consider how vulnerability assessments for housing can incorporate more medical information to determine priority for housing and/or use a health risk assessment tool, like PRISM scores.
4. Categorize MRC beds as “emergency shelter” in the housing inventory count to integrate MRC programs more seamlessly into the continuum, as well as to ensure clients are not inadvertently disqualified from permanent housing opportunities.
5. Discharge MRC clients directly into a permanent housing placement as often as possible (though the length of time needed for this process often exceeds the short-term stays in MRC).
6. Work together to ensure many community-based services are available (e.g., street medicine, FQHC services, laundry, meals, etc.).



“Having a collaborative working relationship where we can bend and flex with each other is key. You can’t do this without medical providers, but this needs to be a standard benefit.”

7. Ensure shelter and MRC staff receive regular training on harm reduction, motivational interviewing, and trauma- informed care.
8. Consider a standardized referral process for MRC programs.
9. Consider holding weekly case conferences between MRC staff and CoC/homeless services providers so that especially vulnerable clients have more coordinated care plans.
10. Collectively advocate for greater affordable housing availability.

## Cost-effectiveness Analysis

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For the past several years, HCA has been engaged in an informal demonstration to test a strategy for providing MRC to Medicaid patients enrolled in a Managed Care Organization (MCO). HCPCS code G9006 (coordinated care, home monitoring) was opened in 2013 to provide an avenue for reimbursement for the Edward Thomas House in Seattle. As described on page 6, the Edward Thomas House is reimbursed a per diem rate if at least one clinical interaction occurs on the day of care (medical care, care coordination, chemical dependency, and mental health care, etc.). If no clinical interaction occurs, no per diem rate is paid. The MRC program at Yakima Neighborhood Health Services was established in 2010, though the program did not start receiving MCO reimbursements until 2015. The MCO contracts in Yakima have different financing arrangements, including paying a per diem rate with an annual cap, a set case rate with annual cap and a set case rate with a two-year cap per patient. [Reimbursements](#) are currently either a per diem rate, or a fixed case rate (with an annual or bi-annual cap).

There are several approaches to conducting a comprehensive cost-effectiveness analysis of MRC. One approach is to compare the cost of MRC to the administrative day rate in a hospital. The administrative day rate refers to the amount a hospital charges for each additional inpatient stay day for those who no longer require acute care but remain hospitalized for lack of discharge options. Currently, the highest amount Medicaid can reimburse for a hospital administration day is \$283.16.

In this context, HCA examined internal Medicaid claims data to determine the day rate for patients already discharged to an MRC setting and where the G9006 code was charged. The analysis showed the average daily MRC rates paid by the MCOs ranged between \$225 to \$350; however, these rates represent an *average* daily rate and do not reflect specific reimbursement levels, which can be lower given different program models.

The encounter rate is not the sole factor in determining cost-effectiveness. There are additional factors that should be considered when making a cost-effectiveness assessment, to include the following:

- Reduced cost of averted hospital re/admissions
- Reduced cost of hospital lengths of stay
- Value of improved health outcomes and connections to care, especially as they pertain to behavioral health and substance use
- Value of providing care in a less restrictive setting

Further analysis is necessary in Washington State to estimate the impact of MRC on these additional factors. As one indicator, [research](#) conducted on the financial impact of MRC programs on hospitals and insurers in Connecticut and Florida found MRC programs reduced the hospital length of stay by 2 days, reduced subsequent emergency department visits by 45%, and subsequent inpatient admissions by 35%, offsetting \$1.81 in hospital costs for each dollar invested in medical respite. One Medicaid expansion hospital in Connecticut found that even after funding 50% of the costs to provided MRC, the net savings would still amount to [\\$1,575 per medical respite admission](#).

## Moving Forward

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The Centers for Medicare and Medicaid Services (CMS) have encouraged states to consider [how to address social determinants of health](#) in their Medicaid plans. Incorporating MRC into the state's Medicaid plan as a statewide benefit with federal funding contribution can be accomplished in different ways, to include through a new or existing 1115 demonstration waiver or 'in lieu of' services available through managed care. Benefits could be added as a 1915 (i) state plan amendment, but the requirement for institutional level of care is less likely to be a successful strategy for MRC. State-only funding would offer additional flexibility. Washington State policymakers will need to weigh the advantages and drawbacks of various Medicaid authorities, noting that some options would be limited to enrollees in managed care. Importantly, requirements for cost-neutrality should recognize and include the value of the broader connections to care, the impact on inpatient/emergency department utilization, and improvements in client health and well-being. State policymakers might also consider start-up funding, guidance to providers, and other factors that would better facilitate program development and expansion moving forward.

Recommendation: Explore with federal authorities and state policymakers how best to implement a statewide benefit that yields the most positive, equitable health outcomes for Apple Health enrollees who are homeless, while also optimizing the managed care flexibilities allowed by federal regulation. Continue forward with plans to include medical respite care as part of Washington State's Medicaid Transformation Project Section 1115 Demonstration Renewal Request as a health-related service for Apple Health enrollees in both managed care and FFS delivery systems.

### Other issues for policymakers to consider:

- **Start-up funding:** Assist new MRC programs with funds to help build capacity, support Medicaid billing systems, and negotiate with MCO plans.
- **Guidance to providers:** Provide guidance to MRC providers on standards of care/quality measures and how to effectively use the new Medicaid benefit (to include coding on claims). Require eligible providers to complete a certificate of attendance at relevant education and training courses aligned with current practice for Department of Commerce housing and emergency services providers (e.g., trauma-informed care, motivational interviewing, harm reduction, etc.). As national training opportunities continue to become available, require MRC providers to [complete standards of care training](#), conduct an annual [organizational self-assessment](#) of their program's fidelity to the standards, and [request technical assistance](#) as needed.
- **Telehealth provisions:** Include MRC programs in any policies that allow for the delivery and reimbursement of care through telehealth.
- **Housing availability:** Increase the supply of supportive housing so more patients can be discharged from MRC directly into a permanent, stable home.

- **Referrals:** Consider allowing referrals to MRC programs from a wider range of referral sources (beyond hospitals), to include FQHCs or other providers, shelters, and others as appropriate.

## Appendix: List of MRC Resources

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- Policy Brief: [Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs](#)
- Case Study: [Spotlight on Yakima, Washington](#)
- [Medical Respite Care Programs: Models of Care](#)
- Literature Review: [Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care \(Executive Summary\)](#)
- [National Standards for Medical Respite Care Programs](#)
- Medical Respite Care Organizational Self-Assessment: [Online](#) and [PDF Guide](#)
- Policy Brief: [Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care](#)
- Policy Brief: [Medical Respite Care Programs & the IHI Triple Aim Framework](#)
- Policy Brief: [COVID-19 & the HCH Community: Medical Respite Care & Alternate Care Sites](#)
- Research: [The Business Case for Medical Respite Services \(2016\)](#)